



'May You Live in Interesting Times': OK, Enough Already!

BY DAVID J. BACHRACH, FACMPE/FACHE

I set out to write a "nice" article and found myself writing things that I know will be provocative to many and downright unpleasant to some. After thinking about the fact that some will be offended by the suggestion that our behaviors have the potential to become more than unpleasant (think *Lord of the Flies*), I offer the following as what "could be" as we confront tough times in the next few years. Let those who are concerned that this could actually be the case respond by engaging with their colleagues in dialogue about how to overcome these challenges without damaging, or even destroying, the vibrant academic communities within which we live. Those who would ignore the potential for sliding down the slippery slope toward chaos do so at their own peril.

Read the newspaper, listen to the radio and TV... the financial markets are tanking, our 401(k)s/403(b)s are worth barely half of what they were a year ago, and 78% of surveyed physicians find the practice of medicine less satisfying than it was only five years ago.¹ Not a day has gone by in the past month when MedCenterNews² hasn't reported on budget cuts and staff reductions at medical schools and teaching hospitals. It all makes you want to crawl under the covers and wait for this all to pass. However, hiding under the sheets is not an option for most of us. Changing times call for changing behaviors—some for the short term, whereas some we will need to change forever.

The individual faculty member may feel powerless, sensing that all the decisions are made in the "Star Chamber" on the top floors of the medical school and the hospital. In reality, many of those working at high altitudes are similarly anxious, as they consider options that will allow the organization to ride out the rough waters ahead. The solutions need to be discussed at all levels, as we all will need to be active participants in the solutions.

Most will ride it out. Illnesses will continue to plague us, and people will continue

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to turn to American medicine for care. Our nation will need physicians to be trained, and will expect science to continue to provide solutions to the many problems we face. Health care resources, as well as all resources, will likely become more scarce before we, as a nation, stabilize and resume moderate economic growth.

However, what we do—and, just as important, how we do it—is likely to require dramatic change. The degree and pace of change may make for interesting times for the careers of those who have joined the field of medicine and health care

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since the turn of this century, a period of nearly a decade during which our nation has seen no economic growth for the first time in nearly 70 years.³ Those who joined the field with me 40 years ago may feel a sense of loss as the covenant we embraced then seems to have been compromised, if not broken entirely.

The challenges we face are broad and deep, but space here allows for us only to explore a few. We'll leave the macro issues of how the nation will serve all its citizens, as well as organize and pay for health care and medical education, to others. Let us look at the factors that are most likely to disrupt the lives of faculty in academic medicine in the near term, and what we may be able to do about these in the decade ahead.

Forces that Would Throw Us Out of Balance

This is not a new problem—but it is being exacerbated by the pressures we are now facing. Reduced funding from all sources (state funds cut back; federal funds for research flat at best, with eroded purchasing value⁴; reduced reimbursement for clinical care while the cost of practice increases; increasing tuition leading to average student debt approaching \$200,000 upon graduation; etc.) and increased pressures are upsetting our sense of balance. Several factors will change our heretofore seen-as-acceptable equilibrium.

Faculty time is being assaulted as never before. The number of clinical and basic science faculty in the academic track grew several-fold from the 1960s through early 1990s, but that number has been nearly level for the past many years. Although faculty growth continues, it has been most dramatic in the non-tenure-eligible clinician-educator track.⁵ All private medical

schools, and now virtually all public medical schools,⁶ depend on their faculty to generate a majority of their salary and operating support, either directly through research grants, contracts, and clinical practice, or indirectly through support from affiliated teaching hospitals through the margin produced from the admission, care, and treatment of patients. These revenue-generating activities compete with fundamental research (which may lead to sponsored support), teaching, as well as time for intramural citizenship activities such as service on committees, mentoring, and other generally uncompensated activities. This comes at a time when medical student class sizes are increasing, and even greater rigor needs to be applied to the curriculum and educational process.

We are seeing the early stages of an even more troubling phenomenon, as those joining our faculties now come from the era of the 80-hour resident workweek. They leave their training looking for a relative improvement in their life-work balance and are paired with more senior faculty who will, in many cases, be working longer hours than they are; this is not what our senior faculty were anticipating when they moved into their 50s and 60s. And this comes at a time when there is talk about an even further reduction of the maximum resident hours worked, which will further exacerbate this issue.

Physicians just out of training must make a choice between the several styles of private practice and a career in academic medicine. They have already chosen a specialty undoubtedly not so innocently influenced by the size of their student debt. Now, the option of academic practice will be even more challenged if the gap between academic and community practice salaries erodes further, as it may if there is a renewed shift of CMS patients to academic medical centers and public hospitals and away from private practitioners. The potential for generational conflict is great as these factors converge.

The leaders of academic communities (deans and department chairs) must address these complex factors in a way that allows for their institutions to maintain a balanced portfolio of activities; attract and retain faculty, students, and trainees; and remain compliant with all the accreditation requirements—all this while they deal with the unknown changes that face them at the macro level.

Faculty recruitment will be difficult in the next few years as positions that might have become available due to retirements remain filled by those who are uncertain that their retirement savings won't expire before they do. Further, those who are unsure that they can sell their house and recover its previously perceived value are unwilling to commit to a move and the acquisition of a new house. In addition, the opportunities for those with a "trailing spouse" may be in doubt, as other departments in the institution or employers in the area have less flexibility to make offers that will preserve the security of a two-income family.

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wasteful processes and underperforming activities from their portfolios. We may expect to move even further toward a productivity compensation program, with greater rigor applied to determining the economic value of each faculty member's contribution. Senior faculty who enjoy the benefits of health and long life as much or more as the population in general will continue to be reluctant to retire for as long as the financial markets remain sketchy. The use of resources (especially office, clinical, and laboratory space and staff) by all faculty will be carefully allocated in order to assure that maximum value is received for the cost of the investment.

We may expect to see an increasing incidence of conflict between specialties whose domains converge. Minimally invasive specialties now practiced by imagers or radiologists will impinge on the practices that were formerly the exclusive purview of surgeons. Other procedures previously performed by surgeons are now increasingly the province of physicians formerly thought of as internists. Specialists may find their domains too narrowly defined and begin to recast themselves as comprehensivists. Primary care specialists will look for a way to establish their place as care managers and leaders of the medical home. Competition for patient "turf" may get more

predatory as resources become more scarce and undesirable behavior produces schisms in the medical community.

What We Can Do

Sometimes the best solutions are simple, timely—and ambiguous. As Americans we generally don't select actions of this nature; rather, we look for those that are comprehensive, complex, and politically correct. We often begin by working on factors that are well beyond our boundaries to control. However, we should first focus on that which we control, and then on those things that we can clearly influence.

We need to take action—quite likely including the following:

- ❖ Focus on actions that will build a more closely knit community. Embrace mentoring down, across, and up the organization. Make it a priority to convey values, as well as knowledge and skill, to others in our community. Take care of one another. Look for signs of burnout and intervene by lending a willing hand and an open ear.
- ❖ Align our members with one another, and with the activities that are most important to our mission. Focus our resources in areas that will allow us to advance our vision toward our well defined goals. Make it a goal to thrive as an organization, not merely survive.
- ❖ Embrace values that strengthen our bonds to one another and to those we serve. Do not let the unsavory characteristics that so often emerge during such periods of stress undermine and overtake us.
- ❖ Allow us the discipline to distinguish the urgent from the important, and allow us to focus the majority of our energies on the latter. Strip energy-depleting waste from our processes so that our precious resources can produce the most benefit for the least investment.
- ❖ Permit us the wisdom to reclaim the resources now committed to the least important things in our codex and redirect these precious resources to those important activities that lie before us such that we will not become stagnant for the lack of new and incremental resources, for these will be few in the ensuing years. Rather, allow us to be innovative and creative as we move the

edge of knowing ever forward, narrowing the “knowing–doing gap,”⁷ for into that chasm falls much that is precious.

- ❖ And finally, let us treat one another with dignity and respect. Let us capitalize on our differences as we pursue the art, as well as the science, of medicine in the years to come for the benefit of those who will follow us.

Notes

1. MGMA Connexion, February 2009, p. 8.
2. www.medcentertoday.com, Jan. 12–Feb. 17, 2009.
3. *New York Times*, Feb. 16, 2009. On Feb. 23, the Dow returned to its 1997 level, a 12-year low.
4. The recently passed federal stimulus bill includes billions of dollars for the NIH and recent statements by President Obama speak to his commitment to reform health care beginning in 2009.
5. *The Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work*. AAMC, 2008.
6. With the exception of the VA-funded medical schools and the Medical School at Uniformed Services University of the Health Sciences.
7. Pfeffer J, Sutton RI. *The Knowing-Doing Gap: How Smart Companies Turn Knowledge Into Action*. HBR Press, 2000.