CURRENT ISSUES
IN
HEALTH CARE DELIVERY:
WORKFORCE, STAFFING, QUALITY, COST

Consensus Statement
Of the
Purple People Protectors
(compiled and edited by
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Based on the Discussion
Of the Purple People Protectors:

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Issue: The American public has modified its expectations of healthcare professionals in the past 25 years and the attractions to health care as a profession are different than in 1960. Describe the major changes in health professions as a result of these factors and explain how changes in the health care delivery system have affected these professions.

INTRODUCTION:

Several factors have altered the role of medical health professionals in the past quarter of a century fundamentally based upon cost of health care, both directly and indirectly. Because the majority of changes have occurred with physicians (both clinical and academic/research physicians), nurses, and new professions (nurse practitioners and physician's assistants) that have evolved, these professions are the focus of this paper. With regard to direct effects, the spiraling costs of health care due to a variety of factors (discussed in the first paper of this course) nurtured the development of the health insurance industry and subsequent conceptualization and implementation of managed care business principles. Decreased financial compensation for various professionals (i.e., nurses, primary care physicians) has also contributed to a change in the defined professions. The role of clinical physicians and other health care providers has changed from the perspectives of the health care system, patient, and physician: the health care system is now operating with a priority on sound business principles; patients are not relying solely on the word of the doctor but on external sources (non-physician professionals and the internet) for medical information; many physicians are finding their relationship with their patients stifled due to a large presence of business administrators overseeing their diagnostic and therapeutic choices and dictating the quantity of time spent with each patient. Indirect effects of cost on the role of health professionals are related to the connection between Graduate Medical Education (GME) and federal funding, which have questioned the contributions of physicians-in-training to the general health care system (i.e., does teaching housestaff provide a sufficient trade-off of services rendered resulting in positive cash-flow to the institution versus the cost of training of physicians to eventually practice in geographic areas of greatest need and to practice in the primary care fields thereby contributing to the pool of primary care providers needed by the current managed care health system?). Further, other indirect factors that influence health professional roles also must consider the disparity between economists looking primarily at the absolute number of physicians and viewing the statistics as a surplus of physicians versus the reality of the productivity of physicians individually and as a whole, which may show that there are not enough physicians to provide access to health care for all citizens (because not all physicians are equally "productive"-- defined by managed care, in terms of FTE, or full-time equivalent -- and not all physicians practice in the areas of geographic need).

Not only in the clinical realm, but academic medicine has also felt the effects of managed care initiatives in terms of its role in society as serving the population that has limited access to health care (the uninsured), providing the forum for teaching health care providers of the future, and furthering our medical knowledge of the present. Because of cost and efficiency concerns, academic medical centers are finding themselves having to compete in the managed care health market and trying to balance teaching roles and

serving the underserved while at the same time, remaining a financially viable institution. The current health care system is placing great pressure on Academia to change some of its responsibilities in society, but there is healthy hesitancy in academic medicine to do so. Academia has a significant connection to GME, which will be described subsequently.

Lastly, brief comment will be made on the status of other health professions that have undergone small changes relative to those made by physicians, nurses, and physician extenders (hence, the reason for the focus of this paper on the latter).

CHANGES IN THE HEALTH CARE SYSTEM AND EFFECTS ON THE ROLES OF DESIGNATED HEALTH PROFESSIONALS DISCUSSED AMONGST TEAM MEMBERS: DIRECT EFFECTS

Examining direct effects of factors that changed the role of the physician in more detail relates to perceptions by the health care system, the patient, and the physician. With regard to the health care system, as stated in the introduction, health care costs prompted the development of cost controls through managed care and a more business-minded approach to patient care. Managed care organizations found that costs could be controlled not only by imposing limitations on how physicians cared for their patients, that is, what tests they ordered, and what treatments they prescribed; they also noted that physicians were traditionally highly-paid professionals in society. They felt that some of the physician-provided services could be rendered by alternative professionals, not as highly-trained, meaning not as costly to pay, but at the same time, assumed "acceptable" in performance of care, at least in the eyes of managed care. Thus, the professions of "physician extenders" were born; focusing on the allopathic realm of primary care, the majority of "extenders" are encompassed by physician's assistants and nurse practitioners. In fact, when patients seek medical attention at a primary care facility, they have a significant probability of actually being seen by a non-physician provider, with or without direct physician supervision, because the health care organization has determined that there would be significant cost savings by using an inexpensive health professional (NP, PA) versus an expensive one (physician).

This practice of using extenders seems to be a sound business practice from an economic perspective; but what is the effect on the physician-patient relationship and how has the physician role changed as well as that of the NP or PA? In other words, what is the perception of the patient and physician (as well as new providers) of the factors that have changed the roles of health professionals today? Although there are varying opinions of the quality of care rendered by extenders due to different scopes of practice and levels of expertise comparing them to physicians, patients who are accustomed to seeing their physician but see a PA may not be as satisfied with their care because their expectations of "being seen by a doctor" are not met. These patients may then perceive their health care organization as depriving them of the "best" care (i.e., physician-based) and become disenchanted with their health care organization, perceiving

that the organization puts cost before quality of care. Because the physician is a part of the organization, these patients could then associate the profit-making desires of the organization with the physician, thereby, poisoning the doctor-patient relationship. The patient may then be prompted to rely on information (or misinformation) gleaned from external sources, such as the internet, television/newspaper, or providers of alternative/complementary medicine. On the contrary, a patient who believes that his health care organization is appropriately balancing cost of delivery of care with quality and finds that there is no qualitative difference between extenders and physicians, in essence, will "de-value" the relationship he has with physician relative to a PA or NP, and increase the "value" of the care and opinion of the extenders. In either situation, the role of the physician is de-valued or diluted and is not the traditionally highly-respected position of 25 years ago; contrarily, the role of the new type of health professional who now also renders care (i.e., NPs, PAs, alternative medicine practitioners) is raised to a higher value.

As opposed to the physician role which has changed from one of the person "in-charge" of the health care of his/her own patients and his/her own practice, to a role of an "employee" or "worker for the organization" vastly shaped by other administrative personnel because of political and economic forces, the role of nurses has expanded and diverged. No longer are nurses strictly the stereotypical Florence Nightingale caring for ill patients one by one. Nursing roles have expanded with respect to altered clinical and increased administrative roles. For example, in the clinical realm, there are now case managers (inpatient and outpatient medicine), clinical nurse specialists (oncology, pain, wound care, diabetes), nurse educators (preventive medicine counseling), intensive care nurses, community health nurses, and nurse practitioners mentioned above. These more specialized clinical nursing roles developed, in part, in response to the need to delegate responsibilities for patient care that previously fell solely on the shoulders of the physician. That is, years ago, patients relied solely on their doctor to address management of their chronic illnesses while at the same time, the doctor arranged for their long-term care through home health agencies, prevented them from getting ill again, and cared for them when they became acutely ill; now, physicians are needed to facilitate care rather than be the sole dispensers of it and all responsibilities that previously belonged to physicians alone are being rationed out to other more specialized health professionals (i.e., the specialized nursing staff listed above) to optimize the quality and quantity of care given patients. Administratively, because nurses nowadays are earning advanced degrees with a focus, for example, on health care administration, "clipboard" nurses are increasing and playing a larger role in managed care and at the highest eschelons of hospital administration. For example, at Tripler Army Medical Center, the preceding two chiefs of the Managed Care Division and the last hospital commander were nurses. An increased number of nurses changing career path from clinical to administrative may, in large part, be related directly to the managed care system which calls for a very high productivity level on the part of the clinical nursing staff (and health professionals, in general) leading to the feeling of "burn-out" in clinical nursing. In addition, clinical nurses feel that there exists a large gap in salary versus the work and services they perform. Hence, former clinical nurses and, perhaps, even newly graduated nurses, are steering away from the traditional clinical nurse career paths to more

administrative ones, where administrative nurses may experience more job satisfaction, better financial compensation, and increased respect not necessarily present as a clinical nurse of old. Therefore, as opposed to the past where physicians found themselves “in-charge” of their patients’ destinies as well as their own, because of changes in the nursing profession, the tide has turned and nurses are in the ranks of those who formulate policies which are dictated to physicians. Clearly, the roles of physicians and nurses have changed due to changes in the health care system resulting directly from economic influences.

INDIRECT EFFECTS

With regard to indirect effects of cost factors on the role of health care professionals, two issues must be analyzed: (1)changes in GME and (2)the notion of physician surplus vs productivity. First, in the 1960's and 1970's, there was a significant increase in federal funding for training, research, and the construction of more medical schools. Why was this increase in physicians being trained undertaken at the federal level? It was assumed at the time that if more physicians were trained, then a perceived shortage of physicians, particularly in geographically-deprived areas, would be resolved. However, the presence of more physicians has not addressed the unequal distribution of physicians in suburban areas versus rural/inner city locations due to providers in these areas being under-paid relative to their suburban counterparts while enduring limited access to technologic advances (diagnostics and therapeutics) and limited opportunities in personal professional growth in the form continuing medical education and consultation with colleagues (i.e., a provider is isolated in rural/inner city areas). Further, the presence of more physicians did not necessarily translate to increased primary care physicians, who are needed to fundamentally make the current health system work and are the most vital commodity in these geographic areas (and, in general). GME, therefore, has begun to change its focus from training specialists to training primary care physicians in the hope that the base of primary care physicians will be expanded so that these physicians can be the "production line" workers that keep the health system running. Again, in terms of value, the role of the physician is then changed, now equated to an employee of the organization or "gate-keeper," who is held to certain clinical practice guidelines in rendering care or who can write a consult so that a patient can move along the conveyor belt of care. In fact, managed care organizations can penalize a physician for exceeding the costs of care for a given patient due to that physician deviating from the practice guidelines. Further, some patients may just see the doctor so that the doctor can write a referral to a subspecialist. The primary care provider is then expected to review designated referral criteria before the consult is written, relying more on objective criteria rather than the traditional factors of clinical experience, judgment, and education. A prime example of this change in how the role of a particular type of physician is viewed is in the practice of Internal Medicine. Before the advent of managed care, internists were viewed as “specialists” whose area of expertise was as a

diagnostician in solving the most complex diagnostic dilemmas. Internists used skills from their medical education, discussion with colleagues, and overall experience in medicine to help them determine which tests to order and what therapeutic path to follow. However, in the setting of managed care, the general internist is not considered a specialist, but rather, is consider a “primary care” physician. Again, the sum total of the newly defined role of the primary care physician is more of a "regulator" of health care costs rather than a diagnostician operating from experience coupled with medical education and judgment, resulting in an altered, and controversially diminished, "value" of the physician profession.

The preceding discussion focused primarily on the changing role of clinical physicians and physician extenders. What about academic physicians? Academic medicine has the primary role in educating our health care providers of the future, as well as providing continuing education for current providers and furthering research (evidence-based medicine), where research serves as a foundation for clinic practice guidelines—all these factors contribute, in essence, to making the system run most effectively for the “good” of the patient. However, teaching housestaff (interns, residents) takes time—time that busy clinicians lack if the clinician is to have sufficient productivity to meet his/her workload “throughput.” True clinicians are left out of teaching; but now, academic physicians are having to face the dilemma of balancing teaching and clinical productivity responsibilities—addressing the financial needs of the academic medical centers to stay solvent and resort to managed care business principles, increasing productivity and efficiency, limiting time per patient visit, but sacrificing the precious teaching time with housestaff in these clinic patient encounters. Clearly, the block of time spent with patients and spent teaching housestaff how to treat patients is in delicate balance and needs to be apportioned appropriately—but who determines where an academic physician’s time should be spent? If left up to the economists, the financial duty to the institution would come first and training would suffer. Further, economists state, based on economic theory, that academic medical centers should only be compensated on a “break-even” basis (i.e., fund the center only what the cost to train the housetaff is). An even more radical economic view is that trainees (housestaff) essentially pay for their own training and still leave enough net revenue for the institution to stay afloat without any public funding; therefore, if public funding is taken away from GME, money can be used for other purposes and there would be less incentive for academic centers to actively seek to employ international medical graduates, who currently help medical centers that employ them obtain federal subsidies simply by filling housestaff training slots. However, in the article by Gbadebo and Reinhardt, Adam Smith is paraphrased as supporting the view that “society cannot safely subject physicians to the stringent fiscal discipline of freely competitive markets,” because ethical issues would come into play. Academic medicine and the professionals in it are finding managed care attempting to change the roles of academicians, then, from a large percentage of time teaching or doing research, to a large amount of time now in clinical duties, helping the academic medical center meet productivity goals (i.e., less “protected time” for teaching and research).

Academic medicine also has a responsibility to society in that it has traditionally provided care to those “uninsured” or who were felt to have poor access to care, i.e.,

charity cases. In fact, for purposes of providing “good learning cases” to trainees (especially in the field of internal medicine), if there were excellent teaching points to be gleaned from a particular patient but that patient had no financial means to pay for care, that patient would receive care from the academic institution for the benefit of teaching its housestaff and the costs would be distributed amongst other paying patients (or their insurance). However, from this aspect, an academic physician is now being posed with the issue of taking care of a poor, uninsured patient (because of an ethical duty and because the patient may prove beneficial for GME training purposes) or forego treating this patient because doing so would cause an undo financial strain on the institution. Such dilemma was not posed to academic physicians of old. Aside from GME, physicians that practice in the realm of clinical medicine as well as research are having to choose one or the other because of the workload pressures on clinical medicine today. Clearly, becoming an academic physician now is also intertwined with economic considerations and no longer protected from efficiency, optimization, and financial concerns that were initially implemented on the clinical medicine side.

The other indirect factor causing a change in physician roles is based on the perception that there is and will be an absolute surplus in the number of physicians unless certain policies are implemented to keep the number of physicians who are trained in check. However, there is a disparity between the number of physicians in the US and the actual FTE cumulatively in the health professional workforce that physicians produce. The best example of this disparity is in the rising number of female physicians over the past 25 years, with these physicians continuing to balance to needs of family life with a career. The result is the choice of some women to reduce the number of hours they work (i.e., reduce their workload or FTE), thereby, reducing the overall workload of physicians provided in the country, despite the absolute number of physicians noted. In order to make up for the difference in primary care productivity needs and, perhaps, less physicians to do the required amount of work, physician extenders, foreign medical graduates, and non-traditional providers (osteopaths) are being employed. The physician's worth by the health system is further placed in the context of "how much productivity can this provider contribute," again, supplying evidence that the physician role (and value) has changed.

Again, this paper primarily focused (as did our group discussion) on the health professions above due to the majority of changes occurring in these areas. Briefly, other health professionals have undergone similar changes and will be discussed herein. It was mentioned in the discussion on geographic distribution of physicians, that allopathic providers tend to cluster in metropolitan areas. However, osteopathic physicians are filling the gap in rural and inner city areas and growing in number. Overall, the changes in osteopathy parallel that of allopathic medicine. So, too, the changes in dentistry have paralleled that of allopathic medicine in that non-traditional practice settings have been implemented (including dental HMOs), geographical maldistribution of providers exists favoring metropolitan areas, and dental hygienists (“dentist extenders”) are now serving in underserved areas and performing responsibilities previously done solely by dentists.

In summary, because of the economic forces shaping the health care system, the public views a "trip to the doctor" differently than before; "going to the doctor" now could actually mean seeing another health professional other than a physician, having shorter, more impersonal visits with the physician, and having more interactions with primary care providers rather than seeing a specialist for each individual problem. The doctor, now, is a facilitator of health care received in the system, rather than the only person who dispenses it. Further, physicians in academic medicine are finding their institutions succumbing to some of the financial pressures and productivity concerns of the new managed care environment resulting in less protection of their role as caretakers for the uninsured and mentors for physicians of the future. Although managed care is attempting to lead newly trained physicians away from specialization and into primary care, nurses, on the contrary, continue to have direct patient contact through specialization and advanced roles in clinical health care, as well as have additional administrative roles where they find themselves in key areas of policy-making and insuring implementation of managed care practices. The playing field has been leveled where all health professionals foster colleagueship amongst each other rather than one dominant profession over all. It is hoped that the administrators of health care can implement positive changes in the system with appropriate constructive feedback from the health professionals they oversee. Further, it is hoped that the patient-physician relationship can be preserved while at the same time quality health care can be provided on an outpatient and inpatient basis with multi-disciplinary teams comprised of health professionals from all walks of life to optimize efficiency and efficacy of the care rendered. All health professionals and health administrators must take note of how this system is running now and how it is projected to run in the future such that appropriate incentives (financial as well as issues pertaining to job satisfaction) will be initiated to avoid the system finding itself with an outstanding theoretical model in place but no health care professionals to make it work.