The Training of the "Helpless" Physician

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Introduction

Each year medical schools turn out well-trained doctors, highly skilled and competent in every phase of practice -- except surviving economically. Medical training programs do not provide young physicians basic information about doctors' options in the workforce -- for example, the pros and cons of private practice vs employment -- nor is there any effort to explain to them the larger economic forces at work in healthcare in the United States, so physicians do not understand the competitive forces that are shaping today's radically changing economic climate. One attempt to institute a seminar-style course in "real-world" healthcare economics at a major State University School of Medicine was met with a refusal to fund even the modest travel stipends for the national experts lined up to teach the course. Also, disillusionment with the realities of the profession is not limited to our broken healthcare system. For the first time in its history, McGill University School of Medicine, Montreal, Quebec, Canada, is experiencing fourth-year students dropping out after being exposed to real-world medicine in their preceptorships.

Few American physicians -- young or old -- understand that in the last 15 years healthcare economics have been radically changed. Physicians have largely abandoned the pure fee-for-service model that has been the economic cornerstone of Western medicine since Roman times. In its place doctors now contract with health plans for rates negotiated in bulk under so-called "managed care" plans. Economically, there can be no greater change in a personal services industry than changing how people get paid; yet medical students, residents, and fellows are provided virtually no education on the nature or implications of this profound change. The need for such practical education has never been greater.

In the meantime, while taking advantage of physician's failure to comprehend and respond to these economic changes, health plans across the country have systematically merged into huge monolithic companies and have converted from nonprofit to for-profit status. According to *Fortune Magazine*, there are 7 healthcare insurance and managed care companies in its 2006 "Top 500" list, generating revenues of over $212 billion. As a result of the for-profit consolidation of the health plan industry, the well-being of health plan profit margins for shareholders must now compete with the well-being of patients' health.

Just as health plans have merged over the last decade, hospitals, too, have aligned. Most local markets now have just 1 or 2 hospital systems that have complete control over these markets. Many of these systems are generating significant net revenues and behaving like for-profit companies despite their tax status as charities. Meanwhile, in the face of these ever-consolidating markets, doctors remain locked in a cottage industry model. The latest available statistics have shown that 82% of physicians practice in groups of 9 or fewer.[1] Doctors, having received no training in adapting to the current market conditions that are occurring rapidly around them, are ill-equipped to function in this radically changed economic -- and ethical -- landscape. These changes unavoidably are undermining the very core of the physician-patient relationship.

In place of old-fashioned fee-for-service medicine in virtually every medical market in America, the economic lifeblood of today's medical practice depends almost entirely on contracts. Almost all of a physician's private patient flow depends on his or her contractual relationships: Private patients are provided either under an employment contract with an employer or they come into the practice through a contract between the physician and a health maintenance organization (HMO) or preferred provider organization (PPO). However, few young

physicians are trained in how to analyze contracts, or when, where, and how to get the appropriate help with their contracting relationships. Instead, unfortunately, they are blithely following the model of older physicians who literally signed away fee-for-service medicine and continue, for the most part, to accept what health plans offer without significant legal or economic scrutiny.

As for nonprivate patients, 36% of the average physician's patient base is paid for by the federal and state government, yet no medical training program offers a practical course in coping with Medicare and Medicaid regulations and claims procedures. Nor is there any medical school training about the practical implications and economic ramifications of treating the 45 million Americans without any health insurance.

Beyond the basics of medical economics, young physicians are generally not introduced to the regulatory and political environment in which they will have to practice. Although most trainees quickly comprehend the concept of malpractice, few appreciate the impact of interlocking laws that require reporting and disclosure of any malpractice claim or disciplinary investigation. The tight web of mandatory reporting requirements runs from every hospital and state licensing board to the National Practitioners' Data Bank and is reinforced by self-disclosure requirements on virtually every professional application. ("Have you ever been named in a lawsuit or been the subject of disciplinary investigation" is a typical question on such applications.) The combined effect of reporting and disclosure means that any black mark on a doctor's record -- even the disclosure of a mere unproven allegation -- can deprive the doctor of economically valuable advantages, such as hospital privileges, employment, or participation in a managed care plan. Understanding the power of this reporting network, including the possibility of its abuse, should be an essential part of every doctor's preparation for the real world.[2]

The foregoing are but a few examples of the practical areas not addressed by medical training. More insidiously, however, medical training is inculcating a culture among physicians that may be deepening their woes and contributing to the decline of the profession.

Training "Helplessness" Instead of Resilience

Modern psychological theory has focused on how individuals can be trained to be "helpless" and how that feeling of "helplessness" contributes to a sense of depression and isolation.[3] Helplessness can be trained into individuals when, regardless of repeated best efforts that should be rewarded, no reward is forthcoming; as a result, the individual eventually learns to give up and sinks into a lonely feeling of futility and malaise. It would appear that collectively the medical profession has mastered this art and is suffering the symptoms en masse.

Unfortunately, medical training is helping to create the foundation for the profession's helplessness. Regardless of the new limitations on work hours, conditions in many training programs remain reminiscent of medieval, monastic, ascetic orders. Self-deprivation -- especially sleep deprivation -- continues to be viewed as a necessary virtue, especially during subspecialty training. Learning is still most often imposed on the basis of the model of strict authoritarian discipline, with a high degree of emphasis on shame and fear of failing. Good patient care is so expected of trainees that it is rarely rewarded. Residents' pay is usually set at bare subsistence levels or below, so there is no financial reward for the hard work of medical training, and indeed most medical graduates emerge with huge school loan debts.

Psychologically, young physicians often expect residency and fellowship to be the crowning experience of their long educational path. Since they were 5 years old, these young people were told that they were the brightest and the best, a message that was socially reinforced as they successfully progressed through school, college, and medical school. Everything about their experience reinforced their belief in the Puritan work ethic: If you

work hard and do well, you will be rewarded -- until they reach residency, a point at which rewards are so few and far between that they begin to believe that if they work hard and do well they will be resented.

Young physicians become so well trained in deferring gratification that many give up on ever getting any meaningful rewards for their sacrifices. With their resilience worn away, many just give up the fight. A dispirited acceptance of one's individual fate seems to be the dominant mood of physicians nowadays rather than a motivated mobilization toward a better lot for the individual practitioner and the profession as a whole. Most doctors focus so hard on trying to provide good patient care -- ie, taking care of others -- that they forget, or have no energy, to take care of themselves. Thus, when some doctors propose positive collective action, they are usually quickly quieted by a few naysayers whose negativity taps into the helplessness learned so well during medical training. The progress of the profession is being effectively paralyzed by its own failure to teach leadership and the skills of self-survival.

Consequently, physicians have lost the social contract or bargain that medicine used to have with America. As Paul Starr observed in *The Social Transformation of American Medicine*, the previous generation of physicians traded years of their earning power to become highly trained, in exchange for significantly higher income and enhanced social status. With physician earnings plummeting over the last decade, it is clear that the medical profession no longer enjoys the benefit of such a bargain.

These changing socioeconomic conditions are undeniable, yet medical education has not adapted one iota. Virtually none of the training programs in the country offer 20 nseconds of business administration or modern medical economics. The rigors of medical training prevent young physicians from acquiring economic survival skills on their own. Instead, medical training effectively places young doctors in a "cocoon," shielding them from the lessons of the real world. While residents and fellows are going through their training, their young nonmedical contemporaries are out in the world making little mistakes with little amounts of money. Meanwhile, residents and fellows are working all the time, living on subpar wages, and amassing mammoth debt from student loans.

So training programs are sending forth untutored and unprepared graduates. Instead of teaching physicians the more businesslike approach of relying on deliberate due diligence and seeking the advice of experienced and qualified advisors, physicians are more inclined to make independent life-or-death decisions that are based on the rapid assessment of a situation and to go it alone and shoot from the hip on the basis of their best instincts. After all, that is how they have been trained to diagnose and treat.

Is this the model for training bold and competent leadership in our most important profession, or are we damning these young people to a future that will thrust them unprepared into a battle for the very survival of the medical profession -- a battle in which the stakes are whether our healthcare will be dominated by profit or by patient need -- a battle that will surely profoundly affect our lives and the lives of the ones we love?

References

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