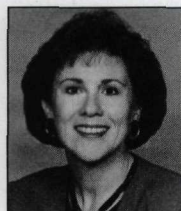


VOCATION LOST?

Hospitals Must Bring Physicians Back into the Mission of Medicine

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Are physicians as “present” in today’s health care as they were in the past? Hardly. The doctor is *not* in anymore—at least they’re not in hospital corridors making rounds or voluntarily attending meetings to monitor and improve care.

The physicians’ parking lot at the average medical center has many empty spaces, even at 7 am, the prime time for physician rounds of hospitalized patients. Now that 80 percent of surgery is done on an outpatient basis, many surgeons base their schedules on attendance at outpatient surgery centers—and reduce the time they formerly spent at hospitals. Hospitalists respond to patient problems that occur on evening and night shifts, further reducing the presence of specialists. Meanwhile, primary care physicians often work entirely out of their offices, referring all hospital admissions to other doctors.

Medical staff meetings reflect these changes. In the past, at least half of the staff would attend such meetings. Nowadays, only a sprinkling of officers, paid medical directors, administrators, and the vice president of medical affairs show up. And they talk mainly to themselves.

The fact is that doctors today are no longer “in” the typical U.S. hospital. And even when they are physically present, they may not be psychologically present to the organization in a meaningful way.

The consequences of this relative absence are enormous. Physicians essentially authored the high quality found in the nation’s hospitals, including advances in patient care and medical science. At the heart of the physician’s vocation is a dedication to treating humanity’s ills with skill and compassion. And this dedication has traditionally been exercised within a medical culture that defined the physician’s relationships with

patients, colleagues, and community. But, in recent years, this broader culture of medicine has been evaporating. Worse, the centrality of the *hospital medical staff*—defined by its historic purpose, prestige, and power—has dimmed in the face of multiple forces acting on it.

LOST PASSION, PROFESSION, PARTNERSHIP

Many influences have worked to erode the historical solidarity of the local medical community. On the national level, these influences include (among many others) advances in technology, reimbursement incentives and disincentives, and the advances of science that have changed the locus of care from inpatient to outpatient.

The medical community has, moreover, been thrust into greater overt competitiveness, different in character from the more graceful (although energetic) traditional competition for patients that was based on affability, availability, and ability. Physicians today tend to identify themselves as medical specialists or even investors, rather than as members of the greater community of physicians, or a particular medical staff, or the local medical society.

At the local level, efforts by managed care organizations to divide and conquer the medical community—as well as physicians’ involvement in business ventures, group mergers, and asset sales—have increasingly focused doctors’ attention on economic matters. Such a focus tends to marginalize medicine’s societal role—the very role linking doctors to the charitable institutions in their midst.

Less noticeable events separate the practicing physician from his or her hospital or peers. For example, some medical staffs have made staff meetings voluntary rather than mandatory. As a result, an important social milieu has disappeared,

a milieu in which the social aspects of the physician's role were reinforced.

Dwindling joy in the practice of medicine is a more insidious force for disengagement. Two decades of complaints about the cost of medicine by those paying the bills have subtly helped to redefine medicine as a *business*, and an inefficient one at that. Medicine is a business, according to many, characterized by "relative value units," "diagnosis-related groups," and compensation formulas that "incent" proper care. All these terms dehumanize the most profoundly human of professions. The business focus reduces those who practice the profession to "providers" or "contractors," updated terms for tradespeople.

The experience of medicine as a calling atrophies. The *vocation* of medicine (as distinguished from its practice as pragmatic activity) is integral to doctors' practice. A vocation compels right action, inspires sacrifice, holds a covenant with excellence on behalf of the patient, and provides a deep sense of spiritual and professional satisfaction in a physician's life.

Meanwhile, overburdened hospital executives, who are just as focused on *their* economic chal-

lenges, have quietly drifted from a core professional practice of their own: caring, respectful, and frequent engagement with physicians in the day-to-day life of the hospital.

For a variety of reasons, then, this diminished sense of medicine as vocation has reduced doctors' participation in the communal, civic, and societal activities of their profession, one of which is collaboration with the hospital and its mission.

CONSEQUENCES ARE BOTH PRACTICAL AND PROFOUND

The practical consequences of reduced physician presence—physical, professional, and psychological—are numerous.

Medical Staff "Citizenship" Physicians' sense of themselves as "citizens" of the hospital tends to evaporate. As a result, it becomes hard to find people to participate in quality-improvement efforts, evaluate new candidates for the medical staff, mentor neophytes, and take leadership roles.

Peer Review Physicians become more tightly focused on their own practices and less willing to perform the traditional duty of peer review.

Bedside Care Clinical care at the bedside is subtly hampered. The potential for error and poor care

Essential Ingredients of the Physician-Responsive Hospital

If it is to have an effective medical staff, a health care organization must first possess:

- A board of trustees that is respectful of the physician's role and dedicated to fostering partnership.
- A CEO who, greatly respecting physicians, strives to have a relationship of candor, integrity, and frequent interaction with them. Relationships are essential and cannot be limited to those doctors in leadership roles. The CEO must care about physicians as people and professionals.
- Senior team members who model the same physician- and patient-centric values, and who regularly engage doctors in dialogue.
- Support for the organized medical staff. This support will be evidenced in many ways, ranging from the close attention staff members pay to critical issues to the loyalty they give to the chief medical officer.
- Outstanding nursing and ancillary care. When evaluating hospitals, physicians routinely rank "quality of nursing care" more highly than any other category.
- Operational and programmatic excellence, including excel-

lence in such key operational attributes as surgical starts, anesthesia quality, availability of beds for patients referred from physicians' offices, timely scheduling of procedures, resources for investment in specialty programs, the presence of well-trained associates, and information technology.

- Transparency in economic matters, including a description of principles adopted by the board of trustees and published for all to see. These principles outline the circumstances under which the organization will make economic decisions and the methods it will use in doing so. Ideally, these principles are developed with the participation of the medical staff's leaders.

- Services designed to help physicians, ranging from providing hospitalists to arranging office or group management. Hospitals should support doctors' quality-improvement efforts by supplying highly qualified support staff and nationally accepted clinical benchmarking databases.

- Adequate physical resources, including dictation areas, sleeping areas for physicians, and high-quality surgical equipment.

increases because physicians sometimes do not even know the specialists to whom they refer patients. Strangers do not make good care coordinators. Because staff physicians make fewer hospital rounds and spend more time on outpatient practice, the care they provide has a greater likelihood of being suboptimal.

Quality and Safety Although U.S. hospitals have been challenged in recent years to improve patient safety and overall quality, their ability to do so will be limited if they lack a wholehearted partnership with a core medical staff.

Even more profound consequences are likely when physicians absent themselves from medical staffs in mind and heart as well as physically. When that occurs, hospital administrators who are responsible for sustaining a health ministry lose irreplaceable partners in collaborating to improve patient care. If administrators are unable to reverse this trend, they may find themselves presiding over the diminution of the priceless qualities that are traditionally associated with the idea of medicine as vocation—compassion, dedication, love, pride of work, and a deep sense of responsibility for medicine in a hospital community. Without that sense of vocation, hospitals may lose their status as communal institutions

and instead become the site of purely commercial transactions.

ADDRESSING THE PROBLEM

Nothing less than renewed inspiration in the medical profession will fully restore the partnership between hospital and staff physicians. Hospital leaders must find some means of dealing directly with the frustration, cynicism, and hopelessness engendered in physicians they work with every day. Nearly all physicians go into

medicine *to do good*. They desire to use their intellectual talents, honed skills, and judgment to make a difference in the lives of patients and in society. They have been trained to sacrifice sleep and well-being to provide excellent patient care.

Hospital leaders—board members, administra-

tors, and mission leaders—cannot by themselves rebuild the traditional medical staff. Nor can they expect physicians alone to divine solutions to the anomie of the medical community. But hospital leaders cannot afford to wait for someone else to solve the problem. They must begin now.

Five principles can guide them. These principles are not limited to problems involving medical staffs. They are applicable to effective organizational change in general. The principles are:

- Relationships are at the heart of influencing others and creating momentum for change. They are essential to creating a new, satisfying local culture for the practice of medicine.

- Intangible and intrinsic motivations are more powerful sustainers of behavior than tangible, extrinsic ones.

- Local change is more easily achieved than global change.

- It is necessary neither to know all the steps in a plan nor the eventual shape of the outcome. What is important is taking the first steps, gaining the good will and participation of others.

- Physicians and administrators must work *together* to ignite the heart and soul of medicine.

It will take only a few people to start the effort—as long as they are the *right* people. I believe that simply beginning the conversation about physicians' attitudes and the joy (or lack of it) they take in the contemporary practice of medicine, combined with a discussion of what medicine could be, will evoke a powerful dialogue and unleash both ideas and a "path" to follow.

FOSTERING THE PARTNERSHIP SPIRIT

Although I intend in this article to offer suggestions about reconnecting physicians to medicine-as-a-vocation, I realize that such reconnection cannot occur without ensuring that the day-to-day experience of the practicing physician is positive. Elsewhere in the article is a short list of fundamental attributes that should characterize health care organizations seeking to rebuild their medical staffs (see **Box**, p. 55).

How do we start? We need five things.

A Compelling Vision That Speaks to Medicine's Highest

Purpose The forces surrounding health care today, especially those demanding improved patient outcomes, are good tinder for igniting physi-

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icians' passion to practice high-quality medicine in their communities. At the beginning of the 20th century, physicians led the crusade for new standards and science-based practice. If board members and administrators encourage and support their efforts and reinforce their contributions, they will do so again.

The effort must be spearheaded by the hospital's leading physicians, who will fashion a new vision of the medical staff and set inspiring goals for quality, safety, and staff excellence and skill—and for physician satisfaction and performance. The time has come for the medical staff to redefine and rearticulate its mission vis-à-vis the community, and for the hospital to commit itself to collaboration in fulfilling this mission.

Resources will be required to fulfill the mission; without them, the goals will be hollow. The hospital must invest in systems and capabilities directly aligned with the new vision of excellence. Capital will be needed for robust clinical data systems, support staff for teams, and high-quality training. At each hospital, physicians and board members will together determine how much of the medical staff's contribution to improved quality is to be compensated and how much is to be voluntary. By traditional definition, a *profession* consists of men and women who, following a common calling, insist that all involved seek the highest possible levels of quality. The medical profession has no business relinquishing, ignoring, or refusing this obligation of medical staff membership.

A Contemplative Opportunity Ultimately, renewal of the healer's vocation must include a reawakening of the sense of the holy, a sense that his or her work has a significance transcending simple survival in the human world. Physicians, immersed as they usually are in the busyness of a challenging profession, have little time to ponder the fruits and frustrations of their journey.

The great faith traditions, certainly including the Catholic tradition, confirm the value of contemplation—reflection, prayer, and dialogue as a means of discovery of the sacred in one's life. A retreat experience can help the weary and perhaps disillusioned physician remember the purpose of healing and its profound impact on human life. Catholic (and other) hospital systems often sponsor annual leadership retreats enabling manage-

ment, board, and physician leaders to experience a sense of unity, share learning, and nourish a mutual commitment to health ministry. It might be helpful for the members of a hospital's medical staff to conduct a retreat in which they could contemplate their mission.

Or the medical staff might hold an annual lecture on "The Vocation of Medicine," focused on the human, spiritual, and universal issues confronting physicians and on the value and meaning of service. Ideally, such an event is a communal opportunity for reflection that can serve to strengthen a shared identity. Catholic organizations are in an ideal position to jointly develop the expertise needed to do this well.

Rebuild the Professional Community All people seek to belong to groups that nourish their values, offer important connections, provide a sense of belonging, and give support in difficult times. Hospitals could hold yearly dinners for physicians and their spouses to thank them for their contributions to the community.

Hospitals should also encourage experienced physicians to mentor those who are just beginning their careers. Such mentoring, usually involving the senior member of a practice and his or her junior, used to be more common than it is today. The hospital could design an orientation program for new physicians. Such a program might bring new doctors and their spouses together for an evening (or weekend) focused on the hospital's mission and ministry and on providing opportunities to contribute to that mission. If done well, this could be a superb opportunity for new doctors to feel valued by the institution and the community it serves.

It is essential to recreate the medical staff as an honored, effective, and respected agent of community care. Accomplishing this will take firm leadership, strong conviction, and the collaboration of board members, medical staff leaders, and administrators.

Physician Leadership Development and Physician "Formation" The times demand that health care organizations invest seriously in the training of physicians willing

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to sacrifice time and treasure to lead their colleagues within the medical staff. It makes no sense for organizations to appoint physicians to lead quality councils and then deny them the tools and resources they need to accomplish their work.

In Catholic organizations, leadership development should also provide an opportunity for "formation," defined as the experiences and events that will, throughout the physician's career, encourage him or her to become a better

healer. Developing self-awareness, enhancing one's capacity to recognize spirit as a vital part of healing, learning to see the patient as a whole person (versus focusing on the object of one's specialty, like a fractured bone), and learning to see the holy in suffering and illness—these, among others, are elements of the formation experience. Obviously, because in most cases different faith traditions will be

represented on a medical staff, such experiences should be discussed ecumenically. But there are ubiquitous elements transcending religious differences that can enrich a formation experience based on medicine as a holy calling.

Honor and Recognition Perhaps nothing characterizes modern culture so much as an absence of heroes and heroines. In health care, we sometimes seem to be focused on problems, rather than on the

everyday good done by physicians and other clinical team members. Whether they admit it or not, many healers are saddened by the fact that they no longer feel honored and valued by the larger society. Although physicians acknowledge that their patients seem to appreciate them (and polls affirm this), news stories often seem to cast doubt upon the overall integrity and values of the profession and its practitioners.

It is impossible to overestimate the impact of such criticism. A hospital and medical staff must do what the larger society does not—counter the barrage of criticism with the recognition of the daily reality of sacrifice, clinical excellence, voluntary leadership, and good patient care. What we who work in health care honor and celebrate becomes a powerful symbol of the culture we wish to sustain. Hospitals and their medical staffs—if they wish more excellence, more compassion, more sacrifice, more contribution to the common good—must honor and thank those who personify those values.

A TIME TO ACT

Virtue cannot be sustained without teaching, reinforcement, recognition, articulation, and passion. If we health care leaders wish to ensure that medicine remains both a vocation and a profession, if we wish to sustain a proud and rewarding partnership with physicians, we are obliged to consider what we can do. We can begin with a dialogue among ourselves about the real state of affairs. Following that, we should begin a conversation with our physicians about what *could be*. ■