

Politics of Health Care Are Pulling Doctors Down

By Niranjan Kissoon, MD, CPE, FACPE, and David Matheson, MD

Physicians of all ages, nationalities, and specialties are disillusioned with the present state of their profession. They are unhappy to the point that many have stated they would discourage their children from pursuing a medical career.

The reasons for this dissatisfaction include heavy workload, unreasonable patient expectations, loss of autonomy and an inability to fully understand and deal effectively with non-clinical aspects of practice.

These corrosive influences are not new nor did they sneak up unnoticed. Yet many of us are unprepared. It is also obvious that, at least in the foreseeable future, these factors will continue to exist. How then can the negative impact of these factors on medical practitioners be minimized?

Non-clinical impact

An examination of the differences in stress and burnout between pediatric generalists and subspecialists is instructive in pinpointing reasons for stress. Generally stress and burnout occur to a higher degree in physicians who spend a greater part of their professional life working in inpatient services.

An extensive survey by the Career Satisfaction Study Group suggested the need to balance outpatient and inpatient hours in order to relieve stress.¹ Having spent most of our lives in the inpatient arena we can appreciate the reasons for these differences. It is not that stress is absent in outpatient practices or in private practice but that these practitioners may have a greater feeling of being in charge.

Another reason for stress in inpatient settings may be the lack of formal training in dealing with issues such as managing conflicts within teams and managing stress effectively.²

A study of the metamorphosis from medical student to seasoned professional unearths some of the reasons for disenchantment in inpatient settings. These sentiments

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To help curb disillusionment, medical students and residents should be introduced to the politics of health care early in their careers.

are condensed from thoughts expressed to us by medical students, residents, and junior and senior colleagues for many years.

Here's a look at the changes:

Medical school — I will treat my patients according to the Hippocratic oath. I will have an exciting career and the sky is the limit. I am ecstatic by my choice of career. I will be too busy curing diseases to involve myself in "politics" and will leave those to others.

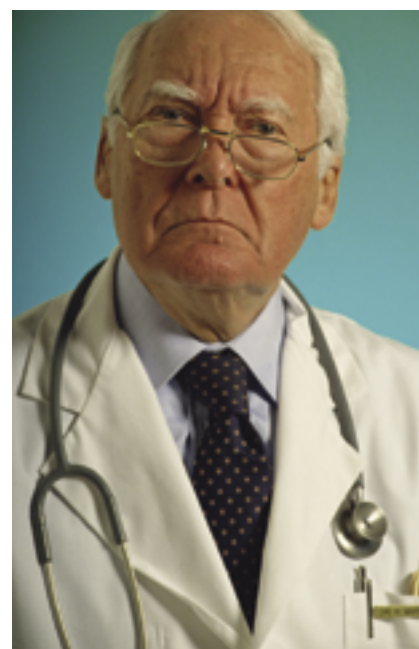
Residency — I will do a good job, I will continue to treat my patients at the exclusion of everything else. I am happy with my choice of profession. I will not get into the politics of this business because it is not medicine.

Early years on staff — I will treat patients well. I will do what is right for my patients and my family. I am getting dissatisfied with my job. I will tackle some political issues because it seems to be important to enable me to take care of my patients.

Later years on staff — I am unable to do right by my patients. I am disillusioned and stressed. I am drawn deeply into the politics of our organization that I do not understand or feel trained to handle. I want to get out of medicine.

We contend that while there are myriad factors that may lead to disillusionment in physicians, the root cause is inadequate preparation in their formative years to deal with political, non-clinical issues.

This transition from bright-eyed, eager medical student to jaded, disillusioned, dissatisfied senior physician is not uncommon



It is difficult to stay silent when the conversation with a medical student or resident finally comes around to the politics of medical practice. It is difficult because we admire unbridled enthusiasm and wide-eyed innocence in treating patients.

Enlightened physicians realize that attention to patients and grappling with politics are not mutually exclusive. However, one of our failings as educators and mentors is we protect our trainees from the realities of practice.

Medical students and residents are self-selected, highly motivated individuals who are eager and impassioned to do good, to push back the frontiers of science and change the world to benefit their patients.

They are idealist and driven to do what is right. They usually have a clear vision of what a physician should be. They adhere to the Hippocratic oath and have for the most part a romantic notion of medical practice.

They learn physiology, biochemistry, anatomy, have high IQs, high emotional intelligence and,

like professional athletes, they hone their skills in a narrow field. At this stage of their career they think in terms of diagnosis pathophysiology and treatment of diseases.

Invariably they are shielded from the day-to-day personal interactions that we face. They are shielded from the radiologist or laboratory refusing to do a particular test, the transfer of patients out of the ICU as a response to pressures rather than the dictates of good care.

It is not uncommon to have in-depth discussions of pathophysiology and diagnosis for hours while many equally important issues relating to socialization, professionalism and market imperatives are shrugged off with the refrain “when you get out there you will see.”³

Consequently, the realities of competing commitments in administration, research and patient care are foreign to them. Indeed both parties contribute to this neglect because, when invited to discuss these issues, trainees are reluctant because it is perceived as unpleasant and unrelated to medical care.

Memories of the undergraduate days recede rapidly and new graduates are soon faced with unpleasant realities.

Let us take, for example, a young pediatric emergency physician. In the emergency department on one shift he may be faced with long emergency department waits, angry parents, parents leaving against medical advice, the radiologist refusing to perform a head CT, the laboratory not having timely sickle cell tests and lack of ICU and inpatient beds.

This physician may complain to the chief of radiology who may suggest that she write a protocol for obtaining CT scans in patients. The laboratory chief wants the physician to obtain support from other services such as critical care, surgery and anesthesia before the sickle cell test will be made available.

In the pediatric intensive care unit the junior physician faces similar daunting tasks. Apart from juggling complex deranged physiology, he now has to make many decisions. Should a patient remain in house or leave the ICU to stabilize. Should an unstable child

Administrative and Professional Educational Needs of Clinicians*

Medical Students

- Patient Safety Realities
- Principles of Quality Improvement
- Ethics
- Communication Skills
- History of Medicine and the Medical Profession

Postgraduate Trainees (Residents and Fellows)

- Patient Customer Relations and Communications
- Information Technology
- Economics of Practice
- Multidisciplinary Team Building
- Medical Jurisprudence

Junior Staff Members

- Chairing Successful Meetings
- Decision Analysis Skills and Biostatistics
- Cultural Conflicts between Corporate and Clinical Medicine
- Comparisons of Administrative and Clinical Decision Making
- The Economic Dimensions of Health Care including Cost-Effective Care

Mid-Career Staff Members

- Principles of Population-Based Medicine
- The Political and Social Underpinnings of Health Care Reform Efforts
- Political and Professional Options for Preserving Medical Professionalism

Senior Staff and Physician Leaders

- Principles of Organizational Justice
- The Political and Social Underpinnings of Health Care Reform

*Many of these topics may have to be revisited at different stages of a physician's career. The timeline is suggested for introduction of the concepts.



be transported to another facility eight hours away.

The young doctor's surgical colleague may be angry because of cancelled surgeries. And parents of patients are angry because they received conflicting opinions by the nurse and the resident.

It is obvious from these vignettes that the idea of avoiding politics is not realistic. Being unprepared results in the acute stress and germinates the seeds of distrust and disenchantment. It is therefore not surprising that physicians, especially those with inpatient practices, are disillusioned.

As a colleague states "I am a nicer person at 0800 hours than I am at 1600 hours. I was also more pleasant, happier, and nicer when I arrived here a few years ago than I am now."

Ways to adapt

There are many books and manuscripts outlining methods to combat our disillusionment and feeling of betrayal and anger at our present predicament.

Faced with the reality that being apolitical is not in one's best interest may broaden our consciousness, and weaken and strengthen us in ways both petty and profound.

Some physicians adapt and in a short time many find themselves volunteering for various committees such as laboratory steering committee, finances committee, medical charting and quality assurance committees. There is wisdom in this move in that it is easier to control your destiny from the inside rather than from the outside looking in.

However, participation is a double-edged sword and may be one of the underlying factors in the dissatisfaction of practice in inpatient settings. This may stem from the fact that writing a business proposal, understanding the corridors of power, reading a financial bal-

ance sheet and running an efficient meeting are not the strengths of these physicians.

Paradoxically, participation in these committees may lead to even more disillusionment, feelings of helplessness and loss of self-control. This transition from bright-eyed, eager medical student to jaded, disillusioned, dissatisfied senior physician is not uncommon; nor is it unpredictable.

The question is how can this cycle be prevented or interrupted?

Fishing upstream

We contend that a crucial element in short circuiting this trajectory should be an educational curriculum for undergraduate and postgraduate students that provides them with the tools to function in the real-life environment.⁴

We do not pretend to be experts in crafting this curriculum, however we offer in Table 3 some of the elements that should be included. This list is not exhaustive. However, the overarching principle should be a curriculum that enables one to work effectively in corporate medical environments while maintaining traditional professional values.⁵⁻⁷

"Education to defend professional values in the new corporate age" as suggested by Arnold Relman, MD, will likely decrease the anguish about the conflict between traditional professional values and the imperatives of everyday practice.

Educating budding practitioners on the realities of medical practice will be a great service and expose them to the non-clinical administrative side of medicine.



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