MAYO CLINIC

EDITORIAL

No Money, No Mission: Addressing Tensions Between Clinical Productivity and the Culture of Medicine

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Sister Generose Gervais, a founder and thought leader of Mayo Clinic, is often quoted as saying, "no money, no mission." But she encourages us to remember the rest: "no mission, no need for money."[1] This statement reveals that Medicine's objective is to serve patients and that supporting patients and their caretakers should precede every business decision.

However, we must contend with the astounding cost of health care, which in the United States composes 18% of gross domestic product.[2] Compared with other high-income countries, the United States spends more on health care, has higher levels of administrative burden, and has lower public satisfaction with its health systems.[3] And despite its expenditures on health care, the United States falls behind other developed countries in terms of life expectancy and population health outcomes.[3,4]

Providing universal access to health care is challenging, and physicians are required to make difficult resource allocation decisions. According to a systematic review,[5] physicians are pressured to use implicit rationing strategies such as discharging patients early, avoiding medically costly patients, and withholding information about expensive treatment options, which causes emotional distress. Consequently, physicians are caught between advocating for their patients and safeguarding their employers' and society's finite resources. According to one doctor, it's like being both the patient's defense attorney and judge.[5]

In this issue of *Mayo Clinic Proceedings*, Shanafelt et al[6] propose a need to heal the professional culture of medicine. They highlight the negative effects of financial burdens, such as shrinking insurance networks and preauthorization, as well as health care organizations' tendencies to emphasize productivity over quality, to limit access based on ability to pay, to shorten office visits, and to treat physicians like units of production. They also underscore harms related to regulatory burdens (eg, patient satisfaction surveys and other quality metrics) and clerical burdens (eg, excessive charting and managing inbox messages).

Shanafelt et al[6] discuss the importance of culture—a group's shared beliefs, practices, and normative values that are often hidden—in providing identity, order, and meaning. They outline 3 levels of culture: (1) *Artifacts* are the visible manifestations of culture, including behaviors, rituals, and heroes. (2) *Tacit assumptions* are the beliefs, values, and unwritten rules that guide daily behavior. (3) *Espoused values* are asserted priorities as displayed in organizations' mission statements and publicly stated ideals. They argue that the professional culture of medicine is threatened. How will patients feel safe and valued despite high physician turnover and shrinking health care resources? How will physicians enjoy practicing medicine, notwithstanding decreasing appointment times, increasing productivity demands, and spending afterhours on administrative tasks? Moreover, how can we address these issues without opportunities for frank discussion?

Shanafelt et al[6] offer solutions. First, we must diagnose the problem by identifying inconsistencies between artifacts and espoused values. For example, we state that physicians are professionals (espoused value), yet we require them to perform preauthorization and excessive documentation to justify billing and avoid malpractice lawsuits (artifact), which reveals lack of trust. Or we tout the importance of fairly

distributing resources to patients (espoused value) while prioritizing optimal patient payer mix and highly reimbursable medical conditions (artifact), which suggests that economic priorities supersede social justice. Second, we must develop "survival anxiety" that is based on the realization that something serious will happen without making positive changes, followed by overcoming the resistance to such changes, which can be manifested by defending tradition ("we've always done it this way"), implicating providers ("you chose this profession"), minimizing the concern ("we don't have the resources to tackle this"), or citing tangentially related problems ("our patients can't even afford food and housing"). Third, we must articulate a vision for the ideal state, which might build on frameworks such as the recent Charter on Physician Well-being.[7] Fourth, we must collaborate with health care leaders to heal the culture of Medicine.

In a study of organizational leadership, Shanafelt et al[6] identified a strong relationship between the qualities of supervisors and the well-being of physicians in health care organizations.[8] Subsequently, Shanafelt and Noseworthy[9] defined organizational strategies to promote physician engagement and reduce burnout, which, they emphasized, serves both an ethical imperative and a strong business case. These strategies include acknowledging the problem of burnout and demonstrating the organization's concern for physician well-being, labeling problematic issues and providing open dialogue, and periodically assessing whether the organization's altruistic vision statements (espoused values) align with the institution's actions and policies (artifacts). From another perspective, it has been observed that espoused values by top managers do not always overlap with the shared values of an organization's members.[10] When discordance exists between espoused values and shared values, there might emerge—organically from among company members—so-called aspirational values that disrupt historical patterns and shape the future of an organization.

In addition, patients have the power to transform the culture of Medicine. A compelling but tragic example is the case of Libby Zion, an 18-year-old college student who was admitted to a New York City hospital in 1984 with otalgia and fever, who was treated with restraints and narcotics by overworked residents, and who died 6 hours after admission.[11] This case resulted in a grand jury investigation and, ultimately, dramatic work-hour improvements for residents and fellows. Although we certainly hope that productivity pressures experienced by practicing physicians never have such drastic consequences, we can imagine a tipping point where doctors and health care organizations cannot, by themselves, effect adequate changes. In due course, healing the culture of Medicine will require a coordinated effort by all members of the health care team.

Finally, health care was never intended to be a lucrative endeavor, yet the expense of health care has been attributed to the desire for profit.[12] According to neurosurgeon Russell Andrews, we have seen the practice of medicine transition from a humanitarian service to a source of revenue for the health care industry.[13] To be fair, however, health care profits also benefit patients by providing high-value care and lifesaving technologies. Therefore, when facing uncertainties regarding whether and how much to expand the industry of health care, we should return to our roots and reflect on our Oath[14]: treat colleagues like family, embrace beneficence toward patients, and do no harm.

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REFERENCES

1. Mayo Heritage Society. Quotations of the Sisters of Saint Francis. Mayo Clinic website, http://history.mayoclinic.org/toolkit/quotations/the-sisters-of-saint-francis.php. Accessed June 4, 2019.

2. World Health Organization. Global health expenditure database. http://apps.who.int/nha/database/Country_Profile/Index/en. Accessed June 4, 2019.
3. Papanicolas I, Woskie LR, Jha AK. Health care spending in the united states and other high-income countries. *JAMA*. 2018;319(10):1024-1039.
4. Murray CJ, Frenk J. Ranking 37th: measuring the performance of the U.S. health care system. *N Engl J Med*. 2010;362(2):98-99.
5. Strech D, Synofzik M, Marckmann G. How physicians allocate scarce resources at the bedside: a systematic review of qualitative studies. *J Med Philos*. 2008;33(1):80-99.
6. Shanafelt TD, Schein E, Minor L, Trockel M, Schein P, Kirch D. Healing the professional culture of medicine. *Mayo Clin Proc*. 2019;94(8):1556-1566.
7. Thomas LR, Ripp JA, West CP. Charter on physician well-being. *JAMA*. 2018;319(15):1541-1542.
8. Shanafelt TD, Gorringe G, Menaker R, et al. Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clin Proc*. 2015;90(4):432-440.
9. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*. 2017;92(1):129-146.
10. Bourne H, Jenkins M. Organizational values: a dynamic perspective. *Organ Stud*. 2013;34(4):495-514.
11. Patel N. Learning lessons: the Libby Zion case revisited. *J Am Coll Cardiol*. 2014;64(25):2802-2804.
12. Ubel P. Is the profit motive ruining American healthcare? *Forbes*. February 12, 2014. https://www.forbes.com/sites/peterubel/2014/02/12/is-the-profit-motive-ruining-american-healthcare/#1778df1f37b9. Accessed June 4, 2019.
13. Andrews RJ. U.S. healthcare's dangerous profit fixation. CNN website, http://globalpublicsquare.blogs.cnn.com/2013/07/11/u-s-health-cares-dangerous-profit-fixation/. Published July 11, 2013. Accessed June 4, 2019.
14. The Hippocratic Oath. National Library of Medicine website, https://www.nlm.nih.gov/hmd/greek/greek_oath.html. Accessed June 4, 2019.