



## Physician, Professionalize Thyself

Cost effective and sustainable methods to improve health care quality can result in significant improvements in the health of poor people in developing countries. Dr. Kenneth Leonard of the University of Maryland suggests that one overlooked strategy is to reawaken or reinvigorate the professionalism of health care workers.

### AT A GLANCE

- About 20 percent of health workers in Tanzania behave in a professional manner in their practices
- These health workers are just as likely to work in the public sector as in faith-based organizations
- The remaining 80% of health workers can easily be induced to work harder simply by exposing them to the scrutiny of their peers



PHOTO: ELIZABETH GUDRAIS

**Doctor in the clinic's pharmacy in Dar es Saleem, Tanzania.**

Dr. Kenneth Leonard, a researcher at the University of Maryland's Department of Agricultural and Resource Economics, and his co-author Dr. Melkiory Masatu have explored a very simple idea to improve health care: acting more professionally. It is one thing for a doctor to be knowledgeable, but it's quite another thing for the doctor to use all of his or her capabilities while delivering health care. For example, a doctor with a large number of patients

might compromise on the quality of health care for each patient in order to get through the day's appointments. Or an underpaid clinician might prefer to chat with coworkers rather than perform an arduous or complicated task, especially without direct compensation for doing so. Dr. Leonard suggests that an appreciable gap exists between the average physician's potential and practice. Through innovative mechanisms, they isolated the extent of



**While faith-based organizations, like this Methodist hospital, are often highly thought of, this research found that health workers in the public sector are just as likely to behave in a professional manner in their practices.**

this gap and determined which factors could make this gap smaller.

In their study, they observed 928 consultations provided by 80 clinicians in Tanzania. They used two strategies to determine the potential of a physician and the quality of care he or she provides.

In the first part of the study, a research team member posing as a patient would walk in for a consultation complaining of the usual symptoms endemic to the study region. The doctor knew that this patient was an actor, but would still need to satisfy all the necessary protocols as required by the central health authority to ensure a correct diagnosis. The “patient” then reported to the research team the protocols that had been satisfied by the doctor. Identifying physician performance was also accomplished by using exit interviews with regular patients (after they exit the chamber of the same doctor), who were quizzed on the protocols satisfied by the doctor

during his diagnosis. This exercise provided the researchers with a means to isolate the quality of care the doctor usually provides from the quality he provides to a known test patient.

The second strategy to determine physician potential involved studying the same doctor for a length of time to understand how he responds to peer review. Another clinician, who was part of the research team, would sit in the observed doctor’s chamber and observe his consultations for a length of time. This exercise exploited a well-known phenomenon in social sciences, called the “Hawthorne Effect.” Quite simply, putting a peer in the chamber makes the doctor conscious that he is under observation (even if the researchers assured him that this intrusion is for research purposes only). It could be inferred that, while under scrutiny, the doctor would provide his best ability in his diagnosis and care.

There is an additional issue with using a checklist or protocol to evaluate

physician quality: If a doctor satisfies the checklist, does it imply that he is a professional physician guided by the aim of providing health care, or is he working with machine-like efficiency, since his facility provides him incentives to do so? Dr. Leonard and Dr. Masatu attempted to isolate how doctors perform when it comes to exhibiting dimensions of professionalism that are not usually rewarded. Indeed, a prime contribution of a physician (which is not rewarded since it is not observed) is to educate his patient about symptoms, medicines, and preventative measures. Dr. Leonard and Dr. Masatu observed whether or not a doctor communicated such information during his consultations. A doctor who satisfies the protocol checklist but does not communicate is not really professional; it is far more likely that he completes the checklist simply because he is incentivized to do so.

Dr. Leonard and Dr. Masatu were also interested in the characteristics that affect professionalism. They researched various categories of caregivers such as nurses, clinical assistants, and fully fledged doctors with varying degrees of education and experience. Their research included public and private facilities, along with facilities provided by non-governmental organizations. The variety of settings helped to study the effects of incentives, labor policy, and decision-making capabilities at the local, regional, and national level.

The results suggest that the average doctor performs significantly below his potential when dealing with day-to-day patients. Peer review initially makes the physician display a higher degree of professionalism; however, with time they return to their usual quality of practice. Doctors practicing in facilities that provide strong incentives for performance exhibit



PHOTO: DANIEL

**Nurses, residents and staff doctors do rounds in the women's ward. Eighty percent of doctors perform better when observed by their peers.**

a smaller gap between potential and practice. However, professionalism is not incentivized; this is evident in the study, as the “professional” doctors who communicate with their patients

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are evenly distributed across different kinds of facilities. It seems that these doctors are guided by a sense of doing good, and that is the only incentive they need. Sadly, they are a minority in the sample researched. Most physicians



**Dr. Kenneth Leonard**



**A physician in Tanzania examines a baby. Twenty percent of physicians provide high quality services all the time.**

act “professionally” under external incentives. Physicians in decentralized organizations, which give more autonomy to the physician, also exhibit better practice protocols but are not necessarily educating the patients about health issues.

However, Dr. Leonard and Dr. Masatu conclude that there are grounds for hope. It seems that inculcating a sense of moral duty and somehow rewarding it may prompt physicians to perform better. This is a low-cost change, as it does not involve retraining the doctors; a sense of altruism would suffice. The problem is that it cannot really be learned. Another avenue would be to provide higher incentives. But this,

too, is fraught with problems as it may lead to corporatization of health care. Thus there are potential issues even with short-term solutions; however, it is pretty clear that addressing the gap between a doctor’s potential and his practice would go a considerable way in promoting the quality of health care.

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You can also read more in the original article by Dr. Kenneth Leonard and Dr. Melkiory Masatu, “Professionalism and the Know-Do Gap: Exploring Intrinsic Motivation Among Health Workers in Tanzania,” *Health Economics*, 2009. ■



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