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REVIEW

Academic I.D. in jeopardy: the erosion of time, professional values, and physician satisfaction

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Abstract The American public entrusts academic medicine with a varied portfolio of critical responsibilities: the thoughtful mentoring of future generations of doctors, the engagement of cutting edge discoveries, and the empathic treatment of patients with complicated illnesses. The erosion of time to perform these duties has led to an estrangement of our key professional values and thus a loss of public trust, the inability to recognize new diseases, reduced communication in our ranks, and physician dissatisfaction. Much of this is driven by an unbalanced focus on the business model of medicine, highlighting rapid patient transactions linked to professional income with financial incentives for high-volume care. Reversing the current trends requires a new type of leadership committed to long-held professional values and a recognition of what drives professional excellence. As internists and infectious diseases specialists without procedures in our practice, we are especially vulnerable to these trends.

Keywords Infectious diseases · Hospital

RVU medicine

Administrators in hospitals and clinics today emphasize "patient throughput", a continual income growth—based on marching large numbers of patients through the health system—because their key focus is business, not science, not art. The metric of patient volume—and of physician salary calculations—in most hospitals is the RVU, the relative value unit, a formula designed by medicare for payment of services. A high level new consult visit for evaluating a patient with a fever of unknown origin might yield three physician work RVUs, for which a physician will be credited with 25–$50 for each, depending on the medical center. The same work RVU is awarded for a clinic visit, whether it takes 1–2 h to review a referring doctor's information or much less time. Furthermore, it has an upper boundary, unchanged if the new patient was evaluated in less than 45 min or required an hour and a half.

Since infectious disease specialists in the academic setting are frequently called upon to evaluate complex patients who are diagnostic dilemmas, we are especially at risk in volume-based compensation plans, particularly when risk for complicated patients is not shared but shifted to those physicians who specialize in complicated patients. Even within any institution's infectious diseases division, those physicians who in prior years were recognized for their diagnostic abilities are now being financially penalized, since volume-based compensation plans reward care for routine, relatively straightforward cases that require little time away from the exam room. Regrettably, some physicians now demur when asked to accept a very complicated new clinic visit consultation, because the extra time needed for a pre-clinic review of a thick chart is not funded.

Public perception of greed

In the March 4, 2013 issue of *Time*, Brill [1] clearly documented the disproportionately high salaries and bonuses

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that CEOs of hospital and health systems receive, at the same time exposing the byzantine billing system that can adversely affect patients financially in widely diverse fashions. Compensation of CEOs at nonprofit US Hospitals averaged $596,000 in 2009, were $425,000 higher at academic centers than at nonacademic hospitals, and had no relationship to quality of care, patient outcomes or community benefit [2]. Many CEOs have little accountability for their top-down decisions; their salaries are preserved. Financial risk is assigned to early and mid-career physicians. If the definition of heroic is taking risks to help others, then anti-heroic is transferring risk from one self to others. Moreover, the executives of not-for-profit academic health systems cannot show that they rigorously review their decisions and continually question their underlying assumptions.

In a December 16, 2013 *Time* essay, Brill again faults hospital administrators for failing to make the secretive chargemaster completely transparent, also noting that the Obama administration failed to enforce Section 907 in the Affordable Care Act, which would strike down tax exemption of nonprofit hospitals failing to inform poor patients about financial aid for their bills. Such revelations are widely read by our patients, adding credence to the public's perception of greed dominating medicine [3].

Today, profit fever enriches administrators, drives up the costs of healthcare on all fronts, and essentially dictates worse patient care, forcing us to move through quantities of patients as if they were widgets on an assembly line. Regardless of the strengths or shortcomings of the Affordable Care Act, all agree that the rising trends in costs of healthcare cannot be sustained. Yet rewarding volume via throughput sustains the rising costs of care. Unfortunately, time, the most precious aspect of the patient–doctor relationship, the indispensable element in research, and the essential ingredient in training young clinicians to become caring, excellent, and rigorous practitioners, has become ever more fragmented.

Recognizing new diseases

An assembly line approach to medicine with little time for reflection hampers the ability to recognize something new.

In the early 1980s, five patients arrived at the University of Virginia Hospital with fever, involuntary eye movements and central nervous system vasculitis. All had been exposed to fleas and wooded areas. One of us had the fortune of recognizing and exploring the cause of a new disease, *Acute Febrile Cerebrovasculitis* [4]. Eventually the epidemiology, clinical courses, serum antibody testing and brain biopsies pointed to a typhus-like organism.

At that time, we faculty members were expected to spend less than half of our time clinically and the rest on reflection, teaching, service and scholarship. Salaries were comparatively lower, yet that era of an academic culture for scholarship and reflection was propitious, since it took us 1 year to unravel the components of the new syndrome. We had no funds flow to support this work. We just thought it was our job.

We 11 colleagues on the investigating team enjoyed features of an academic world that are distant memories at some institutions today: time for inquiry, discovery, a focus on patients and successful therapy, and a rewarding academic collaboration.

Satcher [5] listed 22 new infections identified between 1973 and 1993, and Fauci et al. [6] suggested that such trends continue. Infectious diseases require equal vigilance today to recognize new syndromes, but such recognition requires a commitment of time.

Physician dissatisfaction

The briefer lengths of inpatient stay and high patient turnover add additional health care burdens and emotional stresses for physicians. Notably, career satisfaction for physicians nationally had already declined from 85 % in the early 1970s to less than 50 % by early 2000 [7]. More recently, a 2007 study of faculty members in the Department of Internal Medicine at the Mayo Clinic sheds light on current concerns for academic medicine: 34 % of the 449 faculty surveyed met criteria for burnout. The rate was much higher—54 %—if less than 20 % of the physicians' time (1 day a week) was spent on activities meaningful for the faculty such as teaching or research. Furthermore, 19 % of faculty in the survey stated their intention to leave the institution in the subsequent 36 months, and 10 % said that sometime during that period they would leave academic medicine altogether [8]. Although the data reflect internal medicine generally, we suspect that infectious diseases specialists are not completely spared the general trends.

Time for communication at the academy

The quality of communication at the academy between faculty and trainees and among faculty members themselves can greatly influence professional satisfaction. In an essay published in 2010, one of us noted that attending on the wards is "much less fun and exhausting, [with] limited [time for] levity, banter and humor. I feel guilty if I ask the residents questions about themselves or what they did over the weekend as they type (and they are always typing), because I'm distracting them and using precious time" [9].

The 80-h-work week and the mandate for patient throughput have conspired to distract the house staff from knowing their mentors more closely. With the crammed list of inpatients to be seen on busy ID inpatient consult rounds, there is limited time to know the fellows and to spend as much time teaching as needed.

Physician and author Verghese [10] discussed what he called *Culture Shock—Patient as Icon, Icon as Patient* in a 2008 perspective. Concerned that the time of engagement of house staff and patients is shrinking, he noted, "Patients are handily discussed in the [call room] bunker while the real patients keep the beds warm and ensure that the folders bearing their names stay alive on the computer". In our subspecialty we need to avoid this scenario, recognizing its downsides.

In a recent study of curbside consultations, Cook et al. [11] showed that physicians value these uncompensated discussions which improve communication and care coordination. At our own institution we have seen increased curbside consultations and valuable collegial interactions enhanced after the recent opening of a faculty dining room. Simply stated, it is a platform for faculty to pause briefly, enjoying each other's company and enhancing clinical discussions. We recall the thoughtful warnings of author and philosopher Pirsig [12] from his iconic book *Zen and the Art of Motorcycle Maintenance*: "We're in such a hurry most of the time we never get much chance to talk. The result is a kind of endless day-to-day shallowness, a monotony that leaves a person wondering years later where all the time went".

Untested assumptions

Virtually all academic centers have instituted some form of financial incentive plans for the clinical faculty, usually RVU based. Yet few have questioned their value. They seem to make sense, they sound logical, but we ask, are they effective? Above all have we done no harm?

Two recent reports of medicare data show that financial incentives lead to expensive, unnecessary procedures:

1. In 50 % of patients receiving repeat upper endoscopies, they were not indicated [13]; and
2. The rate of intensity-modulated radiation therapy [INRT] for non-metastatic prostate cancer patients was almost 20 % points greater over time if urologists owned INRTs vs those with no financial incentives [14]. We argue that we should be rewarding value, not volume.

Financial incentives appear to be effective for situations like assembly lines where products can be moved more efficiently by the team. However, in a review of studies of financial incentives for professionals, Pink [15] in his book *Drive* convincingly shows that they not only are useless, they commonly lead to poorer outcomes compared to operating with no such incentives. Pink points out that what professionals value are autonomy, a sense of high purpose, and an ongoing mastery of their expertise accomplished by engagement in their profession without the constraint of a ticking clock. The latter point was underscored in a qualitative study of masterful academic physicians in a Department of Internal Medicine: one's reputation for excellence was the most common theme highly valued by such respondents [16].

Traditionally, the ID physician has been viewed as a superior clinician. There are suggestions that masterful clinicians, however, are less valued than their counterpart high-volume clinicians. In a recent article in *The New York Times*, Agan notes that many medical institutions and universities are purposely reducing the average age of their workforce, accomplished by changes in compensation. The assumption is that medical schools will save money and enjoy more innovation. However, Agan [17] cites the evidence that "less grey hair sharply reduces an organization's innovation potential, which over the long term can greatly outweigh short-term gains". Taleb [18] would highlight the value of experienced experts as the repository of inductive thinking, not yet earned by the novice, not yet published in the standard text books.

New academic leadership

Byyny [19] is convinced that a new form of leadership is needed in medicine, one based on the values of professionalism, service, research, scholarship and teaching. They have long been the tenets of infectious diseases. We would add one more attribute for the new physician CEOs—the courage and inquisitiveness to question dogma, to challenge commonly held assumptions—in a phrase to take risks. We have given examples of such assumptions that have not yet been validated: that financial incentives for professionals in medicine seeing more patients per hour work are of high clinical value; that efforts to reduce the median age of the work force will provide greater innovation, lead to higher quality of care, and save money in the long term; and that patients who continue to be treated unfairly and unkindly will always value their physician and medical center. In the context of trying to make the world a better place, we ask, why are we doing this?

Academic infectious diseases clinicians with limited RVU credits for our work seem especially in jeopardy from current reimbursement trends, the culture for patient throughput and busy services.

Those who advocate for the market system in medicine often recite the standard hackneyed phase—*no margin, no mission*. In a market-based nation, there is merit to this message. Of course we applaud financially capable administers who are creative and nimble in responding to current challenges. The question, however, is how much profit should healthcare generate? At what cost to education, expertise, reflection, scholarship, and job satisfaction? Will the public and we continue to view our activities as caring? If we are to preserve medicine and the subspecialty of infectious diseases as a valued profession, we need to restore time with the patient and time to reflect on the more complicated or puzzling cases. Academic hospitals need to re-examine their costs and charges to restore the public's faith in their integrity. Physicians need to engage in new leadership roles promoting the values of our profession. Such new leaders will be inquisitive and will be judged not by their answers but by their questions. It is not too late. If we stand by and watch this new parade gain momentum, however, the current market-focused trajectory will take us on the ineluctable path to mediocrity. Furthermore, the market has no empathy and no inspiration. The market has neither conscience nor morality nor compassion. It is never reflective. We are reminded of the words of writer and playwright Oscar Wilde who had commented on the market—*it knows the cost of everything and the value of nothing.*

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