Developing Physicians as Catalysts for Change
Aaron E. George, DO, Karen Frush, MD, and J. Lloyd Michener, MD

Abstract

 Failures in care coordination are a reflection of larger systemic shortcomings in communication and in physician engagement in shared team leadership. Traditional medical care and medical education neither focus on nor inspire responses to the challenges of coordinating care across episodes and sites. The authors suggest that the absence of attention to gaps in the continuum of care has led physicians to attempt to function as the glue that holds the health care system together. Further, medical students and residents have little opportunity to provide feedback on care processes and rarely receive the training and support they need to assess and suggest possible improvements.

 The authors argue that this absence of opportunity has driven cynicism, apathy, and burnout among physicians. They support a shift in culture and medical education such that students and residents are trained and inspired to act as catalysts who initiate and expedite positive changes. To become catalyst physicians, trainees require tools to partner with patients, staff, and faculty; training in implementing change; and the perception of this work as inherent to the role of the physician.

 The authors recommend that medical schools consider interprofessional training to be a necessary component of medical education and that future physicians be encouraged to grow in areas outside the “purely clinical” realm. They conclude that both physician catalysts and teamwork are essential for improving care coordination, reducing apathy and burnout, and supporting optimal patient outcomes.

Recent discussions about improving care coordination—a function that supports information sharing across providers, patients, sites, and types and levels of service—have focused on changing policies, synchronizing digital communications (e.g., information systems, patient portals), and eliminating barriers between providers and health entities such as hospitals, ambulatory centers, and neighborhood clinics. While tangible efforts to address these issues should lead to measurable improvements in patient transitions, care coordination is only one aspect of the U.S. health care system. Repairing it will not address the larger, system-level issues. Policy updates, digital integration, and procedural revisions can solve individual problems, but they fail to address the root cause of dysfunction.

 We submit that the core problem in the U.S. health care system is cultural. As outlined by Association of American Medical Colleges president Darrell Kirch,1 we in academic medicine have failed to see that the changing environment around us demands a new, different culture. Medical training and practice are traditionally characterized by autonomy, hierarchy, individual achievement, and competition. However, the complexity of our current environment (and the modern health care system) requires collaboration between individuals and groups to solve problems that are beyond any one person’s ability to address. The dilemma is, as described by Kirch,1 that “while we have held fast to our traditional individualistic culture, the world has fundamentally changed.”

 Yet medical educators continue to train physicians in much the same way as we were taught, focusing on individual accumulation of factual knowledge and skills. When we are placed in complex, interdependent systems, we make our own contributions as physicians and, at best, can serve as the glue that holds the health care team and system together. We acknowledge failures in care coordination, communication, and teamwork, but we are not motivated to change the system, because acting as the glue has allowed the system to function successfully one more time—often at considerable personal cost to us as professionals.

 But what if our trainees and colleagues were inspired to view themselves through a different lens, to see themselves in a different role? We believe that medical students and residents should be inspired to move beyond accepting the role of being the glue that attempts to hold the parts together; instead, they should be trained to act as physician catalysts who initiate and expedite positive changes. This shift would empower trainees to provide insight and take action to improve care coordination—and health care more broadly.

Failure of Care Coordination

Reimbursement for face-to-face encounters and activities forms the foundation of the current U.S. health care system. Care coordination has been used as a mechanism to connect these episodes of care. Certainly, in the traditional academic medicine model, physicians demonstrate knowledge, skill, and poise in clinical decision making and treatment. However, the model does not inspire them to identify or respond to shortcomings between episodes of
care. While physicians are comfortable reading a pathology slide or interpreting a lab result, we become uncomfortable and default to our training to act as glue when the system fails—that is, when information is misplaced or not retrievable. This is just the sort of situation that Daniel Ehrmann has encountered as a medical student; in this issue of Academic Medicine, he describes his frustration with his inability to obtain a patient's brain biopsy from another institution. We believe that such problems are not only a failure of care coordination but also one of physician leadership.

This is not to say that complete physician involvement and oversight are needed to overcome the faults in care coordination. Rather, a team approach should be emphasized, with physicians often initiating and leading change in response to opportunities for improvement. Problems such as those described by Ehrmann simply cannot be passed down the administrative ladder or, worse, accepted as inherent. Conversely, team priorities and team roles must be defined and shared.

Failings within the care coordination arena are really a reflection of larger systemic issues, such as shortcomings in communication between providers and health care entities as well as between providers and patients. This lack of effective communication is further exacerbated by shortcomings in shared team leadership in a hierarchical culture that often inhibits the involvement of medical students, residents, and patients and, thereby, limits the development and application of solutions developed from the novel perspectives of team members.

Redefining the Role of the Physician

We propose framing the role of medical professionals, particularly medical students and residents, more broadly. We believe that physicians should be identified not as the glue that binds together elements of a dysfunctional system but, rather, as the catalyst that accelerates change. The difference between these two attitudes represents an essential shift in both perspective and approach. In a formative sense, a glue is a bonding agent that joins dissimilar materials; however, excessive weight or force can shear the formed joint. In contrast, a catalyst is a substance that drives and accelerates alternative pathways for action. It stabilizes transitions and is able to withstand heat and pressure. Importantly, by definition, a catalyst is not consumed in the process it facilitates.

Faced with physician burnout amid systemic dysfunction, we simply cannot fail to offer such a fundamental and positive transformation for medical students and residents. It is essential that we equip trainees with the tools they need to partner with patients, staff, and faculty to assist in implementing change, provide them with instruction in the process of change, and guide them to perceive that work as inherent to the role of the physician. This perspective would allow future physicians to identify themselves as catalysts for change in health care. They would recognize unique and faster pathways for action and facilitate the change process with other team members. Rather than feeling trapped and powerless in a system with inherent flaws, catalyst physicians will see opportunities within those flaws and act on them.

Refining the Goals of Leadership Development in Medical Education

One method of inspiring catalyst attitudes is through leadership development in medical education. We view leadership training as an opportunity to provide medical students and residents with the tools, including communication and cooperation skills, that will help them produce change for the benefit of patients and families. Unlike glue, which is “used up” with each application, we believe that trainees who learn to be catalysts can gain resilience (i.e., decrease burnout) and find meaning in leading changes that support patient- and family-centered care. The next step is to reinforce catalyst attitudes in the clinical setting.

Unfortunately, we do not do a very good job of teaching teamwork as comprising a set of skills that are honed through experience and exposure. As an example, we rarely put nursing students and medical students in the same room at the same time or guide them in learning role definitions and methods of effective coordination around the needs of others. Yet, we assume they will be able to communicate effectively and act as high-performing teams after they graduate and enter the clinical arena. It should not be surprising that breakdowns in communication are a primary cause of nearly two-thirds of the adverse events reported to the Joint Commission.

In addition, physicians need to be trained and empowered to take effective action. Students and residents are offered glimpses into a failing and broken health care system, but they are limited in their ability to affect the clinical decision-making process. For instance, a third-year student on an internal medicine unit may witness a hasty and inefficient discharge system. However, students are typically given little opportunity to provide feedback or suggest changes, and they rarely receive the training and support that would equip them to assist with the change process. What can result is cynicism, apathy, and burnout, which we are now witnessing in many of our young physicians. These physicians should instead be inspired by the chance to lead change in positive and unique directions and to improve both health care and population health.

This role transition requires movement beyond the traditional textbook-and-test model of medical education. We should inspire our trainees by encouraging and coaching complex decision making in areas outside the “purely clinical” realm. Physicians today require an ever-increasing breadth of knowledge and competence outside the clinical sphere. It is apparent that the skills of an adept physician are evolving to become more about multitasking than memorizing, more about prioritizing team goals than placing central lines. Meanwhile, our medical curricula often demonstrate a reverence for the classic standardized patient encounter, without reinforcing skills that extend beyond evaluation and management in the face-to-face setting.

To move forward, we suggest promoting interprofessional training as a necessary component of medical education. Imagine inviting first-year medical students to join teams of first-year nursing, pharmacy, medical assistant, social work, and other health profession students. In this collaborative setting,
instructional scenarios—many without clear-cut answers—could prompt varied responses, high-level processing, and team development. Such interdisciplinary learning teams would support a deviation from the traditional hierarchical cultures in medicine. Most important, this sort of training environment would inspire responses to systemic shortcomings, insulate trainees against apathy and burnout, and prepare a new generation of physicians to act as catalysts for change.

Evidence of Success in Leadership Development

While the business community has recognized the importance of leadership development for several decades, the medical world has begun to integrate such training only recently. The academic medicine community should recognize, as business and industry do, that leadership training need not be reserved only for managers and administrators. In medicine, physicians must be prepared to be active leaders. Leadership should be acknowledged as a competency, to be learned and demonstrated by all. To take this a step further, we believe that leadership training need not be constrained by profession. Diverse medical teams must be created early, with the goal of advancing the priorities of the group. Fittingly, a catalyst can never function alone.

While residency programs have begun to integrate leadership concepts in line with new core competencies, such as systems management and design, medical school curricula generally lack components on topics such as these. Most prominent among these core competencies is the increased emphasis on professionalism and interpersonal skills and communication. Meanwhile, in the United Kingdom, the National Health Service has advanced leadership training as a core component of medical education with the overarching goal of preparing doctors to engage in continual transformation of the services they provide throughout their careers. We encourage the application of such a broad-spectrum approach to redefine medical education in the United States.

To support curricular changes, we suggest aligning team approaches with institutional needs. Training environments would benefit greatly by giving residents and medical students—as well as nurses, care coordinators, and patients—opportunities to share their perspectives and voice potential solutions to existing problems. We encourage institutional change that promotes administrative decisions based around team input. Such efforts require effective, coordinated administrative and educational communication and planning. A host of recent calls for the transformation of U.S. medical education have voiced similar goals of integrating communication and leadership development.

Conclusions

Restructuring health care delivery and medical education is necessary for essential system change. Success in improving care coordination is inextricably linked to the promotion of teamwork, physician leadership, and communication, and it requires a transition from care provided by individual experts to care provided by expert teams. We believe that these fundamental goals can be applied to the myriad of health system problems today. Solving those problems requires the recognition that teamwork is essential to optimal patient outcomes. Evidence-based medicine and quality initiatives reinforce the fact that better outcomes and lower costs are driven by a team-oriented approach.

Medical educators should actively equip future physicians with the tools they will need to shape and influence the systems of care that are now evolving across the country. There are far too many cracks developing, and last-minute patches simply will not do any longer. The modern health care system demands a new culture, built on effective teamwork, and a new generation of physician catalysts to lead the way.

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