



Representing Wayne State Faculty and Academic Staff

NEWSBRIEFS

577-1750

aaupaft@wayne.edu

http://mywebpages.comcast.net/aaup_aft/

November 2003

“Learning” or “Revenue”: Mission Creep at the School of Medicine?

What is the Union’s Role?

Steve Babson

There is no easy agreement between the conflicting goals in our School of Medicine, where many faculty members in clinical departments are expected to serve opposing purposes. As academics, they are counted upon to produce knowledge and to transmit their learning to future physicians. As clinicians, they are expected to produce revenue.

When does the second goal so overshadow the first that it undermines the meaning of “academic”? And what is the AAUP-AFT’s role in addressing this and other issues of concern to faculty and academic staff in the School of Medicine?

"For its part, the AAUP-AFT is currently reassessing its role in representing the SOM's faculty and academic staff. That reassessment cannot succeed without a two-way process of communication and learning; this article represents one step in that direction. Are the issues raised here of concern to the SOM's faculty and academic staff?"

A National Crisis

Wayne’s School of Medicine is not alone. Across the nation, Academic Health Centers (AHCs) are struggling to replace revenues lost through declining reimbursements and the slowed pace of public support for academic medicine. To compensate for lost income, AHCs are under pressure to cut costs and generate more patient revenue, leading to higher workloads for clinical faculty and ever more exacting measures of their productivity. Revenue from research grants and contracts is also highly prized, though time for scholarship is hard to find when clinical faculty are pressured to take on more revenue-generating patients.

Teaching is correspondingly devalued and becomes, in effect, the most expendable of roles for clinicians and basic scientists alike. Indeed, as David Korn is quoted in *Academic Medicine*, “education... has become in many institutions somewhat of a byproduct of their principal business lines of research and clinical service delivery.”

Commenting on this national trend, S.W. Bloom goes one step further: “medical schools need medical students,” he observes, “not so much to teach them but to give the entire apparatus of the school a justification for being.”¹

How We Got Here

Before Medicare and Medicaid were enacted in 1965, medical schools generated less than 3% of their revenues from clinical practice, and most of their modest funding for research came from private foundations and

industry. Today, clinical revenues are nearly 50% of total medical school revenue, and research grants and contracts represent a further 30%— more than half of it in the form of federal grants.

This explosion in public funding has had many positive outcomes, not the least of which is the provision of healthcare for the poor and elderly, as well as breakthrough discoveries in medical science. AHCs across the nation have expanded dramatically over the last 30 years, with the number of medical faculty more than doubling between 1975 and 2000. WSU’s School of Medicine (SOM) grew as well, becoming one of the largest AHCs in the nation with nearly 800 medical faculty.

Today, the public revenues that fueled this growth are no longer a supplementary feature of AHC budgeting— they have become the lifeblood that

con't on page 2

sustains the enlarged scale of academic medicine. Wayne's SOM is particularly vulnerable to the slowed pace of this public funding. While Medicaid reimbursements in other states have fallen behind costs, nowhere is this more true than Michigan, where the Engler administration by 2001 had cut Medicaid capitation rates to the lowest in the nation, 50% below the national median.² The growing number of uninsured and underinsured patients puts additional pressure on hospital budgets throughout Michigan, but this is especially true for the Detroit Medical Center: while 10% of the population in Oakland and Macomb counties are uninsured, that figure more than doubles to 21% for Detroit.³ Uninsured patients tend to postpone medical treatment before they arrive at the hospital emergency room and are, therefore, sicker and more in need of expensive services for which there is no revenue.

The Drive for Clinical Productivity

Until recently, the productivity of doctors was measured against one of three scales: hours spent providing clinical services; patients treated; or revenues generated. To varying degrees, all three are flawed. "Hours worked" might give equal results between two doctors when, in fact, one is treating more patients than the other. But counting patients might also be misleading: an urban clinic will draw a larger number of uninsured patients who tend to be sicker, each requiring more intensive treatment and, therefore, more time; an adverse "payer mix" means that such a clinic will also generate less revenue, even though its doctors may be working harder with fewer resources.

Administrators seeking an alternative measure are now turning to a "relative value scale" developed by the federal government and the American Medical Association. Confronted by wide variations in billings for Medicare reimbursement, Congress passed an amended Social Security Act in 1992 that called for a new fee schedule based on uniform national standards. The federal government has since elaborated separate codes for 7,500 medical procedures covered by Medicare, each with a standardized measure of the "relative value units" consumed by physician's work, by support services, and by malpractice costs. "Brainstem surgery" (Code 61576) has an RVU for the physician's work of 52.13, while "Removal of sutures" (Code 15851) has an RVU of only 0.86, the two values reflecting the far greater amount of time, skill, and effort for the first of these procedures. After adjusting for geographic differences in costs, total RVUs are multiplied by a "conversion factor" (currently \$36.79) to arrive at the Medicare reimbursement.⁴

Administrators are increasingly using the same relative value scale as a measure for determining physician contracts, salaries, and bonuses. There is considerable debate over the validity of such a productivity measure. Some welcome the fact that RVU analysis eliminates "stopwatches and clipboards" in quantifying performance, while also correcting for variables doctors cannot control, such as patient/payer mix. On the other hand, some studies question whether RVU analysis can measure quality, whether it fully recognizes decision-making or cognitive activities, and whether it undervalues non-procedural specialties like primary care or rheumatology.⁵

There may be less debate, however, over how the system changes the balance of power in clinical settings. As noted recently in the *Journal of Medical Practice Management*, "RVU cost analysis places the knowledge, and therefore the power, in the hands of the administrator."⁶

"Learning" or "Revenue"?

Whatever the merits of RVU cost analysis in managing medical operations in general, there is good reason to question its relevance for schools of medicine. However one measures physician productivity, the growing pressure to increase clinical workloads beyond what is necessary for teaching or clinical trials tends to diminish the time and resources available for scholarship and education. "In the past," George Taylor observes in *Pediatric Radiology*, "the ability to show potential or proof of academic productivity was an important part of securing and keeping a position in an academic department. This aspect of professional activity has been relegated to a distant second place by the need to recruit and retain enough staff to take care of increasing clinical workloads."⁷

Taylor's study of a large academic pediatric radiology department found that a 46% rise in the number of RVUs per radiologist strongly correlated with a 69% decline in the number of peer-reviewed publications per faculty member.⁸ There is mounting evidence that the negative impact of revenue-centric management is even greater when it comes to teaching. Describing conditions that are all too typical of the prevailing dynamic in academic medicine, a recent study of the school of medicine at the University of California, San Francisco, noted that "by the 1990s, clinician-educators found themselves expected to cover their entire salaries and associated overhead through

their clinical efforts while volunteering for the teaching of medical students and house officers, if the teaching activities could be made to fit.”⁹

There are various proposals for addressing this imbalance, many of them focused on adjusting standard RVU analysis to incorporate scholarship and teaching. Like RVUs, “Teaching Value Units” (TVUs) would establish a point scale for lectures, mentoring, interviewing student candidates, and so on, based on the educational value and complexity of each task.¹⁰ Similar measures quantify the value of scholarly activities.¹¹

By widening the measure of productivity to include teaching and scholarship, these proposals represent a positive step towards recognizing the undervalued dimensions of academic life - but only a small step. If there is no matching institutional commitment for rewarding academic endeavors through salary, bonuses, and support services, then TVUs and other metrics are mere window dressing on an enterprise that remains revenue-centric.

Proposals for how institutional support should be structured range from endowed chairs for educators, to supplementary resources for support of outside research grants, to “Teaching Academies” that recruit and reward outstanding teachers. All of these proposals require a commitment of money, time, and resources— none of which is easy to come by in the current economic and political climate. Unfortunately, WSU’s SOM appears to have conceded to these pressures with the recent announcement in *Prognosis* (4/21/03) that monetary prizes for the school’s Teaching Awards have been discontinued “due to budgetary constraints.”

Politics and Bargaining

“Medical schools of the 21st century,” Dr. Robert Watson argues in a recent issue of *Academic Medicine*, “should rediscover their original reason for existence. Simply stated, they, and only they, have the mission of selecting and educating the next generation of physicians responsible for the care of the public.”¹²

It is easy to endorse Watson’s vision in the abstract, but far more difficult to actually move academic medicine in that direction. Part of the solution entails a reorientation of public policy, and that means a political debate at the federal, state, and local levels. Some of the relevant proposals may be a matter of consensus and may even have a reasonable

prospect of short-term implementation— for example, the establishment of a regional Public Health Authority to oversee the DMC. Other proposals are more controversial and have little prospect in the near term – for example, a national healthcare system or some public mechanism for supporting the healthcare needs of the uninsured and underinsured.

Closer at hand are the practical levers for decision making within our university. Among these is collective bargaining. On the so-called “main” campus, the AAUP-AFT is already in the thick of issues that have

direct bearing on the university’s mission: from the nature of tenure, to the adjustment of workloads, to the “factor statements” that establish promotion criteria. Many of these issues have important

implications for the SOM— including, for example, the issue of fractional tenure in clinical departments that we are currently taking to arbitration (see recent *Newsbriefs* on our website).

The AAUP-AFT leadership is aware that WSU’s SOM has special problems that are not faced by other parts of the university. Furthermore, a ruling of the Michigan Employment Relations Commission in the 1980s legally prevents us from representing clinical faculty in their employment relations with the practice plans, which are nominally an optional feature of the job. **We do have an important role to play, however, in representing clinical faculty when productivity measures are used to assess the performance of clinical faculty in their academic roles.**

Even so, the union has not yet been able to make the kind of contribution in the SOM that it wants and needs to make. In part, this reflects the historic divide between the main campus, where AAUP-AFT membership has been concentrated, and the medical campus, where membership has been low. There are reasons why this may now be changing as the new Fair Share provisions of the contract boost union membership in the SOM, and as the current financial crisis demands new approaches by all concerned.

For its part, the AAUP-AFT is currently reassessing its role in representing the SOM’s faculty and academic staff. That reassessment cannot succeed without a two-way process of communication and

"However one measures physician productivity, the growing pressure to increase clinical workloads beyond what is necessary for teaching or clinical trials tends to diminish the time and resources available for scholarship and education."

con't from page 3.

learning; this article represents one step in that direction. Are the issues raised here of concern to the SOM's faculty and academic staff? What more do we need to know? We are planning a comprehensive survey— what questions do we need to ask? In addition, we intend to develop a committee representing the SOM within the union to act as a sounding board for issues that are relevant to collective bargaining.

It is our hope that we can arrive at a common agenda for the SOM across the remarkable diversity of its many departments, specialties, and sub-cultures. We look forward to hearing from you by email (aupaft@wayne.edu), campus mail (103 Belcrest), or phone (577-1750).

ENDNOTES

- ¹ Korn and Bloom are both quoted in Robert Watson, MD, "Rediscovering the Medical School," *Academic Medicine* v. 78, #7 (July 2003), 659.
- ² Detroit Health Care Stabilization Workgroup, "Strengthening the Safety Net in Detroit and Wayne County" (August 2003), 5.
- ³ *Ibid.*, 31.
- ⁴ Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004," and Addendum B.
- ⁵ For a recent summary of these issues, see David Coleman, MD, et al., "Measuring Physicians' Productivity in a Veterans Affairs Medical Center," *Academic Medicine* v. 78, #7 (July 2003), 682-689.
- ⁶ KP Glass and JR Anderson, "Relative Value units and Cost Analysis, Part 3 of 4," *Journal of Medical Practice Management* v. 18, #2 (Sept.-Oct. 2002), 66.
- ⁷ George Taylor, "Impact of Clinical Volume on Scholarly Activity in an Academic Children's Hospital," *Pediatric Radiology* v.31 (2002), 788.
- ⁸ *Ibid.*, 787.
- ⁹ Molly Cooke, MD, et al., "The UCSF Academy of Medical Educators," *Academic Medicine* v. 78, #7 (July 2003), 667.
- ¹⁰ See, for example, Nagma Khan, MD, and Harold Simon, MD, "Development and Implementation of a Relative Value Scale for Teaching in Emergency Medicine: The Teaching Value Unit," *Academic Emergency Medicine* v.10, #8 (2003), 904-907; Michael Yeh, MD, MPH, and Daniel Cahill, MD, "Quantifying Teaching Productivity Using Clinical Relative Value Units," *Journal of General Internal Medicine* v.14, #10, 617; and N Schneider et al., "Recognizing Clinical Faculty's Contributions in Education," *Academic Medicine* v. 77, #9 (Sept. 2002), 940-941.
- ¹¹ Cooke et al, "The UCSF Academy of Medical Educators."
- ¹² Robert Watson, MD, "Rediscovering the Medical School," *Academic Medicine* v. 78, #7 (July 2003), 662.

Wayne State University Chapter

AAUP-AFT

5440 Cass, Suite 103
Detroit, MI 48202-3680

AAUP-AFT Executive Board

President

Charles J. Parrish

Vice President

Naida Simon

Secretary

Susan LaLiberté

Treasurer

Robert Arking

Joint Observer

M.L. Liebler

Joint Observer

Allen Goodman

Contract Implementation

Anca Vlasopolos - Faculty

Barbara Jones - Academic Staff

Grievance Coordinator

Mary Cay Sengstock - Faculty

Lothar Spang - Academic Staff

Information Coordinator

Steve Babson

Academic Staff Chair

Felicia Grace