Choosing Between Clinical Practice & Administration

After wrestling with the decision, this family physician ended up where she started, but she gained a good deal of insight along the way.

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Sitting at my desk, I recognized the full weight of the decision before me: Should I accept a full-time administrative position which would mean leaving the clinical practice of medicine? It stunned me that I was contemplating leaving a career I dearly loved. Yet I had become inspired by the quality movement in health care. The Institute of Medicine reports[1,2] substantiated that our health system falls short of its potential, and I wanted to help bridge the "quality chasm." I felt I could contribute more as a full-time medical director of quality than as a part-time medical director with a part-time clinical practice. Nevertheless, when a job offer presented itself, I found myself struggling over a decision.

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KEY POINTS

- The author initially couldn't decide whether to leave her clinical practice for a new opportunity as medical director of quality.
- To help her weigh her options, she applied the techniques of rational decision making.
- Decision criteria included life balance, career growth potential and contribution to community.

ILLUSTRATION BY C.M. SCHNEIDER

How I got here

I was imperceptibly drawn to the cause of quality improvement at the outset of my professional career. Learning to be a physician, I was on the hunt for absolute truth – clinical axioms upon which to anchor my medical decisions. However, I recall a number of instances in which, just when I thought I held certainty in my fingertips, it was knocked

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The author, a family physician, had been on the hunt for "the absolute truth" since her medical school days.

She found medical dogma peppered with contradictions and became interested in the quality movement.

Accepting a position as a medical director of quality meant leaving her medical practice behind.

To help her weigh her options, she used the techniques of rational decision making.

away like the precious catch of a football that would have won the game. I recall an early example of this on my medical school neurology rotation. When I proudly reported the carotid bruit I discovered on an examination, a respected professor chastised me, advising that I shouldn't even listen to the carotid arteries since she wouldn't advocate endarterectomy for anyone. Soon thereafter, I presented this pearl of wisdom to another esteemed neurologist, who immediately (and forcefully) knocked it out of my hands and presented a new one to me.

I found that similar contradictions peppered much of medical dogma, and I adapted by growing my own form of wisdom, often ranking experience as my most trusted – though not always rational – teacher. While experience has its distinct value, sometimes the "wisdom" that comes from experience conceals other sources of information from view. When this happens, experience eventually congeals into a personal "style of practice," which I have learned is often a euphemism for excessive variability in medicine (and there is far too much of it for all of us to be correct). To combat this, we now have clinical guidelines. However, they are not enough. Human factors interfere with consistency of quality in medical practice. Constant interruptions combined with the vagaries of life beyond the office doors and in the interactions between health care workers affect the care patients receive on any given day. Life simply gets in the way – of patients trying to make lifestyle changes and of physicians struggling to deliver high-quality care to each patient. This was disquieting to me. My concern for the patient in the next room who was short of breath would distract me so much that I failed to recommend an eye exam to the next patient with diabetes. Noncompliance showed itself in my patients, my co-workers and myself.

Then I had an opportunity to work with the Institute for Healthcare Improvement, where I learned that there is more to behavior change than merely wanting to change. I learned that real progress can be made through the application of systems theory, the science of improvement and sound behavior-change methods. I attempted to integrate this insight into the operations of my own physician group and decided to further my education by enrolling in a master's program.

Before long, I became acutely aware of my limited capacity to create the level of change our medical systems required. I realized that change management would require more than just a fragment of my time. At the same time, I saw that my patients were not getting enough of me. One example stood out. Sue and I had been through much together. I diagnosed Sue's chronic illness when she was young, and later I empathized with her desire to have a child. When she was finally able to bring a child into her life, I cared for him for a short time until she and her child stopped coming to me. When I saw her one day she explained, "You're just not as available as a new mother needs." Her words resonated painfully. I had been blessed with close relationships with Sue and many other patients, but those bonds were suffering. I felt they deserved more. A decision loomed.

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Decision criteria

When I was first presented with an opportunity to move into a full-time administrative position, I balked. I was viscerally attached to clinical practice. In addition, I'd heard other physicians say that after so many years "on the dark side," one no longer even qualifies as a physician.

In order to bring reason to the table, I decided to use the techniques of rational decision making I advocated in other areas. I chose the following decision criteria and weighed my options according to each:

Gaining mastery. As a family physician, I found variety appealing. However, I had crossed the line of appropriate variety in my workday. My days were packed with meetings, leadership in several different forums and a busy practice. Being pulled in many directions was interfering with my sense of mastery in both areas. I knew that my desire to significantly impact the quality of health care in just my little corner of the world would require more from me administratively.

Life balance. I had become a workaholic,

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She considered the following criteria: life balance, others' opinions, career potential, financial compensation, community contribution and the well-being of her current practice.

She determined some criteria to be more important than others. Ultimately, she accepted the administrative position.

Not long afterward, she returned to part-time clinical practice. She simultaneously continues her work in quality improvement.

On reflection, she determined her decision-making approach was too logical and underestimated what was in her heart.

plain and simple. It was interfering with my relationships and with my effectiveness at work and at home. Two of my three sons were approaching adolescence, and I recognized that my youngest had been cheated out of time with mom too often. Change management requires endurance, and I could see that my stress level was adversely affecting my stamina. I knew I needed a better life balance, regardless.

Career growth potential. The position I was offered would put me in the role of health system leadership, giving me an opportunity to spread my influence beyond a group practice and to more broadly use the skills I learned in the master's program. Although transforming medical practice within my group was an important start, I knew it would not satisfy me for the long term. This was another win for the new role.

> I decided to approach my decision with the techniques of rational decision making I advocated in other areas.

Contribution to community. Caring for the adults and children in my church, my children's school and our health system gave me a sense of belonging. As a full-time administrator, I would still be able to contribute to my community but in a different way. This criterion appeared to support either choice.

Practice well-being. My practice's well-being was not at risk. If I took on this new role, I would leave nine capable partners who would provide excellent care for my patients. This was not a significant issue, regardless of my choice.

Approval of others. While I expected to feel the impact of disapproval from patients and colleagues, I realized that I could not allow it to influence my decision. Seeking approval from others would likely lead me in circles. I quickly eliminated external approval as a gauge.

Financial considerations. I made a good living as a family physician. Although I would experience a slight increase in salary in the new position, that was not reason enough to accept it. I knew myself well enough to realize that without a passion for my work, life would be less satisfying for me. I was not willing to trade money for the fulfillment to which I had grown accustomed. I therefore decided not to allow financial reasons to affect my decision.

The grass may be greener …

Weighing my options, I decided to accept the position I was offered and soon began work as a full-time medical director of quality. But from day one, the new job felt like a new suit that didn't yet fit. I hoped to grow into it over time and tried to focus on the work ahead, but after more than 10 years in clinical practice, I had a hard time forgetting about my patients.

After several months, I decided to return to part-time clinical practice. I did so purely for selfish reasons, which I term "for the love of the game." Today, I simultaneously care for my patients and continue my work in quality improvement. While this choice does promote my confessed workaholism, my logical approach underestimated what was in my heart.

Returning from the world of full-time administration, I believe I did what was right for me. But I suspect that what I have gone through dramatizes a tension that exists in the minds of many family physicians. Most of my colleagues love practice but don't love what has happened to it. Some wouldn't think of leaving full-time practice. We need every one of them. Some are willing and able to transmute their love of the profession into full-time dedication to improving it. We need every one of them, too. But most of all, we need all caring family physicians to ask themselves how they are best suited to serve and to live out the answer. FPM

Send comments to fpmedit@aafp.org.

1. Committee on Quality of Health Care in America, Institute of Medicine. *To Err is Human: Building a Safer Health System.* Washington, DC: National Academy Press; 1999.
2. Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academy Press; 2001.