Author's response to reviews

Title: Channelling professionalization processes to better fit medicine to the changing population health needs

Authors:

Thomas Plochg (t.plochg@amc.uva.nl)
Niek S Klazinga (n.s.klazinga@amc.uva.nl)
Barbara Starfield (bstarfie@jhsph.edu)

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Author's response to reviews: see over
Cover letter revised manuscript MS: 1042499923287727 - Channelling professionalization processes to better fit medicine to the changing population health needs

Monday, 9 September 2009,

Dear Editor,

We hereby submit the revised version of our manuscript, “Channelling professionalization processes to better fit medicine to the changing population health needs”. Below we provide a point-to-point response to the comments raised by the two referees and how we addressed them in the manuscript. Hopefully, the revised manuscript is now acceptable for publication in BMC Medicine. We look forward to your response.

Yours sincerely,

Thomas Plochg
Niek Klazinga
Barbara Starfield
Revisions made

We are grateful for the positive and constructive comments of both Glyn Elwyn and David Gray on our manuscript. We responded in the following ways to their suggestions and comments to further improve the manuscript:

Reviewer Glyn Elwyn

- We agree that the title should be catchier and do more justice to the work. We therefore changed the title into: ‘Transforming medical professionalism to fit changing health needs.’
- We agree with the reviewer that the abstract should be revised to better do its work. We therefore rewrote the abstract.
- It is a useful suggestion to highlight the seven strategies in a table. We have added one on page 11 within which the seven strategies are listed.
- It was suggested that the intro could pose a tighter and more urgent issue - that of technical solutions versus coordination around the person, never mind the population. We agree that we could address this issue more explicitly. However, the argument we want to make goes beyond the issue of coordination per se, as we believe that the answer is the production of new expertise (based on systems thinking rather than reductionism) solidified (organized) in broader, more generalist specialty domains. Such domains would reduce the number of different physicians involved in chronic care and thus save costs, increase labor productivity and diminish the coordination problem. The current lack of coordination is in our view the symptom of a deeper problem: an inadequate expert model. To overcome this inadequacy, we propose the channeling of professionalization processes in order to get a new expert model that better fits the changing health needs. In order to stress this broader context, we made several changes in the abstract and the intro:
  - The two final sentences of the first paragraph of the intro are changed as follows: “...as illustrated by widespread cost, workforce and quality problems. A high degree of skillful coordination is promoted as the panacea but basic re-organization of medical work to the changing health needs is likely to be required.” Moreover, we changed references in two ways. To support the statements concerning widespread cost, workforce and quality problems, we now cite McGlynn (2003), the whole book of Nolte & Mckee (2008), the green book of the EU (2008) and Schoen (2009). To support the statement on more coordination we refer to Hofmarcher (2007) and Reuben (2007). The references to Anderson (2001), the two chapters of Nolte (2008), and Schoen (2007) were cut in this paragraph.
  - In the second paragraph we changed the ‘practice of medicine’ into ‘organized medicine’. Furthermore, the verb in the second sentence ‘organize’ was changed into ‘provide’. Last, we added ‘more vested’ specialties in the final sentence.
  - The first sentence of the third paragraph was changed into: “Arguably, health policy could trigger, support and speed needed changes; the sociological literature on professionalism provides clues how this might be done.”
  - The first sentence of the final paragraph was changed into … “are opting to enforce coordination and to remove power from the medical profession” in order to stress the issue of coordination again. Last, we changed the final sentence into: “This paper suggests a long-term vision accompanied by several strategies by which the self-regulatory capacity of medical professions is consciously activated.”
to transform medical professionalism and related professional processes of care that better fit changing health needs.”

- We agree with the reviewer that we insufficiently cite the rich sociological literature on professionalism; we only referred to the books of Freidson and Abbott. We therefore added citations to the very recent paper of Martiminiakis et al (2009) at the end of the first sentence of the third paragraph. In this paper, the sociology on professions is summarized and introduced to a medical audience. Furthermore, we cite the novel book of Ellen Kuhlmann and Mike Saks (2009). This book provides a scholarly overview of the sociology of professions.

- The reviewer suggested the book by Collins and Evans on 'rethinking expertise' and the problem of demarcation they pose at the end of their book. We were unaware of this book and thank the reviewer for drawing our attention to it. This book provides an interesting and relevant outlook upon expertise and is certainly relevant for our argument. We inserted a citation to the book on page 12 to support our statement on the second strategy. We also added the following text at the end of the 2nd sentence: “… hindering the demarcation of new generalist expertise.” See also our next response.

- The reviewer correctly points out that specialist expertise is about marking new turf and creating new fences by exams and colleges. However, we did not overlook this central issue. In our view, it is incorporated in strategy 2 which concerns the procedures of professional organizations for establishing new specialty boards and colleges. These procedures need to be satisfied before emerging specialties can become a fully approved medical specialty. When approved, specialties get the right of their own specialty training including colleges and a restricted labor market. The work of Freidson provides very interesting thoughts on this issue. We changed the text on page 11-12 describing the second strategy in order to be more precise. The paragraph on page now ends with the following phrase: “This requirement will be especially hard to satisfy for the proposed generalist domains, since their underlying knowledge is broad and overlaps with the vested ones. The absence of a clear definition of the field may explain the relatively low prestige of branches of medicine such as geriatrics, intensive care medicine, and emergency medicine across countries. Existing professional procedures frustrate their opportunity to build their own professional bodies and colleges.” Moreover, in the new table 1 we signal the second strategy as one addressing the transformation of professional institutions including the establishment of new professional bodies and colleges.
Reviewer David Gray

- We agree that the title should be more clear, catchier and better justify our work. Since the first reviewer also commented on the title; we changed it to: *Transforming medical professionalism to fit changing health needs.*

- The reviewer suggested expanding more on the deficiencies exposed by the UK strategy favoring acute services over primary care. The literature, particularly the writings of Freidson (2001) and Abbott (1988), supports the case that specialization is intrinsic to professionalization processes, driven by advancements in science and technology and thus is an incremental and continuous development. The central thrust of the paper is that health policy could or should channel or redirect this incremental development in a different direction. Against this background, we believe that expanding on the explicit strategy in the UK would detract from our argument. Therefore, we decided not to expand more on the UK strategy in our paper.

- The reviewer is correct in noting that geriatrics has been long established in the UK. However, from an international perspective there are large differences. In many countries, geriatrics is far from a fully approved medical specialty. This is outlined in the BMJ paper by Grimly to which we refer in our manuscript. Given the international readership of BMC medicine, we believe that it is not necessary to rephrase this sentence. The position of geriatrics in the UK is internationally quite unique.

- We agree with the reviewer that the power lies not merely at the individual but at the group level of professional bodies or organizations. We therefore changed the second sentence of the paragraph on page 10 on medical leadership into “This asks for medical leadership, as the medical profession itself is largely responsible for how medical expertise is organized. Medical professions must…” Moreover, our revisions made for the second strategy in response to the comments of Glyn Elwyn also stresses that professional bodies have a responsibility in leading the changes as we propose.

- We agree that being appointed as ‘leader’ does not mean that others follow. It remains to be seen whether medical professions are able to influence the change as proposed in our paper. However, we think that elaborating on this issue does not fit our paper.

- The reviewer notes that the limitations of care models of non-clinicians is an important issue directly related to the theme of the paper. In earlier drafts of the manuscript, we wrote a whole section on this relationship. However, we noticed that it undermined the readability of the manuscript. The argument became too complex and hard to follow. We therefore decided not to elaborate on this issue in this manuscript. In the future we hope to write another paper elaborating on these aspects.

- The reviewer asked us to explain the idea of competition amongst specialisms. In his experience specialisms never compete. It is correct that specialisms generally do not compete at the clinical or personal level. However, according to sociologists theories, specialisms or professions more generally do compete at the systems level for jurisdiction (or the exclusive authority) over a circumscribed body of discretionary knowledge. Since these domains are not static –due to advancements in knowledge and technology-specialisms continuously have to maintain and protect their domains. On page 4, last paragraph, we changed ‘proponents of a specialty’ into ‘specialty boards’ to make this more clear.

- The reviewer disagreed with our statement concerning strategy 3 (medical research) and 4 (technology development) on pages 12-13. In his perception specialists usually want to incorporate evidence from clinical trials quickly- it is the bureaucrat and cost-cutter that tries to control technology use. It is certainly true that bureaucrats hinder technology development. However, we want to make another point. Since technology development
and scientific advancements are critical to professionalization processes as explained earlier, professional bodies attempt to influence and control the agenda setting and investments for research and technology development to control their jurisdictions. For emerging specialisms it is critical to obtain funding for technology development and medical research to mark their turf. Without this financial support, they will never be able to claim jurisdiction over the diagnosis and treatment of certain patient groups. Turf battles amongst specialisms are also manifest in the acquisition of research funding and technology development. In our view the existing text on strategy 3 and 4 is clear enough in this respect. Therefore, we did not make any changes to address this comment.

- The reviewer disagrees with our statement on page 9: “this has far reaching consequences for the staged organization of healthcare systems, in particular the ‘gate’ function of primary care”, arguing that in the NHS at least, the gatekeeper and the general physician co-existed happily before the shift towards specialism alone and therefore thinks there is no threat to the gatekeeper function. Our argument is not a plea for a return to a previous, better, era of the general physician. We promote the general physician, but in the context of healthcare systems in the 21st century. The existing health needs require new generalist expertise based on systems thinking which brings along new generalists, not only the family physician. We expect and observe that other specialties (e.g., geriatrics, pediatrics, occupational health physicians) are getting a more generalist character and might have consequences for the sustainability of the gate keeping function of primary care. However, we agree that we were too strong in making this statement. We therefore changed the sentence (page 9, 2nd paragraph, 5th sentence) “… will blur the boundaries… in to ‘may’ blur ….

- The reviewer questions how less educated health personnel could help in caring for the older patient with multiple co-morbidities. The rationale for this third stage in our proposed solution is that the needed generalist domains will carry heavy workloads. We hypothesize that individual physicians cannot practice these domains fully on their own. Therefore, some work should be executed by less highly educated personnel. Our suggestion –based on the analytic framework of Eliot Freidson- is that only the non-discretionary work is eligible for delegation. However, we cannot predict and forecast how much work in the care for patients with multiple co-morbidities is non-discretionary in nature. Apparently, the reviewer assumes that most of the work in chronic care is discretionary and would not lend itself to delegation. Future experiences will have to show how discretionary this expertise is and whether a third stage in our model is needed. We have a lot to learn about ‘whole person’ care—a subject that has been neglected in health services research. We interpreted the comment of the reviewer for more explanation, not for changes in the text. In our view, the text describing this third stage on page 9 adequately makes the point.

- The reviewer is correct that medical leadership has been inadequate and that it is partly responsible for the abandonment of the generalist in favor of the specialist. In that perspective, it does not make sense to promote medical leadership for initiating the desired change. Still, we believe that the proposed changes cannot be made other than by the medical profession itself as the profession primarily controls how medical expertise is organized. There must be medical leaders within medical boards and academic medical centers that take the lead in marking new more generalist turf. If these leaders cannot be found or are unwilling, there will no other option than letting non-clinical managers impose their managerial and market based instruments to enhance coordination; in our view, this would be an incomplete solution.

- The last comment of the reviewer concerns the use of mortality data as quality indicators. We believe there is some confusion here. The observation that we want to share here is
that health services research is gradually becoming able to measure the performance of healthcare services and systems in terms of population health outcomes. If this becomes reality, healthcare providers will have an incentive to show that their expertise contributes to population health gain. To avoid confusion and distraction of the point, we deleted the reference.

**Minor changes**

- We formatted the manuscript according to the guidelines of BMC Medicine.
- We made small changes to the text in the manuscript to improve the language.