

# Academic physicians as factory workers: identifying and preventing alienation of labor



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Recent changes in the culture of academic obstetrics and gynecology have increased the potential for disconnect between physicians and their patients. These changes include increased emphasis on productivity, burgeoning bureaucracies for purposes of compliance, arbitrary clinical goals such as low cesarean delivery rates, the electronic medical record, and lack of respect. These changes are predatory on professionalism when they alienate obstetrician-gynecologists from their patients. The concepts of alienated labor and non-alienated labor in the political philosophy of Karl Marx can be used to explain this alienation. We identify alienated labor by analogy to factory workers who perform routinized, thoughtless tasks for goals they do not set to create profit for others, the factory owners. We identify non-alienated labor by analogy to skilled craftsmen who use their highly advanced skills guided by deep experience to fully own the products of their labor. We then suggest that academic physicians are at increasing risk of becoming factory workers and experiencing decreased professionalism while their colleagues in private practice are better positioned to experience non-alienated labor and sustained professionalism. Based on this analysis, we propose five remedies to prevent alienated labor in academic obstetrics and gynecology: expanding the concept of rewarding productivity to include excellence in clinical care and teaching; critical appraisal of the compliance culture and the large bureaucracy it now seems to require; setting evidence-based and therefore clinically realistic goals such as a lower cesarean delivery rate; reforming the medical record to return to the original purpose of the record of promoting communication among care teams with data extraction for billing a secondary purpose; and creating an organizational culture that respects the contributions of clinical academic obstetricians to the mission of their department and medical school. We close by calling on academic leaders in the specialty to work with their clinical practice and teaching colleagues to identify and prevent alienation of labor in academic obstetrics and gynecology.

**Key words:** academic medicine, alienated labor, clinical goals, clinical practice, compliance, Karl Marx, electronic medical record, non-alienated labor, practice guidelines, productivity, respect

## Academic physicians can become alienated from patient care

Recent changes in the culture of clinical practice in academic medicine have created an increased risk of alienation of academic physicians from their patients. In our judgment, this increased risk of alienation has at least 5 origins.

The revenue generated by academic physicians through the clinical faculty practice plan has become essential for a successful business model of a medical school. Revenue streams for research and education are not sufficient to cover their costs, much less the cost of a medical school's sprawling administration.

Academic physicians are therefore expected to become ever more productive, reducing them to mere cogs in the business machine of a medical school. As the demand for productivity to support cross-subsidization intensifies, clinical faculty become increasingly survival oriented, a focus that shoves patient care and education to the side or even out of sight.

By their very nature, bureaucracies grow, a tendency that is accelerated with increased demands for compliance of all kinds. Clinical faculty are increasingly expected to act like compliant bureaucrats.

Arbitrary clinical goals can be set, such as the World Health Organization's universal goal of a 10–15% cesarean delivery rate.<sup>1</sup> Such goal-setting becomes arbitrary when it does not take into account the characteristics of a department's patient population. The result can be that too few cesarean deliveries will occur and therefore increase perinatal risk. Arbitrary goals are thus experienced as strictures that at best are detached from safety and quality and at worst are a threat. When the inflexibility that maintaining strictures requires is added to this volatile mix, cynicism grows.

Academic physicians know very well the administrative mantra of “no margin, no mission.” The electronic medical record has become essential for maximizing revenue streams and thus the “margin.” The electronic medical record has also become tyrannical in its time demands, encouraging a culture of “work-arounds” such as “cut and paste” that increase the risk of missed diagnoses when a patient's condition changes subtly. The rolling computer carts of patient teams have often become the first thing that a patient sees from the hospital bed, creating a persistent visual barrier between physician and patient that previously did not exist. The professional

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responsibility to look at and listen to patients on rounds has eroded.

Academic clinical physicians increasingly are treated as means to the ends of supporting organizational priorities other than patient care and teaching, especially the research enterprise. One result is that academic clinical physicians come to believe that the organization does not respect them for their contributions to patient care and education. To use a current parlance, these physicians are not the “academic stars.” In its worst form, this attitude of organizational leaders results in clinical faculty thinking of themselves as mere means to the ends of others and not as an end in themselves. Permitting a culture of disrespect for colleagues may contribute to burnout.<sup>2</sup>

These changes should be seen as predatory on the professionalism of academic physicians. Professionalism requires a commitment to scientific and clinical excellence in patient care and to keeping organizational or guild interests secondary.<sup>3</sup> An organizational culture that up-ends these commitments exists when academic physicians think of themselves as cogs in the business machine, bureaucrats, and compliant with strictures that combine to turn them into “factory workers” who experience increasing alienation from their patients. The purposes of this clinical opinion are to elucidate this alienation and to propose remedies for it.

### Identifying alienation

#### The contrast to private clinical practice

The first step in explaining this alienation is to contrast academic medicine to private practice. One of us (F.A.C.) recently moved a short distance on the Upper East Side of Manhattan in New York City. I went from being Chair of a Department of Obstetrics and Gynecology, in which almost all of the physicians were full-time employed faculty, to being Chair of a Department of Obstetrics and Gynecology, in which almost all of the physicians are in private practice (1-person to at most 4-person groups).

My new colleagues expressed a sincere commitment to giving humanistic care to their patients and taking the time necessary to fulfill this commitment to

every one of their patients. These physicians are dedicated to education of residents and students, even though they receive no reimbursement. They help each other clinically, especially in emergencies, even though there might be no compensation. They believe that they can allocate the additional time that some patients require, for example, for the management of complex clinical problems. They report that to practice the way they wanted often required longer work days and more call at night and on weekends, which they do happily. For example, 1 colleague recently devoted many hours to a critically ill patient who delivered a critically ill newborn at 26 weeks. He skillfully helped her and her husband to manage the clinical and ethical challenges of subsequent neonatal critical care in a way that exemplified professionalism.<sup>4</sup> New colleagues' incomes cover a wide range, and income was not their primary motivation for remaining in private practice.

They felt comfortable with their earnings level and job security, even though these might be enhanced by transitioning to full-time employed status. They view such status skeptically. They are concerned that full-time status brings with it a set of organizational strictures that could come between them and delivering excellent patient care. For example, they are concerned that they would experience pressure to meet productivity goals and thus not allocate time based on patients' needs and concerns. They did not see having more controlled hours as an incentive, because this would compromise their ability to “be there” for their patients. Indeed, controlled hours might promote a “shift mentality,” already a disturbing phenomenon in residency training.<sup>5</sup>

Shaped by my experience as an academic physician for more than 3 decades, I brought to this new position the belief that the best and most dedicated clinicians and educators are to be found in full-time academic positions. Full-time academic physicians, so I thought, were a step removed from the intensity of the business aspects of clinical practice. This insulation freed full-time academic physicians to engage in patient care, teaching,

and research without the intrusions and pressures of the business aspects of clinical practice. Indeed, in my previous position as Chair, I took it to be a fiduciary responsibility to faculty colleagues to minimize the predatory influences described in the introduction and their adverse effects on professionalism. My new colleagues, by contrast, did not express even a hint that they thought of themselves as “factory workers.”

#### The concepts of alienated and nonalienated labor

This personal reflection illustrates the disconnect in academic medicine but does not provide the conceptual framework to supplement this illustration. When physicians become “factory workers” and experience a disconnect from their patients, they experience a kind of alienation from being professional physicians. The *locus classicus* for the concept of alienation is the philosophical work of Karl Marx (1818–1883).<sup>6</sup> He introduced the concepts of alienated and nonalienated labor.

Marx explained that alienation of labor occurred during the industrial revolution when skilled, independent craftsmen lost their livelihoods to industrial production and took up work in factories. Before this change, skilled craftsmen such as carpenters or farriers, who were self-employed, experienced no distance between the processes and outcomes of their work and its products. Skilled craftsmen enjoyed the deep satisfaction from experiencing excellence in the use of their intellectual powers and manual skills. Skilled craftsmen held in their hands the products of their work, which they owned completely and then sold to their customers. The master carpenter could determine by looking whether a bevel was uniform; the master farrier could tell by look and heft that a cooling metal shoe was ready to be nailed to the horse's hoof. Customers paid for these expert judgments and their translation into unrivaled manual skills. For Marx, nothing came between the skilled laborer and his products. To be sure, there were competition and fiscal pressures, but these self-employed master craftsmen were able, through their diligence and

earned reputation for excellence, to enjoy a level of economic security.

All of this disappeared with the rise of the factory. When skilled craftsmen took up factory work as the alternative to unemployment and penury, they discovered that their work was now routinized and repetitive, to achieve efficiency and high-volume production. Such work benefited the owners of factories, the owners of capital in Marx's discourse, not the workers. Moreover, the owners of capital owned the product of the factory workers, creating something new: an experienced loss of control over the processes of production, and the subsequent physical and psychological gap between work and its product. Marx called this gap between work processes and their product the "alienation of labor."

Nonalienated labor is the labor of master craftsmen who earn this status over the many years that it requires to master the fund of knowledge and manual skills of practicing carpentry or being a farrier at the highest level. Long before Marx, Plato, in *Republic*,<sup>7</sup> described the excellence that master craftsmen experience by using a metaphor: it is like coming out of a cave's darkness and chill into the bright light and warmth of the sun.

Marx's concepts of alienated and nonalienated labor now come to bear. The disconnect in full-time academic practice characterized by the changes described in the introduction to this article should be understood as the direct product of alienated labor. Alienated labor in academic medicine will only increase as these changes intensify. Marx would tell us, correctly, that no physicians should even be willingly become alienated from the processes and outcomes of clinical care. Private clinical practice dedicated to excellence in patient care and education should be understood as the nonalienated labor of master craftsmen and craftswomen.

### Preventing alienation

Private clinical practice dedicated to excellence in patient care and education and without the organizational strictures of academic medicine may place physicians in a better position to experience

the excellence of being master craftsmen and craftswomen than their full-time employed colleagues who may be at risk for becoming "factory workers." The task is to replicate the advantages of private practice medicine, to the extent possible, in academic medicine, to reverse the trend toward alienated labor and its predation on professionalism.

Productivity is essential for meeting the demand of "no margin, no mission." The challenge is to prevent margin from becoming the goal rather than the missions of patient care, education, and research. The key to prevention is to expand the concept of rewarded productivity to include excellent patient care and education. Excellent patient care surely includes good Press–Gainey scores but also includes assessment by members of the healthcare team. Excellent patient care includes the extended time required to explain fetal complications of pregnancy or the genetics of gynecologic cancers. Clinical faculty should be confident that investing time in their patients will not result in being "dinged" for lack of productivity. Excellent education should be assessed by learners and the results used by clinical faculty to become better educators. The goal should be creating an organizational culture that keeps clinical faculty focusing on what is important by keeping margin the means to the end of the mission.

A viable business model requires a competent, functional bureaucracy to meet the demands of compliance from payers, regulators, accreditors, and parent institutions. Clinical faculty should be educated that meeting compliance standards is essential to the missions of patient care, education, and research, and to appreciate that some compliance standards do not make sense to administrative colleagues responsible for documenting compliance. Compliance officers need to take responsibility for minimizing the burdens on clinical faculty of meaningful and meaningless compliance. Teams of clinical faculty and compliance officers should periodically critically appraise the compliance culture to prevent it from distorting the commitments to the missions of patient care, education, and research.

Goals for clinical outcomes should never be arbitrary; they should always be evidence based. For example, the World Health Organization (WHO) goal of a 15% cesarean deliver rate makes no sense if an academic department has a higher acuity practice. An appropriate cesarean delivery rate for such a patient population will necessarily be higher, a judgment that should be based on risk stratification, which the WHO goal ignores. Setting clinical goals that will command respect can be accomplished by empowering academic physicians to draw on their expertise to create and to continuously improve evidence-based guidelines.

One origin of the written medical record originated is the 18th-century British Royal Infirmaries. Academic physicians kept a clinical diary each day that described the patient's condition, management plan, and progress or failure to progress. The diary functioned as a memory aid during the course of the patient's admission and also as the basis for teaching medical students. The record later became an institutional document to support communication among the successive clinicians who cared for the patient. With the rise of third-party private insurance after World War II and then Medicare and Medicaid in the 1960s, the record was put to a second use as a source of information to justify payment. It was quickly discovered that the paper record was not adequate for this purpose, which led to the invention of the electronic record. Physicians rightly have resisted this change because they sense that the original purpose of the record has been supplanted by the need to document billing. The electronic record should be changed with physicians taking the lead in restoring the record's original function while allowing for billing data to be extracted. The horse should be put back in front of the cart. Changes should be promoted and tested with users, to evaluate whether they promote or impair clinical judgment and treatment planning and the communication of these to team members. Promoting the safety and quality of patient care should be the primary goal of the electronic record. Data for billing can still be

extracted but should not be the dominant or, worse, sole consideration.

Academic leaders should reject an organizational culture that promotes disrespect for academic clinical physicians by subordinating the clinical role to research. There should be both a clinical and education track for promotion that have meaningful, clearly stated criteria that the promotions committee promulgates and follows consistently. Academic titles should not modify the standard appointments, so that not even a hint of second-class status is communicated inside and outside the medical school. Peer-reviewed awards for clinical and educational excellence should be common. Junior faculty should be mentored to support their progress in eligibility for such awards and, over time, for successive promotion. In such an organizational culture, the revenues produced by clinical academic physicians will remain crucial to the mission of the

medical school, and these physicians will be valued and respected and no longer treated as a mere means to revenue production.

### Conclusion

The disconnect that many academic clinical physicians experience between themselves and patient care and teaching now has a diagnosis: alienated labor. Karl Marx thus has pertinence to academic medicine that was not previously appreciated. The challenge is to identify and to prevent alienated labor. Academic leaders should join with colleagues to identify remedies that will replace the alienated labor of “factory workers” with the nonalienated labor of professional physicians. ■

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