EDITORIALS

Are Clinician-Teachers Good for Anything Other Than Teaching?

Tough times at American medical centers have motivated some to ask whether clinician-teachers are a luxury they can no longer afford. Many health maintenance organizations, for example, have reduced their commitment to teaching activities under the belief that they cause a drag on profits or a loss in care.¹ Of course, academic medical centers are not immune to economic forces, and several prominent organizations now pressure faculty to focus on research, patient care, or other activities that produce large revenues.² Self-interested administrators seem to recognize the importance of medical education, but suggest that it not be located in their own backyards.

Advocates for clinician-teachers need strong defenses against these pressures, and two such defenses are described in this issue. Investigators in Ohio document a clear plan for allocating discretionary teaching dollars according to teaching effort.³ Investigators in Michigan describe the range of incentives that are being offered to nonsalaried faculty.⁴ Together, these two articles document that some institutions are serious about supporting clinician-teachers, and they show how support for individual clinician-teachers can be made both fair and imaginative. Hence, the pie can be sliced in an equitable and innovative manner. However, neither of these studies says much about the absolute magnitude of support. That is, how big should the pie be? We answer this question by describing reasons for increasing support for all clinician-teachers.

The most direct argument is that teaching hospitals provide better clinical care than nonteaching hospitals, at least for some patients.^{5,6} The superior outcomes are somewhat surprising, given that trainees most likely make more errors than experienced physicians. Perhaps, however, a greater frequency of error is more than offset by a far greater frequency of double-checking, thereby resulting in more mistakes but fewer egregious mistakes. Alternatively, perhaps the academic environment encourages more striving for excellence. If so, truly outstanding care might be more frequent at teaching hospitals. Whatever explanation, an institution that values patient care may wish to retain its teaching status.

A durable health care institution must also consider how teaching affects recruiting. The back pages of this and other medical journals indicate how much money institutions spend advertising to fill vacancies. These visible activities usually are accompanied by less visible activities such as consulting headhunters or entertaining lavishly, undertakings that incur cost without providing

care. Furthermore, unfilled vacancies are inherently unproductive. Hence, a health care institution may be more efficient if it can recruit from a steady stream of its own trainees.

Thoughtful planning also entails thinking about referrals. All else being equal, physicians tend to refer patients to professionals they know and respect. And rightly or wrongly, clinician-teachers leave powerful impressions on trainees that may last a long time and reach into diverse areas where trainees are dispersed. These early impressions can be especially important for cases involving rare disorders, for example, when a psychiatrist diagnoses a patient with Wilson's disease and can remember only one previous patient seen during training. Eliminating clinician-teachers may eliminate these referrals.

Optimizing patient care also requires continually updating staff about advances in medicine. Like other successful businesses, successful health care organizations must provide intramural, staff-enhancing activities like weekly grand rounds.⁷ Yet, finding individuals willing to present in such venues can be a problem. Clinician-teachers are uniquely qualified, and they may have special incentives if they are expected to have full teaching dossiers. Moreover, clinician-teachers are less likely to be absent because they are presenting at scientific meetings or reviewing grants at study-section meetings. Having fewer clinician-teachers means spending more elsewhere on staff development.

Some claim that the biggest cost of a clinician-teacher derives from the inevitable association with trainees. According to this theory, trainees are inefficient clinicians who cause excessive testing, unnecessary treatments, wasted time, general chaos, and other economic losses. The available evidence confirms that the direct costs of care at teaching hospitals are marginally higher than they are at nonteaching hospitals.^{8,9} However, this is not an argument against clinician-teachers, but rather an argument against one type of teaching. Some institutions believe that trainees create indirect profits by allowing, for example, the hiring of fewer nursing staff. Whether trainees are profitable or not depends on the balance between their service contributions and other aspects of their educational program, and that varies from place to place.

Generous donations from grateful individuals provide one small, yet pleasant source of revenue for many health care institutions. Some donors are specifically interested in teaching excellence, and forgoing a teaching program means sacrificing these donations. In addition, donors who are interested in promoting research excellence are some-

times more enthusiastic if they see that the institution is successful at attracting trainees. Moreover, donors who are interested in clinical care usually appreciate the importance of education. Together, these arguments suggest that a drop in teaching activity may eventually lead to a drop in donor activity. And, of course, grateful alumni can be another source of donations.

Perhaps the most pernicious attack on clinician-teachers is the claim that a small reduction in support can be absorbed without any loss in performance. Such a belief presupposes a gain in efficiency, a supposition not generally supported by observation in any type of education.^{10,11} To be sure, practitioners of medicine have enjoyed large gains in efficiency recently because of advances in technology; however, teachers of medicine draw much smaller benefits from computers, biotechnology, and other such marvels. Education still takes about the same amount of time because the human brain has changed little in the past millennium. Moreover, technology cannot replace human interactions because nothing substitutes for the clinician-teacher's inspiration, praise, and encouragement.

The most compelling argument for supporting clinician-teachers is not mercenary but altruistic. The practice of medicine survives only by being taught to others. An institution that supports clinician-teachers identifies itself as an institution that supports other humanitarian efforts.¹² Moreover, such an institution provides an environment that prevents burnout by using keen young minds to recharge its practitioners. In this time of economic uncertainty, the theory of rationality dictates that all decision makers should follow high moral principles. Teaching others is one such principle.—**DONALD A. REDELMEIER, MD,** and **STEVEN L. SHUMAK, MD,** *The University of Toronto Program in Clinical Epidemiology and Health Care Research, and the Department of Medicine of the Sunnybrook and Women's College Health Services Centre, Toronto, Ont, Canada.*

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