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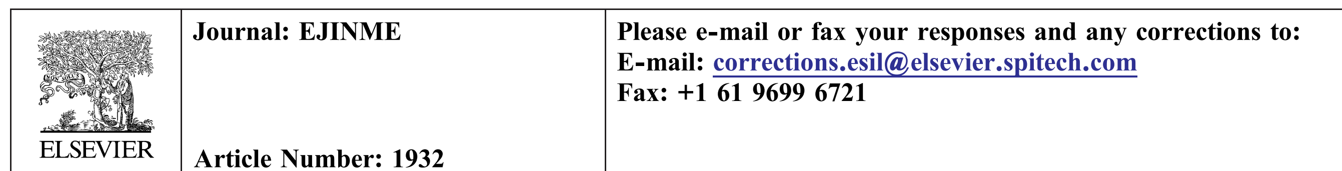

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European Journal of Internal Medicine xxx (2010) xxx–xxx

Contents lists available at ScienceDirect

European Journal of Internal Medicine

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Debate

Why management and leadership education for internists?

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ARTICLE INFO

Article history:
Received 21 June 2009
Received in revised form 7 April 2010
Accepted 13 April 2010
Available online xxxx

ABSTRACT

Around the world, there is an increasing need for more efficiency in healthcare alongside cost containment. Internal medicine physicians are in a pivotal position in this regard. In many countries, they act as bridges between ambulatory/continuity of care systems and hospital-based intensive care and sophisticated therapies. Within the medical field, they often bridge gaps between many specialities increasingly required to provide modern medical care. These skills of managing complex environments, being sensitive to health economics and using large amounts of information, are not normally taught or developed in programmes of internal medicine. While some skills are natural and acquired through practice, other skills would benefit from insights from the fields of management. On the other hand, it seems critical to have internists playing a leading role in the future care of aging populations, and they are the most likely to understand the needs of these multi-pathology cases. On a practical level, internists face the daily challenges of engaging and leading as many people as possible to provide the best care; this requires very good leadership, negotiation, team-working and change-management skills, all of which can be vastly enhanced with specific education initiatives that are targeted and customised to physicians' needs. Management education for internists should be "spiral", starting from medical school and expanding to incorporate issues as the physician maturates into new activities and responsibilities. In practical terms, current internists and residents of internal medicine can be brought into contact with such education by a combination of workshops as well as residential and online courses.

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1. Introduction

Worldwide societies are aging fast and demanding more of everything. The rising burden of chronic and behavioural-related diseases increases pressure on the healthcare systems. These healthcare challenges are especially felt by internists, geriatricians and family physicians as well as by the organisations where these professionals try to deliver first-class healthcare service in the face of an increasingly informed public and a myriad of expensive medical treatments and technologies [1]. Aging also means that the hospitalised patient of today is often suffering from multiple pathologies as well as interrelated problems and that the best care is increasingly called into question by departmental and super-specialised hospital systems. If trends toward developments in ambulatory care continue, a hospital patient in the future will likely be a very complex clinical case, calling for the participation of several specialities and most importantly requiring a general medical knowledge-based physician to act as a coordinator. Different countries have significantly different health services and systems, even in Europe alone. These may determine different roles for physicians with regard to the management of the health sector organisations, with doctors and internists playing more active or passive roles in this respect. Nevertheless, internists cannot place themselves away from this debate in their respective countries.

Despite wide variation, internal medicine is mostly, and in most countries, characterised by a large scope of activities: diagnosis of complex cases; follow-up of multi-pathology medical cases; and/or medical support to surgical cases with extensive co-morbidity. In many countries, it is the basic root training for emergency and intensive care and even the support staffing for emergency and intensive care departments. In some countries, geriatrics has been separated from internal medicine, while in other countries, the care of very old patients remains in the realm of internal medicine. Regardless of these differences, even in some countries where internal medicine has lost its weight in hospital dynamics, it is slowly returning with the sheer number of co-morbidities each patient presents, demanding specialists such as cardiologists, neurologists or nephrologists, increasing unease and calling for generalist physicians to integrate the medical care required.

It follows that internists' work is thus characterised by functions of the following: a) knowledge integration; b) resource allocation and usage; c) coordination of broad medical and clinical teams, and d) negotiation/decision-making in the face of conflicting demands/ strategies over the same patient. Through their medical training, internists are normally quite ready for the integration of clinical knowledge. On the other hand, training regarding healthcare economics as well as resource usage and misusage is often lacking, and considerations of this type are often not stimulated by the internal medicine establishment. While some choices of expensive resource usage are part of good medical practice, others fall in the many grey

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0953-6205/$ – see front matter © 2010 Published by Elsevier B.V. on behalf of European Federation of Internal Medicine.
doi:10.1016/j.ejim.2010.04.014

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areas of medical diagnosis and treatment options, and here is where a sense of health economic cost–benefit analysis, efficiency and equity are felt as lacking. A third function is adequate clinical team coordination. This coordination function is often the integration of demands from several medical "sub-specialities" such as pneumology, cardiology or gastroenterology when conflicts arise in the care of the same patient. An example is anticoagulation for arrhythmia in a cirrhosis/oesophageal varicose patient under treatment for tuberculosis. Coordination between hospital, ambulatory care and social arrangement is another example. Finally, the ability of negotiating in favour of the patient encompasses much of present practice. Negotiation with administrators for resources, with intensive care units for critical care support or with difficult families when it is time to discharge a patient. As demands arise and the number of complex case increases, negotiation and prioritisation skills will only become more critical in internists' work.

2. Relevance of management education to internists

Structured medical training is now almost 2500 years old; in contrast, management training for doctors is a recent concept recognised worldwide as desirable and highly relevant. Despite the areas of overlap, management knowledge and skills differ from leadership. Leadership is often about changing the status quo, but the status quo often evolved from strategies that best used resources to maintain ongoing performance. Although this distinction exists academically in practice, most good management education programmes include subjects akin to leadership, and, inversely, there is no way one can teach leadership without providing a solid basis of economics and management subjects. From the above discussion, internal medicine is likely to require doctors with skills in both of these broad areas and with the judgement to understand when to choose each of them.

Current internal medicine training, with very few exceptions, mostly deals with clinical knowledge acquisition, clinical skill development and diagnosis formulation. While these should of course remain the core elements of the education, without training in certain areas of management and leadership, some of the aspects of internists' work will remain in the area of learning by doing or by trial and error or will simply remain undeveloped, resulting in significant underperformance. There are multiple benefits of this education. However, there are no specific studies that have looked at internist performance after management or leadership training in the broadest sense, but non-technical skills are being increasingly introduced into medical curricula and in that of advance life support training or other medically critical situation management exercises. Outside medicine, there are a number of studies that have looked at decision-making, leadership skill development or management decision-making and how these have benefited from specific training programmes [2]. There is no reason to assume that critical decision-making such as that done by internists in environments like emergency or critical care could not be equally subject to controlled and evaluated development programmes. In the broadest sense, health management education for many will represent the [first] occasion to gain knowledge of the fundamentals of health economics and organisation management skills for complex healthcare units. This is useful for their daily work, which is as dependent on relationships and teamwork as it is on scientific knowledge and expensive technologies. Additionally, it introduces new and useful concepts to doctors who may come to function as unit heads, triggering awareness of old problems and new solutions. Additionally, introducing doctors to a management language enables better understanding when engaging with professional managers who are spreading in healthcare and with whom they have to learn to partner. Potentially more difficult but surely highly needed worldwide is good strategic leadership. Courses in these fields aside from equipping participants with reasoning and awareness tools also provide *momentum* and serve to further develop new non-technical skills. By doing so, these may bring new ideas to fruition and innovative solutions for healthcare settings where, so often these days, motivation and morale are quite low [3].

3. How can management and leadership be incorporated into internists' education?

In healthcare, management and leadership skills require the knowledge of health economics and many aspects specific to its different fields, such as marketing, strategy or organisational behaviour. These skills and an understanding of healthcare systems, policy and the epidemiology of diseases represent what we can call health management. This field spans from high-level organisational/strategic/operational management to areas of personal effectiveness skills. This education can be useful at the different stages of a physician's career and are likely to be taught best in a progressive manner, in a spiral educational structure, which can be split into four main stages: A) medical school; B) residency; C) medium-level responsibilities (e.g., leadership of a unit); and D) senior levels (e.g., leadership of a department). Each stage has inherent challenges and opportunities, which will make education in these areas invaluable. At each stage, the current or future internist should gain the knowledge and skills to equip him/her to outperform in the following step. This stepwise approach also facilitates an understanding not only that it may be important to provide more economics content at one stage than another but also that the focus within the same topic can be different between stages. For example, in the broad area of strategy, in Stage 2 (junior doctor), this would refer to personal strategy (time- and career-management strategies), whereas in Stage 4, it would entail organisational strategy. The specific contents of each management area can and should be detailed and refined for each stage. Management and leadership education do not need to happen separately from clinical teaching; this is exemplified by a novel crisis management course combining teamwork/leadership teaching and clinical medical practice that is being provided in Singapore General Hospital, Singapore [4].

Currently, very few medical schools in the world actually provide any sort of management [5] and leadership education to their students (or faculty, for that matter [6]). Likewise, only recently have discussions about internal medicine residency programs begun to consider the incorporation of such education areas. Some physicians in many countries seek this education via MBAs [7] or other management school courses, often tailored to senior clinicians [8]. This means that, in practice, most if not all young internists lack such an education and demonstrate this lack of training. For example, at the EFIM congress in 2005 and in 2009, we hosted the introductory workshops in management and leadership, which were very well received by colleagues attending because "they had never been brought into contact with these sorts of ideas found to permeate their work". It is my belief that while we wait for the official incorporation of such education to come to medical schools, internal medicine programs and examination requirements, current internists and residents of internal medicine can be brought into contact with such an education by a combination of workshops and residential and online courses. One vehicle and venue that seems particularly advantageous are conference workshops, which, despite being short in duration, can have the effect of triggering interest and bringing about awareness at a time when people are open to new ideas in the development of their career. Internists are currently often part of medical school deaneries or post-graduation deaneries or are members of hospital boards; in all of these venues, initiatives to bring about education in these areas are possible and desirable. I would alert, however, to the danger of such an education being provided outside of the healthcare context. Often people knowledgeable about the theoretical and business context of most management and leadership themes are unfamiliar with the workings and constraints of healthcare and thus have a discourse that does not resonate with clinicians. The problem is that one such experience,

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Please cite this article as: Martins HMG, Why management and leadership education for internists?, Eur J Intern Med (2010), doi:10.1016/j.ejim.2010.04.014

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such as, a ten-hour lecture course on basic economics — taught without any connection to health or medicine — can be enough to forever turn off a clinician's interest in any such management/leadership education. In my opinion, such courses can be better developed by a combination of people with expert knowledge and people with some frontline experience filtered/taught through the lens of the theoretical frameworks. An extensive review of current courses, programmes and resources on management and leadership for the internist at a pan-European level is outside the scope of this paper but of high relevance and urgency.

4. Conclusions

Management and leadership knowledge as well as skills are interrelated and will be increasingly called upon by challenges facing internal medicine. While education programmes will need to adapt to this reality both at the undergraduate and postgraduate levels, the present need for such an education can be satisfied by a combination of workshops as well as residential and online courses. Hospitals, internal medicine departments and internal medicine societies worldwide should start such activities if they are to equip internists for the demands of healthcare in the 21st century. This will prepare colleagues for leading the necessary changes and securing the relevance of a holistic approach to patient care, which characterises the internist view of patients and the care that they need.

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