Educating Psychiatric Residents in the Age of Organizations and RVUs: a Debate

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There has been ironic drift in the meaning of “professionalism” over the course of the twentieth century. Early in the century, it had a vaguely pejorative sense, applied by defenders of early twentieth century liberal arts education and gentlemanly amateurism to those who trained for commerce and who held a commercial attitude toward the world [1, 2]. Later, it acquired an anti-commercial sense, standing for “traditional” values of service and excellence against the pressures of standardization, management, and profit [3].

Over the course of its semantic drift, some of the old meanings have remained attached to the term complicating and challenging its new meanings. These survivals allow individuals to choose between the major and the minor meanings to psychologically invest in.

In our day-to-day interactions, we are exposed to these two divergent attitudes toward “professionalism” in formal statements and texts from representatives of rational order and financial accountability, and in the public rhetoric of educators and officers of our occupational or professional groups. The proto-business or organizational sense of professionalism, rhetorically contrasted to a gentlemanly ethic of amateurism, surfaces in discussions of quality and safety, organizational (as opposed to occupational) responsibility, market incentives, etc. An alternative and romantic sense of professionalism, with its memes of elitism and dedication, is the major key for medical teachers and trainers, and for leaders of professional bodies. They resist the encroaching commercial meaning, in lectures and articles, charters and codes, and public declarations.

These ideologies compete for our loyalty in our workspaces and in our training sites, from the classroom to the “bedside.” Each ideology emphasizes a particular “logic” [4], and each encourages commitment.

Many observers have detected a surge in the business-minded attitude of professionalism [5–8] and, except for occasional declarations from the ramparts [9, 10], a weakening among those who advocate for a professionalism in the sense of a fraternity dedicated to a noble purpose, or at least a loss of confidence in having an undeniable “message” and an unquestionable authority against the leveling and universalizing arguments of industrialism and the market. Professionalism in this second sense is at risk of becoming quixotic.

This text invites the two attitudes to talk to each other in the form of a debate. The advantage of the device of a debate is that it creates a dialectic. A debate forces the greatest contrast on the two “positions.” Out of this engagement might come a synthesis, a new and more adequate ideology. And then, as new semantic strains appear, the next round is cranked.

This debate, which was dramatized in a recent Association for Academic Psychiatry conference, is inadequate in many ways. The RVU (which stands for Relative Value Unit, is by now part of most physician’s vocabulary, and is an objectification of clinical value and implicitly of physician labor) in the title is not itself crucial, but it is a metonym of the management revolution which is the focus of the debate. For another thing, the positions are extreme and leave the reasonable middle range unexamined. But, if it strikes resonances in our community, if it clarifies the ideologies, and contributes to the discussion of our internal contradictions in places where decisions are made, then it will have some value.

The Proposition:

In order to reduce burnout and demoralization, psychiatric educators should radically revise residency training programs to match the current work environment by emphasizing management and business theory.

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In Support of the Proposition (1)

I never thought I would be making this argument. Like you, I had analytic training; early in my career, I was under the sway of the radical humanism of Leston Havens; I was steeped in anti-capitalist ideology in graduate school. But here I am.

Maybe it is a case of a young man having heart, but an old man having a brain.

Here is why I support the proposition. Residency training must change to fit the new healthcare environment. While we have made some changes in the way we train psychiatrists over the last thirty years, these changes have been more on the order of reform than revolution. The time calls for a radical overhaul of our curriculum to bring it in line with what we do as psychiatrists and with the socio-economic contexts of our practice.

Over the last couple of decades, we have not managed to fully deconstruct the deep state of psychoanalysis, but we have become less committed to psychotherapy. We are half-hearted in how we teach various psychotherapies, usually depending on the enthusiasm and background of available faculty members. And, we are not as insistent as we used to be that residents enter their own therapy.

We are much more committed to receptors and ion channels.

Psychiatry has become a smaller niche. Almost none of us practices real psychotherapy, and almost all of us tinker with receptors. We are more likely to be called or consider ourselves as psychopharmacologists than mental health utility players.

As significant as these changes are they pale by comparison to the magnitude of the changes in the market for our services. We are less likely to be self-employed and more likely to be employees of medium or large organizations. The out-of-pocket market has almost vanished in most areas and the fee-for-service market is on its way out; we are headed toward a completely new basis for reimbursement.

Despite these radical changes in the political economy of psychiatry, we continue to teach it as if we are still independent medical artisans.

I argue that we are not teaching our residents about the massive complexity of the systems they will practice in, and by not doing teaching about it, we expose them to avoidable personal risks as they enter the work world. We are being disingenuous in how we portray their work futures, and this sets them up for existential crises. We are not doing them any favors by introducing them to humanism or self-reflection, or any of the other failed counter-ideologies.

We as educators must drag our Residency Review Committees into the twenty-first century and adjust what we teach and how we teach it to fit the new realities of the healthcare market. Specifically, must teach them to think like business people for them to survive and compete in the new medical system.

In a recent Rolling Stone interview, the guitarist Joe Walsh said that he wished someone had told him that music is a business, as well as an art. We owe it to our trainees to tell them the same: medicine is a business as well as a practice. In English history, there was a king called Canute. He believed he could command the waves to stop. We have been Canutean for too long. It is time to reconcile ourselves to the waves.

There are at least two reasons to make these changes: one ethical, the other out of concern for our graduates' wellness.

We have a duty to show our trainees how to be doctors first and then psychiatrists. Part of this includes showing them how to function in clinical settings as they are currently organized, not as they were and not as they might be in narrow niches in New York, Boston, or San Francisco. It is unethical for us to teach a psychiatry as it was practiced fifty years ago. It is unethical to promote the myth of psychiatrist as a lone Obe Wan Kanobi, just as it would be unethical for surgeons to promote the myth of Hawkeye Pierce or for physicians to promote House. Our ethical duty is to teach them what we know about the real world—remember it is happening to us too—instead of continuing to promote a midcentury mythology involving couches, cigars, and cultural respect.

We also owe it out of concern for their psychological well-being. We should try to do what we can to reduce the risk of demoralization in our trainees as they enter the healthcare markets. We do not have a lot of control over many of the factors associated with burnout—such as lack of resources or the types of demands that they are exposed to—but we can prepare them. We can influence their expectations, and we can and should correct them when they are too far from reality. If we are not clear with them about the roles they will be expected to fill, then we put them at risk of becoming disoriented and angry. If we do not teach our residents about the economic landscape, if we do not give them a map, and do not tell them how the non-physician inhabitants of this environment think, they will be lost, confused, angry, and will quickly become demoralized.

Research shows that inaccurate expectations and role confusion are major contributors to incivility and burnout [11–13]. As a supervisor of mine said, the secret of happiness is adjusting ones expectations. We have been encouraging the wrong expectations in our trainees. We must be honest about what is going on out there. The reality principle applies to us too. We have to give up the fantasies and see reality as it really is.

What is the reality that we need to educate them about?

Only romantics and the authors of the Physician's Charter argue that medical practice is universal and ahistorical [9]. Medical practice has always been influenced by local economic markets and political environments. The economic and political environment for our practices is extremely complex, but fundamentally, we practice medicine in an age of capitalism and organizations.

Organizations are run by managers whose duty is to make the best use of available resources to reach the goals of their organization.

Like it or not, managers see us as knowledge workers—human resources to be managed for the goals of the organization [14].

Managers find physicians to be difficult employees: we do not think like them; we have different priorities; we put patients first; they put the organization first; we have knowledge that they do not have; we want to be independent; they are not in the room with us when we interact with their customers; we do not follow organizational rules; and we whine that we are special.

Managers have to find ways to get around this. They impose rules and policies; they monitor us and hold us accountable to production standards, etc. They try to fit us into their hierarchies.

Who will win? The managers will win. Physicians are among the last occupation to succumb to the management revolution. And while psychiatrists are almost unique in currently being able to practice at the margins of the market on a fee-for-service basis, this is going to go away. Except for a shrinking proportion of psychiatrists who maintain boutique practices, the rest of us will be work in managed settings, be they hospitals, group practices, universities, prisons. Managers are not going away; our glory days are behind us. We have to find ways of working with managers, or we will go crazy and they will put us out of business.

That is the new reality. If we are to be mature about it and adapt to the new reality, we have to ‘walk our talk’ and respect the Reality Principle. We have to see this reality for what it is: a global socio-economic revolution in how work is organized.

We have to teach this reality—for reasons of ethics and for the health and happiness of our trainees. We have to teach our trainees how managers think and why. We cannot beat them; the best we can do is to find a working compromise.

In Opposition to the Proposition (1)

Doctor, you refer to the Reality Principle as the rationale for importing management theory into the psychiatric curriculum. That is, we should confront fantasies of humanistic practice with the cold hard reality of being just another cog in the machine. Only by seeing reality as it truly is can the physician/psychiatrist avoid the role confusion that leads to demoralization and burnout.

My challenge to the proposition is not that we should not adjust our curriculum to match the current state of our art and science, nor that we should not introduce our trainees to the basics of business. We should definitely do both.

You argue that we should give up our independence and adopt the methods of bureaucracy and industry, to fit in better, to be less deceived, and to be more content with our roles.

I would like to step back and distinguish your model of management-driven medicine from physician-driven medicine.

The business-minded position you take is consistent with a morality that I call organizationalism. Organizationalism refers to the obligations that we take on when we become an employee. You have adopted an organizationalist perspective, and you present it as the only perspective. You ignore a complementary morality: professionalism. Let us spend a little time distinguishing between professionalism and organizationalism.

When we join any group, we are asked to accept the values of that group, to see things as members of the group seem them, to do things in the same way as other members. When we entered medical school, we were exposed to a particular world view and a particular value system. We took on obligations to two primary groups: patients and colleagues.

To patients, we pledged to put their interests first; to treat all patients equally; to demonstrate compassion; to respect patients’ autonomy to make medical decisions; and to protect them from undue harm.

To colleagues, we pledged to communicate respectfully; to be dependable; to resolve conflicts amicably; to protect our profession by reporting those who are deficient in character or competence, or who engage in fraud and deception; and to refrain from interfering with colleagues’ relationships with their patients.

When we finish our training, we are professionals but we are not employed. We have to convert our credentials into income. We look for a job. A few of us become our own organization as a solo practitioner; most of us enter organizations. When we sign our job contract, we accept some obligations to the organization. We agree to contribute to the goals of the organization and to follow rules and policies. We must live and work according to two different moralities.

Organizationalism follows a logic of rational-legal principles [15]. The organizational ethos emphasizes compliance, rule following, seniority, and rank. The typical organization is hierarchical and bureaucratic, consisting of levels and offices.

Professionalism follows a different logic: Weber called it traditional authority, to contrast it with rational-legal or charismatic authority. Professionalism emphasizes commitment, and collegiality. The typical organization type for professionalism is the clan or fraternity [16].

We have to find some way to act in accordance with both organizationalism and professionalism. You ask us to respect only organizationalism. You are silent on our obligations to patients and colleagues. You do not help us or managers to work through the contradictions between organizationalism and professionalism, when they arise. Contradictions in our roles—as professional and as employee—are a primary source of burnout. How do we help our trainees navigate the tension—surely not by ignoring our responsibilities to our profession.

Another way that your argument is one-sided is that it lets the manager off the hook. Not only do you ask physicians to hand over the keys to the manager, but the manager that you have in mind is a simple top-down autocrat.

When a physician joins an organization and becomes an employee, he/she agrees to assume some obligations to the organization. However, the employee expects that the organization will also be a means for personal fulfillment, a way to satisfy personal needs. When both occur, something called “fusion” occurs [17].

This means that managers should not simply expect that employees will work solely and tirelessly for the good of the organization. The manager is also responsible for encouraging the personal development of the employee. I worry that you privilege the organization’s needs too much and dismiss the individual employee’s needs. The organization ignores the individual’s needs does so at its peril.

On a different point, I would like to distinguish between expertise and caring. It is true that modernity is associated with the emergence of expert systems and that expertise is distributed throughout a system. The expertise in my department is vastly greater than the expertise owned by any single faculty member.

However, when caring is distributed across a group or division, individuals are responsible to care about a limited domain of issues. Nobody is ultimately responsible for caring about the whole. Caring for, and even more importantly caring about, is the most important quality of a good physician. It is the difference between a good and bad doctor. It is a very fragile quality. Real caring cannot be mandated. It can only be encouraged and nurtured.

Healthcare organizations are fortunate because they hire professionals who want to care for and about patients. They should not make it more difficult to care with their management practices.

When we burn out individual caring, we are left only with organizational caring, which is not good enough.

An interesting example of the contrast between an organizational style of caring and an individual style comes from my training. I had a supervisor who chided me for too quickly apologizing for something or other. He told me “you’re not in the customer service department.” What he meant by this was to be careful of trying to gratify the patient’s needs or requests. More important is to understand where the requests come from. Do they emerge from a dependent or a narcissistic personality style? Are they realistic or fantasies? My job is to care about helping the patient to gain insight, even if it induced frustration; it is not to provide immediate gratification or to improve customer satisfaction.

This distinction would probably be lost on a manager who is focused on improving customer satisfaction scores so that the organization can compete in the market place or receive

additional funds from Managed Care Organizations. That is the manager’s job, but it is not necessarily the psychiatrist’s job.

Our residents should be taught, like I was, the arts of confrontation, which might elicit distress but which are in the service of a greater good—the patient’s well-being.

In Support of the Proposition (2)

Thank you, Professor, for that learned discourse on organizationalism and professionalism.

I note from your resume that you have tended to work in organizations at the trailing edge of modern medicine. You appear to have a preference for the nostalgic. Beyond the ivory towers we work in is a real world. And this real world is hard. It is a Darwinian world. Our environment has changed on us—the environment will select for certain characteristics.

I think that you might have drawn the wrong conclusion from your supervisor’s admonition, and if he wasn’t wrong then, he is certainly wrong now. We are in the business of customer service. We are a service industry. Just like flight attendants, we are practitioners of emotional labor [18]. Our reputation is tied to our customer service.

When we perform our role, our customers pass judgment on the adequacy of our performance—and they share their judgment: with friends and family members, and on the web.

It is not just our reputation that is at stake. Hospital reimbursement rates, and hence our income, are tied to customer satisfaction. In other words, it is not just a transference issue anymore.

Back to the distinction you make between organizationalism and professionalism.

I do not disagree that they can be in tension. I propose that what we teach as professionalism is outdated and in need of revision because of the requirements of organizationalism. I propose that if we brought professionalism in line with organizationalism, we would not feel the tension that, as you say, can lead to role confusion and burnout.

It is increasingly difficult to defend professionalism today. The sociologist Elliot Freidson noted that central to professionalism is an elitism, a claim to special privileges, and a claim to a monopoly [4]. All are difficult to sustain today. Elitism is based on a claim to know better and on the value of special credentials. Now our patients have 24-hour access to Dr. Google. No longer do physicians have secret knowledge; everyone has access to it.

It is also difficult to sustain the claim that doctors do what they do solely in the interest of the patient. You do not have to be a patient very long to know that your interests are not always primary.

In case you had not heard: consumerism is eating professionalism for breakfast.

If we are to survive as an occupation, we cannot cling to medieval notions of guild and privilege. As physicians, we are no longer an economically insignificant cottage industry; we are small, but essential cogs in one of the largest segments of the economy.

We have to prove our value, not just to our patients, but to the managers and policy makers. We have to work on getting along, not just getting ahead. Getting along means getting along with managers.

It may come as a shock but our value is not as apparent to others as it is to us. We do not have the cultural authority that we had in the 1950s. Re-securing our claim to an organ (a key moment in the legitimization of a medical specialty), even though we share it with neurologists—like Solomon’s baby—might give us some marketing advantage, but it still does not guarantee our value in the market.

Ultimately, it is not the neurologists we have to worry about. We have to prove that we have more value than a nurse practitioner who can independently diagnose and prescribe. Why should managed care organizations pay us more than nurse practitioners. Is our strategy to market ourselves as a luxury brand? In most markets, this is a risky strategy.

Back to our educational mission, it may be that the recent Residency Review Committee’s requirement for Quality and Safety projects is the thin end of the wedge for the kind of changes being proposed. The Quality and Safety movement has been a great success. It has refocused our attention and challenged some traditional notion. In particular, it has decentered the physician and focused attention on our systems. This is the attitude we should inculcate in our residents.

To summarize, I support the proposition that we must revise our training programs because our world has changed on us. If we do not adapt to this new world, we will not survive as an occupation. We ourselves have to be clear-eyed about this—we cannot keep acting as if the waves are not coming in, as if our future as a profession is assured. The new world is run on business principles and by organizations. We must teach our residents about this world and how to survive in it. The best way to do this is to radically reorganize our anachronistic training programs and teach the logic—business logic—that the rest of the world runs on.

In Opposition to the Proposition (2)

Thank you for bringing us back to our mission as educators. The oft-quoted dean of Bostonian psychiatric education, Elvin Semrad, said that as an educator “You have to help the resident *not to go dead*” [19]. There are many ways to go dead. A common way is to inhibit oneself from asking questions—perhaps because you do not have time or, you do not want to have to go deeper, you bridle your curiosity. Would you have our residents ask more questions, or are you satisfied

when they get the right diagnosis and the right billing code? Presuming that we can keep our residents alive until graduation, I fear that the narrowly defined job description and the short leash that your organizations would put on psychiatrists will only hasten their demise.

You make some neoclassical economic arguments about why professionalism is moribund. It is indeed difficult in the modern consumerist environment to defend claims to special status based on expertise. That is, until you need that special expertise, when you become ill. There is a world of difference between the web-page flitting amateur, or even nurse practitioner with two years of graduate training, and the theoretically trained and empirically experienced psychiatrist. This is our source of value—to our patients—when we compete with nurse practitioners.

The most valuable product we offer is wisdom, or what the Greeks called *phronesis*. Wisdom and judgment are all the more important because, despite our efforts to standardize problems and to develop algorithms that anyone, including Nurse Practitioners, can march through, many problems resist being standardized. When we cannot pull an algorithm off the shelf, we have to rely on judgment. Judgment is our margin.

I maintain that we do not just want to train informed or competent psychiatrists, we want wise psychiatrists. The question is how do we encourage wisdom in our trainees?

My grandparents were firm believers in the value of travel. They themselves traveled around the world. They taught me the value of getting different perspectives.

For them, it was a crucial ingredient of wisdom. I think that we need to encourage travel in our residents for the same reason. Sure, travel through management theory like you are recommending. Peter Drucker’s notion of the management revolution [14], Herbert Simon’s concepts of bounded rationality [20], and A.O.Hirschman’s recognition of the importance of voice in organizations [21] are all crucial readings. But travel as well through sociology, anthropology, economics, and history. Have them swim for a while in the psychoanalytic literature; dip into the existential and humanist libraries.

Our predecessors sat for thousands of hours with their patients—Freda Fromm Reichmann reportedly climbed a tree to connect with a patient. They listened to them, observed them, and tried to make sense of them. It would be unwise to squander this inheritance.

I submit that we *do* want residents to know about industrial modes of production *and* we want them to know about projection, countertransference, the double-bind, and triangling.

Of course, being wise might not completely protect them from the homicidality that the Electronic Medical Record induces in even the most balanced clinician, but it allows us to locate the pathology where it belongs. There is something in that.

The last point I would like to make involves loyalty. Uninformed managers only care about RVUs and short-term profitability. Wiser managers know about the ‘loyalty effect’. One author found that a 5% improvement in customer retention yields a 25–100% increase in profits. Conversely, low employee loyalty is associated with high exit rates and high costs of recruitment, etc. Wise managers know that “work that is congruent with personal principles is a source of energy. Work that sacrifices personal principles drains personal energy” [22]. Managers are not being wise when they ask psychiatrists to sacrifice their personal and professional values to get along with managers. They squander our loyalty. One message is that we should choose our managers wisely.

This proposal is wrong headed and hard hearted. It should be rejected for three reasons:

- i) It is based on a naive view organizationalism and a primitive view of management.
- ii) It ignores the importance of professionalism—for our patients and for our colleagues—and the need for training that is informed by professionalism.
- iii) It would not lead to significant changes in burnout and demoralization; it would only worsen it because it denies us the possibility of finding meaning in our work.

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Compliance with Ethical Standards

No IRB or ethical examination is indicated for this commentary.

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