March/April 2000
Volume 3 Number 2

ecp
EFFECTIVE CLINICAL PRACTICE

EDITOR
H. GILBERT WELCH, MD, MPH

ASSOCIATE EDITORS
JOHN D. BIRKMEYER, MD
JAMES SARGENT, MD
LISA M. SCHWARTZ, MD, MS
STEVEN WOLOSHIN, MD, MS

EDITORIAL

WILLIAM E. SCHECKLER, MD
University of Wisconsin Medical School
Madison, Wis

Eff Clin Pract. 2000;3:92-93.

The Bright Side of the Managed Care "Dark Side" Demon

American culture is replete with examples of good versus evil, of "the Force" versus "the Dark Side." Our literature, movies, television, and politics tend to view life through the prism of the adversarial nature of this struggle. We love to place blame. We want to find evil and rid ourselves of it. Recent television commercials depict Uncle Sam as the dupe of $46 billion in Medicare fraud and ask patients to search for such fraud in their own medical bills, rather like a patient police force. Politicians want to give us a patients' bill of rights. From movie scripts to the floor of the American Medical Association house of delegates, managed care has become the "Dark Side" of U.S. medicine.

The article by LePore and Tooker in this issue[1] focuses on physician satisfaction with managed care. Their telephone survey of a national random sample of practicing internists wisely divided managed care physicians into three groups: those who are employed by a single plan (staff model); those who contract with a single plan; and those who contract with multiple plans—by far the most common situation. Of the 751 internists responding to the telephone survey, 689 were affiliated with a managed care plan. Of those so affiliated, 9% were staff-model HMO salaried physicians, 6% were under exclusive contract, and 85% had multiple contracts. The main lesson learned from the study was that salaried and single-plan physicians were much more likely to be very satisfied with their contracted managed care organizations. More important, these same physicians were much more likely to believe that their managed care organizations were "committed to quality patient care."

One of my colleagues is fond of saying, "When you have seen one managed care organization, you have seen one managed care organization." A huge diversity of arrangements are all lumped under the rubric of "managed care." Therefore, it is refreshing to see a study separate different types of managed care arrangements. It would have been even more interesting to see whether there was a difference between primary care internists and focused care or "specialty" internists.

My colleagues and I have conducted our own studies in Dane County, Wisconsin, that tend to reinforce the findings noted by LePore and Tooker. Since the early 1980s, we have been following physician satisfaction, and to some extent patient satisfaction, with HMOs and managed care arrangements in our county of 400,000

This paper is available at ecp.acponline.org.

© 2000 American College of Physicians–American Society of Internal Medicine

persons.[2, 3] Practice arrangements in our community consist of one staff-model HMO and three multispecialty group practices and practice networks. There are one university and two nonprofit community hospitals in town. Each multispecialty group practice relates to only one hospital, and each has its own home-grown HMO. Satisfaction levels, which have been high, have increased over time with managed care but have gone down with fee-for-service care. Everyone is least happy with Medicare. It is likely that satisfaction with managed care and HMOs has increased in part because physicians have control over or involvement in creating HMOs through the structure of their own group practices. In addition, this increase in satisfaction is probably related to the lack of out-of-state, for-profit involvement.

We observed the greatest satisfaction among generalists: family physicians, general internists, general pediatricians, and general obstetrician–gynecologists. Satisfaction was higher among generalists because they were more satisfied with HMO-generated income and with what they perceived as the expanded clinical freedom in HMO practice. However, among all three specialty groups in our study—generalists, referral specialists (medical and surgical), and hospital-based specialists—support of HMO development substantially increased. In a 1986 survey, 38% of 545 physicians reported that they were "supportive" or "very supportive" of HMO development; in a 1993 survey, 65% of 676 physicians responded this way.[3] Our survey instrument was validated, and our findings were confirmed in a survey of physicians in Indiana.[4]

More recently, a large group of generalists collaborated on a much more ambitious investigation of physician satisfaction in the workplace. Their foundation-funded survey used a validated, mailed questionnaire. The physicians surveyed were drawn from the American Medical Association's master file and were a national random sample of family physicians, general internists, general pediatricians, referral internists, and referral pediatricians. Information on the development and use of the survey instrument has been published elsewhere.[5, 6] Reports at meetings, which will soon be published, show that the relation between the time allotted for a patient visit and the time perceived to be optimal for that visit is key to physician satisfaction across all specialties and all managed care organizations. The more the allotted time corresponds to the time perceived to be needed, the higher the career satisfaction.

What does any of this mean to young physicians preparing to enter practice? I would offer three simple messages. First, the words "managed care" tell you very little about the actual practice arrangement. Viewing managed care only as the "Dark Side" of medical practice is a huge misdiagnosis. Second, if you work principally with one organization (e.g., a managed care system), you are more likely to be able to exert some control and autonomy over your practice. Because of this, you will be happier. Third, your professional satisfaction will be more closely related to having enough time to do the job right than to how much money you make. In sum, when considering a prospective practice, it is wise to examine its processes, business arrangements, and all aspects of physician work life. It is worth taking the time to do so. Physicians who are happy in their work are more likely to practice medicine for a long time, provide a higher quality of care, and have more satisfied patients.

References

1. LePore P, Tooker J. The influence of organizational structure on physician satisfaction: findings from a national survey. Eff Clin Pract. 2000;3:62-68.
2. Schulz R, Girard C, Scheckler WE. Physician satisfaction in a managed care environment. J Fam Pract. 1992;34:298-304.
3. Schulz R, Scheckler WE, Moberg DP, Johnson PR. Changing nature of physician satisfaction with health maintenance organization and fee-for-service practices. J Fam Pract. 1997;45: 321-30.
4. Bates AS, Harris LE, Tierney WM, Wolinsky FD. Dimensions and correlates of physician work satisfaction in a midwestern city. Med Care. 1998;36:610-7.
5. Konrad TR, Williams ES, Linzer M, et al. Measuring physician job satisfaction in a changing workplace and a challenging environment. SGIM Career Satisfaction Study Group. Society of General Internal Medicine. Med Care. 1999;37:1174-82.
6. Williams ES, Konrad TR, Linzer M, et al. Refining the measurement of physician job satisfaction: results from the Physician Worklife Survey. SGIM Career Satisfaction Study Group. Society of General Internal Medicine. Med Care. 1999; 37:1140-54.

Correspondence

William E. Scheckler, MD, Department of Family Medicine, University of WI Medical School, 777 South Mills Street, Madison, Wisconsin 53715; telephone: 608-263-3637; fax: 608-263-5813; e-mail: wes@fammed.wisc.edu.