New York University's Advanced Management Program for Clinicians (AMPC)

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The Advanced Management Program for Clinicians (AMPC) was established in 1986 with the help of a grant from the W.K. Kellogg Foundation.[1] It is designed for health care professionals who are currently in management positions and for those who seek career shifts in the direction of health care management and policy. The AMPC program represents New York University's response to some of the sweeping changes affecting the health sector: (1) the growth of large health care organizations; (2) pressures by payers to contain health care expenditures; (3) increasing intervention by government and corporations in the practice of medicine; and (4) disgruntlement among clinicians about their working environment.

In this paper we briefly review these trends and discuss our goals in creating the AMPC program. Next, we describe the program's distinguishing characteristics. And we conclude with some reflections about the issues raised by two and a half years of experience in training physicians in this program.

TRENDS

The trends reviewed here were those factors that influenced us in designing the AMPC program.

THE GROWTH OF LARGE ORGANIZATIONS IN THE HEALTH CARE SECTOR

The changing industrial structure of health care organizations—horizontal and vertical integration—have resulted in very large and new kinds of

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working environments for physicians as well as other health care professionals. David Mechanic has referred to these trends in a manner that resembles the way they are perceived by clinicians, as "the growth of bureaucratic medicine" [1]. Eli Ginzberg characterized some of these changes first as the "monetarization of medicine" and subsequently as the "destabilization of health care" [2,3].

From the point of view of designing our program, what struck us was that clinicians would have to learn more about the complex environments in which they were working. There is an increasing demand for learning job skills in the areas of health services management, financial analysis, human resources management, information systems, marketing, and strategic planning.

PRESSURES BY PAYERS TO CONTAIN HEALTH CARE EXPENDITURES

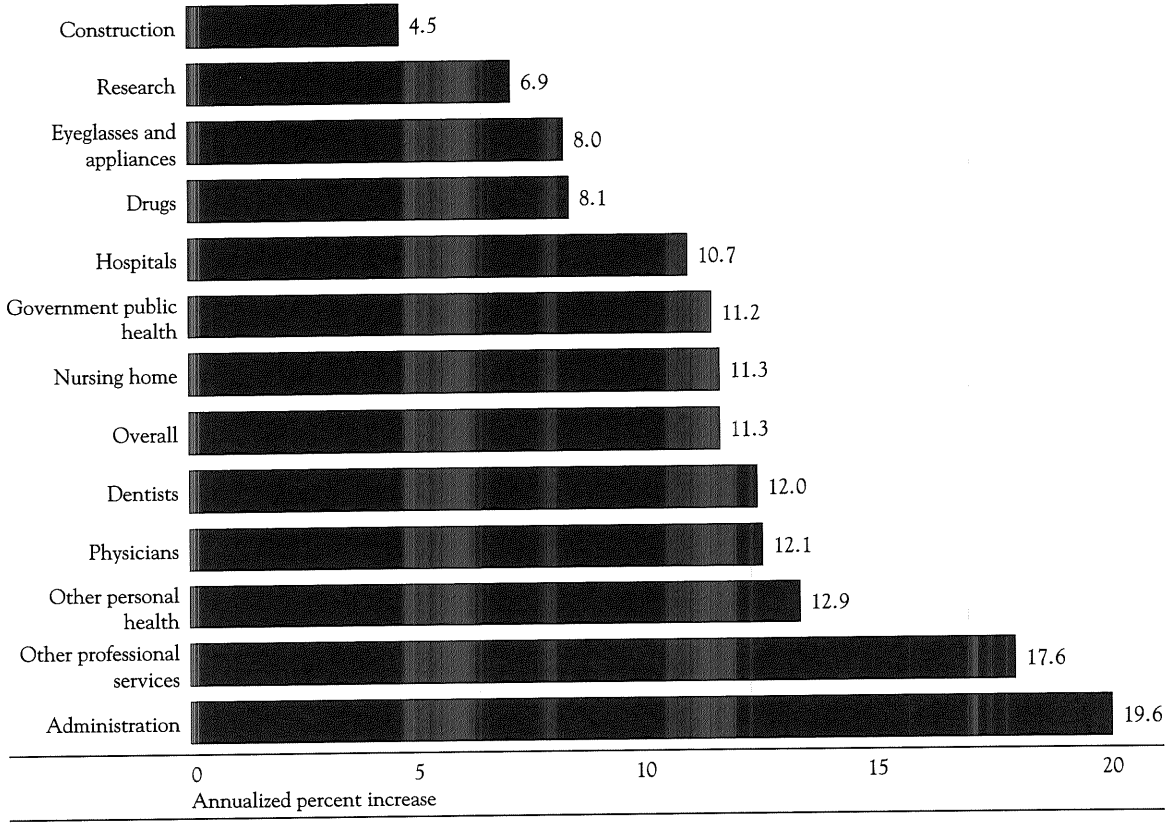
Pressures to contain health care expenditures have operated simultaneously on several levels, those of the federal, state, and local governments, business coalitions, private insurers, hospitals, and other health care organizations. In spite of these pressures, through 1986 there had been no success in containing the growth rate of health care expenditures in constant dollars [4]. In fact, as noted in Figure 1, the most rapid growth has occurred in the area of health administration, which has, in turn, probably increased managerial control over clinicians in health care organizations.

This state of affairs has surely sensitized clinicians to new administrative and economic terminology, such as *cost accounting* and *cost finding, bottom-line management, efficiency, effectiveness, cost-benefit*, and *cost-effectiveness*. The frequent misuse of such terms, in ordinary parlance as well as in professional publications for clinicians, was sufficiently glaring to persuade us that we might be of assistance in raising the level of discourse among clinicians on these matters.

INCREASING INTERVENTION BY GOVERNMENT AND CORPORATIONS IN THE PRACTICE OF MEDICINE

The pressures by payers to contain costs have led to increasingly elaborate forms of regulation and external control if not outright intervention and bureaucratic annoyance from the point of view of clinicians. The increase in second-opinion programs, the imposition of preadmission as well as concurrent hospital utilization review procedures, and the frequent challenges to clinicians as to whether procedures are "medically necessary"

FIGURE 1: Annual Increases in Health Care Expenditure by Type of Service, 1980–85



Source: Calculated from data from Office of the Actuary, Health Care Financing Administration, July 1986; adapted from G. Anderson and J. Erickson, National Medical Care Spending. *Health Affairs* 5 (3): 123–30, 1986.

have probably made the American medical profession less autonomous in its clinical decision-making authority than any other medical profession in the world.

In this context, we felt there was a need to teach concepts and skills in the area of quality assurance and, even more important, to improve understanding of the politics of medical care, the role of government in the health sector, and the economics of health care financing and reimbursement. Familiarity with these concepts and with current policy issues can help clinicians fight back in many cases and occasionally even reexamine their assumptions.

DISGRUNTLEMENT AMONG CLINICIANS ABOUT THEIR WORKING ENVIRONMENT

The previous two trends have contributed to a growing sense of disgruntlement among clinicians. And yet the response by clinicians has been quite varied. In the fall of 1988 we admitted our third class of roughly 30 AMPC participants. As with the first class, we found that some clinicians are interested in making a job switch. Others want to improve their capacity to perform at current jobs. Still others are interested simply in understanding current trends and responding to them more knowledgeably.

In designing the AMPC program for practicing professionals, we were challenged by the notion of somehow producing what Donald Schon calls the "reflective practitioner" [5]. In addition to teaching job skills, providing a sense of sociopolitical context, and enhancing familiarity with administrative and economic discourse and ways of thinking, we sought to dismantle the all-too-familiar image of professionals as "too busy with action," to reflect and of academics as "too busy with reflection" to act. The goal of the program has not been to substitute one professional identity for another but rather to encourage the clinical identity and to explore ways in which it can be made more sensitive to other perspectives and more open to what Schon calls "reflection-in-action" [6].

DISTINGUISHING CHARACTERISTICS OF THE AMPC PROGRAM

A PROGRAM FOR CLINICIANS, NOT JUST PHYSICIANS

Although roughly three-fourths of the 90 AMPC participants have been physicians, the program was originally conceived for a broad range of

clinicians, including dentists, nurses, and social workers. In light of the first and second trends mentioned above, we remain persuaded that a variety of health care professionals will increasingly have to learn to work together as a team in new ways. This is true not merely in clinical practice with respect to the proper coordination of services but especially with regard to management issues and coordinated responses to shifts in health policy.

A MULTIDISCIPLINARY APPROACH

The AMPC program is part of the Program in Health Policy and Management, which is located within New York University's Graduate School of Public Administration (GPA). Like medicine and other health professions, the fields of public administration, business administration, and health policy and management are not scientific disciplines. Rather, they are professions that aim to understand and sometimes to devise pragmatic strategies for dealing with real-world "wicked problems" [7]. In pursuing this goal, these professions rely on a wide range of social sciences and draw freely on the theories and methods of these disciplines. In the field of health policy and management, we emphasize, in addition to teaching job skills, an in-depth understanding of the health sector from a range of disciplinary and professional perspectives.

Given the nature of our field, we felt that it was important to expose AMPC participants to a multidisciplinary approach and to link the program, through the use of case studies and guest lecturers, to clinician faculty, management practitioners, and policymakers [8]. We thus formed the Inter-School Committee of Affiliated Faculty to tap some of the leading scholars in the health care field who were located outside of GPA and to improve linkages with other professional schools at New York University and with leading practitioners outside the university.

AN INDIVIDUALLY TAILORED CURRICULUM

Since the clinicians we sought to attract come from diverse backgrounds and have a range of professional goals, we felt it was essential not to impose a formulaic approach in the design of a curriculum. Therefore, for candidates seeking a Master of Science degree in management or policy, we allow a choice of six courses, to be selected by individual participants in conjunction with their adviser. The full resources of New York University are available to all participants. These include courses in the

schools of law, business, medicine, social work; arts and sciences; and education, health, nursing, and arts professions.

There are only three required courses in this individually tailored curriculum: both semesters of the year-long Kellogg Seminar in Health Policy and Management and a course of independent study, culminating in a final paper.

Clinicians who already have advanced degrees and no particular interest in obtaining further degrees may obtain an Advanced Professional Certificate by completing five courses in one area of specialization. And those clinicians who simply want to take a course or two are occasionally accepted as special students and invited to participate in the AMPC program.

THE KELLOGG SEMINAR IN HEALTH POLICY AND MANAGEMENT

This seminar serves an integrating role for each participant's individually tailored program of study. It has four objectives. One is to expose AMPC participants to the professional literature in the field of health policy and management. Another is to stimulate discussion and analysis of the issues in this field. A third is to introduce participants to the health program's core faculty, to AMPC's affiliated faculty, and to leaders in the field of health policy and management—both at NYU and outside. The fourth objective is to develop an esprit de corps among AMPC participants and to introduce clinicians to new perspectives and values about the health care field by encouraging informal discussion with core faculty members.

There are three themes that recur throughout the Kellogg Seminar and serve to integrate the range of topics and issues covered in the readings and lectures. The first focuses on the health care industry's current structure and evolution. The second concerns current shifts in federal and state health policies and the issues they raise for policymakers and managers. The third deals with the response by managers in health care organizations to change in the health care sector.

A FINAL PAPER: CASE STUDY OR MINITHESIS

Since most participants in the AMPC program hold full-time jobs at which they struggle with full-blown problems, we sought to convert this traditionally academic exercise into a more pragmatic, professional project. It usually takes one of two forms. It may result in a case study, based on analysis of management problems or policy issues affecting health care

organizations. Or it may result in a paper that begins by identifying a problem in some health care organization and then reviews the academic literature on the problem and compares how other, similar organizations have grappled with the same problem.

Under both options, the final paper always involves individual attention to each participant's project by two members of our core faculty. This process usually sparks a new interest in the literature, methods, and theories that are taught in the field of health policy and management and in the experiences that are shared among participants, lecturers, and faculty.

Issues Raised by the Experience of Training Physicians in the AMPC Program

David Kindig and Santiago Lastiri, who have been tracking the growth of physician managers, note that the numbers of physicians involved in administration is likely to increase in the future [9]. Physicians who have participated in the AMPC program will certainly be sensitized to the possibilities of playing a new role in this evolving specialization. To what extent they will do so, however, and how representative they are of their peers who wish to go into administration, we do not know. In a separate paper, we intend to evaluate more systematically the characteristics of the clinicians in the AMPC program.[2] At this time we wish merely to conclude by noting five issues raised by the experience of training physicians in the AMPC program.

First, there is no doubt that the program has enriched the quality of our students. Along with the Kellogg Seminar and the independent study, all AMPC participants have selectively participated in our normal health program classes for students pursuing an M.P.A. degree or a Ph.D. in public administration. Although there is no typical curriculum for the average AMPC participant, the range of possible courses covered corresponds closely to those succinctly outlined by Hillman, Nash, Kissick, and Martin [10]. In the future we must ask ourselves whether we should continue to allow such flexibility for all in the choice of courses or whether it would be wiser to recommend a more structured curriculum for some.

Second, now that the original grant from the W.K. Kellogg Foundation has expired and that the AMPC program has become virtually

self-financing, we must ask ourselves who would most benefit from the program; and health care organizations should ask themselves who should be required to take this kind of program. Of course, it is premature to speculate about this issue, given the uncertainty surrounding the roles, positions, and educational requirements of physician managers. For example, should chiefs of service be required to obtain training in management? Should similar requirements apply to department heads and medical directors? These questions, in turn, raise some issues about what, exactly, physician managers should do?

Third, will physicians in management roles do different work than do other managers, and will it require different training? For example, will physician managers spend most of their time supervising other physicians? Will they be more involved in production and operations management because of their clinical expertise? Is it cost effective to require all managers engaged in these kinds of tasks to go to medical school or to take the same kind of medical curriculum as full-time practioners?

Fourth, can the growth of a new medical specialization in management be interpreted as an adaptive strategy by the medical profession to preserve a certain position of power through what Eliot Freidson calls "reorganization" [11]? As Kathleen Montgomery argues, the growth of physician managers may represent a kind of "reprofessionalization," whereby physicians appear to be continuing a tradition of seeking professional advancement by increased role differentiation [12]. If this is indeed the case, what, other than reallocating the growth of administrative expenditures back to physicians, will be the impact of this change on the quality of medical care and of health care management?

Finally, any reflection on the future of physician managers cannot avoid the question of loyalty. To whom will physician managers be most loyal? To their patients so as not to jeopardize the doctor-patient relationship? To their peers and professional specialty associations so as to promote their own professional interests? Or to the organizations for which they work? And what would be in society's best interests?

NOTES

1. The authors submitted a proposal to the W.K. Kellogg Foundation, entitled "An Advanced Interdisciplinary Program to Train Health Care Professionals for Management Responsibilities and Leadership Positions," in August 1985.
2. We are currently working with Kathleen Montgomery on this project.

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