Improving the culture of medicine

Francine Lemire MDCM CCFP FCFP CAE ICD.D, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER

Dear Colleagues,

Physicians place high expectations on themselves in acquiring the necessary competencies for service delivery. Over the past few years, considerable distress has been experienced by many physicians. The rate of burnout in the medical profession has raised questions about the culture of medicine and whether strategies can be put in place to improve it. *Culture* refers to "the shared and fundamental beliefs, normative values, and related social practices of a group that are so widely accepted that they are implicit and no longer scrutinized" and it "provides identity, order, meaning, and stability."[1] There are 3 layers of culture: our *espoused values,* which are what we claim our priorities to be; *artefacts,* which are our actions and the manifestations of our culture; and *tacit assumptions,* which are the underlying things we believe and value.[1]

In recent years, physicians have experienced an increased level of dissonance between their professional values and their behaviour and actions. This dissonance can manifest itself in several ways.

At the organizational level: Physicians take their professional role seriously—we trust them—yet substantial documentation can be required for billing purposes; the implied message, therefore, is we do not trust them. Physicians are highly trained—we should maximize their clinical contribution to care—yet clerical burden is excessive; the implied message is that we do not value their time. Physicians value shared decision making in the context of wanting to be patient-centred—yet decision makers, in their efforts to balance budgets, preferentially target physicians, family physicians especially, regarding discretionary funding to recognize complexity of care; the implied message is that economic priorities are more important than patient agency.

At the individual provider level: Prevention is more important than treatment—yet many physicians do not practise self-care and do not have a family physician; the implied message is that physician health is not important. To err is human—yet physicians involved in adverse events might not be supported in recognizing the multifactorial nature of medical error; the implied message is that errors are not tolerated and physicians are expected to be superhuman, and a culture of blame is sustained.

In the core educational arena, there is emerging evidence of factors that influence the culture of family medicine. For instance, we know that the hidden curriculum (eg, "You are too bright to go in family medicine") has a negative effect, whereas paying attention to high-quality undergraduate family medicine educational experiences has a positive effect. Especially valued is exposure to a well-run practice, team-based care, mentoring and role modeling that shows the primacy of the doctor-patient relationship, and attention paid to work-life balance.[2]

Some have argued that another reason for this dissonance is that we have a traditional male-dominated culture of medicine at a time when more women have entered the profession and when both women and men pay greater attention to achieving better balance between their personal and family life and their professional life. Both male and female physicians hold similar values and aspirations (altruism, providing good patient care, wanting to be useful and appreciated) across generations and experience frustrations regarding a growing bureaucracy and administrative duties.[3]

Culture has the potential to change when a stimulus that upsets the equilibrium is at play. The stimulus now is burnout, which is more prevalent in medicine than other professions—and worse yet in family medicine. It is associated with lower-quality care and lower patient satisfaction, and with increased medical errors.[2,4]

What can be done? It is suggested that we seek to find specific areas where change might be feasible, particularly if those involved are given the opportunity to be engaged and are supported rather than coerced to change. Emergence of the fourth aim of the Quadruple Aim is helpful in validating the importance of clinicians' wellness in achieving the objectives of better health, better patient experiences, and lower costs. Offering choices in addressing physician wellness is important. Areas being considered as part of a menu of options include defining a desired future state by creating a charter on physician well-being; fostering positive role models through the creation of dedicated chief wellness officers; and creating support groups and professional development opportunities, such as conferences on physician health.[1]

The CFPC's approach up to now has been to support the Canadian Medical Association, which has been the most active in this area, in order not to duplicate efforts. We look forward to collaborating with them in appropriate ways as their plans get further developed.

Cet article se trouve aussi en français à la **page 305.**

References

1. Shanafelt TD, Schein E, Minor LB, Trockel M, Schein P, Kirch D. Healing the professional culture of medicine. *Mayo Clin Proc* 2019;94(8):1556-66. Epub 2019 Jul 11.
2. Erikson CE, Danish S, Jones KC, Sandberg SF, Carle AC. The role of medical school culture in primary care career choice. *Acad Med* 2013;88(12):1919-26.
3. Van Zalinge EAB, Lagro-Janssen ALM, Schadé B. The increasing number of female general practitioners: why we need to change medical culture. *Eur J Gen Pract* 2009;15:65-6.
4. Siow S. *Physician, be well thyself!* Presented at: Alberta College of Family Physicians Family Medicine Summit; Banff, AB: 2020 Mar 6.