# BLOG POST

**To Be or Not To Be - Of Callings And Careers: Is This The Question?**
12/13/18

One of the very noticeable trends in medicine today is the outsourcing of hospital inpatient care to vendors and physician groups who provide "hospitalist" services. A hospitalist is a physician whose primary professional focus is the general medical care of hospitalized patients. They do not have an office practice. They usually work in 8-12 hour shifts. Their specialty has arisen in the setting of a growing trend of primary care and some specialty care physicians to no longer come to hospitals. These outsourced hospitalists provide services that today are a key component of inpatient healthcare delivery that used to be performed by one's personal physician in conjunction with consultants requested by your personal physician. Hospitalists are among the fastest growing sector of physicians in the U.S. Indeed, the complexity of today's hospital environment, with heightened use of electronic health records (EHRs); numerous onerous rules, regulations and compliance issues; oversight by secondary, tertiary and quaternary organizations; time-consuming administrative tasks and use of metrics and dashboards which monitor performance, etc. leaves many physicians seeking more controllable outpatient office or work settings and relegating their practice to more predictable and less chaotic work environments. Additionally, smaller groups or solo physicians simply cannot always be available for unexpected hospital emergencies or unscheduled inpatient evaluations that could arise unexpectedly during the day when that physician may be looking at a full schedule in the office. Larger groups can accommodate these emergencies more easily if they truly practice as a group and share or cover each other's patients when the need unexpectedly arises. (These larger groups may assign someone to hospital duty for a day or a week at a time to provide continuity for their patients. The fact that their primary physician within the group did not see them during hospitalization does not interrupt the usual doctor/patient relationships as 98% of care for any particular patient in a particular practice is more often delivered in an office or outpatient setting where the continuity of care is adhered to in a schedulable fashion.) However, from a patient's vantage point, not seeing your own doctor at a critical juncture in your care, in what you may perceive as possibly a critical life-or-death issue, is troubling and challenging. Having to tell your story and history repeatedly to strange physicians who change shifts every 8-12 hours and who may not be as knowledgeable or have the training background of your primary physician, is often upsetting to patients. As one hospitalized patient put it to me recently – "it's almost akin to abandonment." The current design motif spoken of frequently in healthcare circles is "designing around the patient" – really?!? It frankly, and candidly, seems designed more around the needs of physicians, care deliverers and the hospital.

Now then, there are ways of making this business model work, but that discussion goes beyond what I wish to spend the balance of this dialogue addressing – especially with the onset of many early career physicians as well as physicians at all aspects of their careers opting for more "regular hours" (a.k.a. shift work). Frankly, we are witnessing a fundamental change in the culture of medicine. The complexity of care delivery referenced above has resulted in more measurement efforts; dashboards and focus on operational efficiency than we have ever had previously – in large part for good reason, as changing reimbursement structures, quality concerns and costs continue to challenge hospital and health system



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operations. To monitor our efforts at improving operational performance and efficiencies, we also have taken to surveys which assess patient and physician satisfaction scores, hoping that our efforts are pleasing physicians and patients and enhancing engagement. However, despite all of this attention to operations and engagement, we continue to have higher rates of physician and nurse burnout and job dissatisfaction than previously recorded. Patients are also frequently dissatisfied. This raises a fundamental question of "why". The answer undoubtedly is multifactorial but one contributing factor is that at the present time, particularly among physicians and nurses, there is a feeling that there has been loss of "meaningful" work in their daily activities. Over 50% of clinical activities are administratively focused resulting in what used to be a "calling" now feeling like a "job" – not a profession, but a "job" with all of the connotation one associates with working on an assembly line. Perhaps this is to be expected when we focus on "plant operations", "shifts" and "workers". (Incidentally, the terminology often used for nurses, doctors and other healthcare personnel today is the generic "provider"!) One has to wonder if we have squelched one of the sustaining pleasures of becoming a medical or nursing professional. Healthcare by its very nature is a relationship business – often a long-term relationship. Most nurses and physicians used to say that they went into medicine because they felt they had a "calling" or wanted to "make a difference" in people's lives. I would note in my consulting activities and speaking engagements, greater than 75% of clinical audiences would indicate their belief that they had a calling as the reason they become clinical professionals. This number has steadily declined to under 40% currently. I recently took note of a book entitled *The Job* by Ellen Ruppel Shell which makes the point that work provides "structured activity, shared experience, status and collective purpose", all reasonable endpoints. My premise would be that healthcare currently finds itself providing "work" but has lost some of the shine in terms of "purpose" or at least how we may talk or give the appearance of concern about "purpose." With our efforts focused so heavily on being able to manage for efficiency and productivity, we have abdicated and forgotten the psychological, human, and spiritual components of healthcare delivery that are the anchors of relationship building. It used to be said that healthcare was a special business, but as it morphs, it is losing its "specialness". Ms. Shell makes the point that "good work" is not the same as "meaningful work." "Good work" is work that provides acceptable pay, prestige, opportunity to grow and learn. "Meaningful work" is much more nuanced. In fact, how people find "meaning" in their work turns out to be more about the person than the job and how the person views their work. Housekeepers, plumbers, carpenters, doctors, nurses, clerks and others are all able to view their activities as just a "job", or some may see it as a "career" and some see it as a "calling" irrespective of pay, rank or job title. The fact that some feel their job is a "calling" isn't necessarily preferable and may look at their job as a mere means to an end – as the saying goes "working to live, not living to work". In healthcare, however, we previously seem to have attracted a significant majority of people who went into the field in large part seeking something beyond a routine "job." They could have entered more lucrative fields of endeavor, but opted to work in an arena that allowed them to make a major difference in people's lives. I still see this idealism early in physician's careers and training, but the luster of "meaning" seems to fade quickly these days.

So where does this leave us? I feel leadership needs to infuse more emphasis on "purpose" into our lexicon in our discussions with caregivers. Our emphasis has swung too far to verbiage around operational performance, scorecards, dashboards and incentivization with targets and measurements that *may or may not be true reflections of quality, outcomes or what our patients' desire*. Emphasis on patient satisfaction scores fall far short of what is truly at the heart of the doctor/patient relationship – namely empathy, loyalty, compassion and a deep understanding of a human being's physical, mental, emotional and sometimes spiritual needs. Importantly, healthcare clinicians and physicians also have needs – some of



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which revolve around "good work" and security. However, we have in the past and need to continue today to recruit, reward and build care delivery teams that understand the complexities of human beings and the importance of relationship building. Healthcare leaders must aid our care delivery personnel in experiencing purposeful fulfillment and translate required work into a meaningful undertaking. Performing "meaningful" work for the good of others is why we do what we do. Now more than ever before, especially as we approach an age of artificial intelligence (AI), with the real and serious risks of information overload, leadership has a responsibility to mitigate meaningless work by advocating for the measurement of what matters and adhering to the anchors of great healthcare by *truly designing* care *around people* – a design motif that reflects knowledge and understanding of *context*, *human illness* and *complexities* of *human beings* will all the facets therewith . . . as well as the need for operational excellence. Perhaps we need to entertain a level setting at this point and renewed focus on the anchors of successful healthcare delivery. Efficient operational performance is important but so is our understanding of adherence to the tenets of professional service. I am reminded of what the French Jesuit priest and philosopher, Pierre Teilhard de Chardin stated, and if I may take the liberty of paraphrasing: *we are not necessarily human beings looking for a spiritual experience. We are spiritual beings looking for a human experience* – a meaningful human experience based on relationships, empathy and human compassion – for recipient and "provider".

-Ronald N. Riner, MD



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