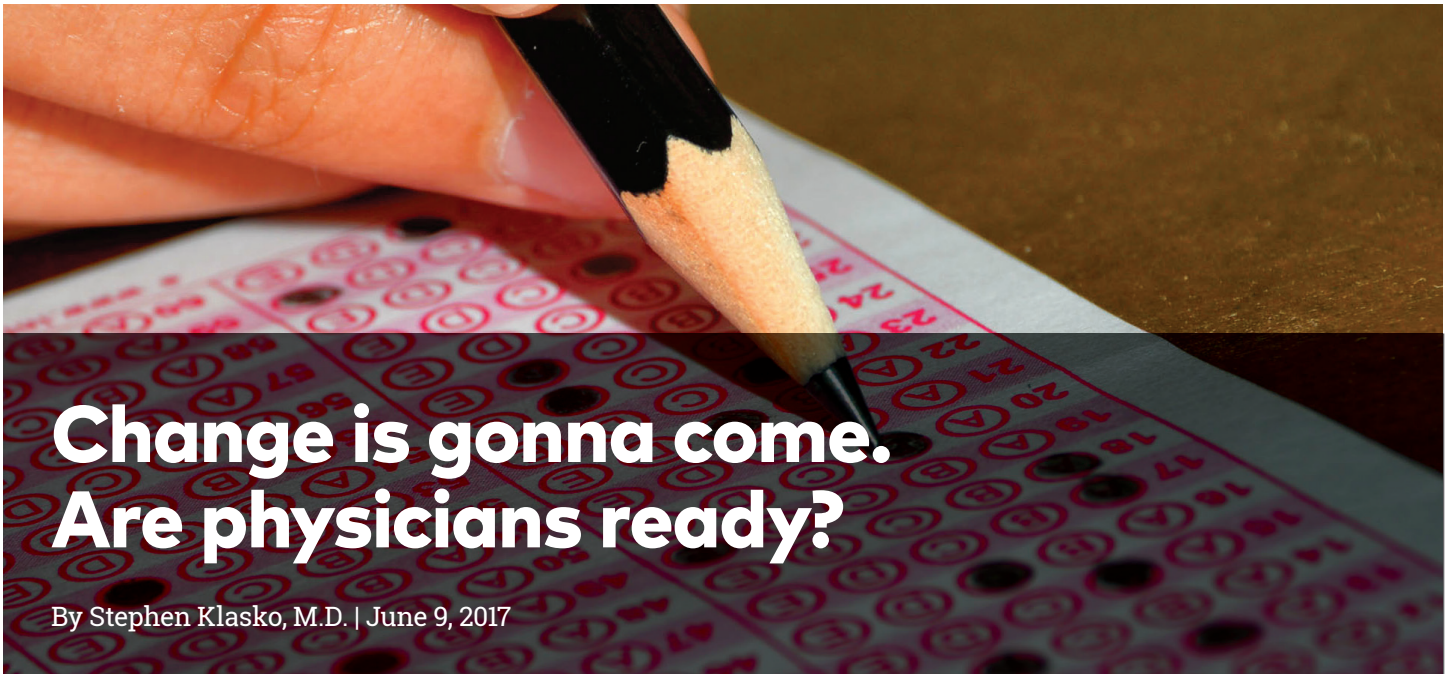

Change is gonna come. Are physicians ready?

By Stephen Klasko, M.D. | June 9, 2017

"There have been times that I thought I couldn't last for long/ But now I think I'm able to carry on/ It's been a long, a long time coming/ But I know a change is gonna come." - Sam Cooke, singing "A Change Is Gonna Come"

In 1995, when I was finishing up my MBA at Wharton, a finance student came up to me and said, "Steve, you are so lucky to be in an industry" — healthcare, he meant — "that is going through the kind of disruption we have never experienced before."

I did feel good about that. After all, I was a practicing obstetrician with a new set of skills, and I felt that we physicians were best positioned to solve healthcare's problems, given our strategy, focus, discipline, and patient-centered approach.

I felt good, that is, until the next day in the OR lounge, where discussion of the same situation — an industry going through dramatic transformation — elicited this response from a senior surgeon: "I'm thinking of retiring early. There is a 100 percent chance that healthcare will get worse with this kind of change."

This juxtaposition of attitudes defines the state of American healthcare today. For the better part of a decade, I have been hearing that healthcare is moving toward a value-based world, that accountable care organizations and other shared-savings models will usher in this new age.

Whether or not this turns out to be true depends on the mindset of the physicians involved, whether they think like the young finance student or the seasoned doctor.

Disruptive innovation in healthcare

For most of my research life, I have depended upon Clayton Christensen to help me understand how humans deal with innovation and disruption. Christensen is the father of "disruptive innovation," the idea that the dominant way of doing things can be overturned, sometimes quickly, by cheaper, faster, and more consistent competitors.

I was fortunate to hear Christensen on a panel that discussed surgery — and how a cheaper, faster, more consistent engineering of the surgical process would win. A surgeon standing next to me immediately exclaimed, "That's exciting!" At the exact same time, another surgeon said, "That's depressing."

So which surgeon do we stand with? Which one will succeed in an ACO? One of these surgeons is ready, eager even, for innovation as a competitive advantage in medicine. The other fears the change.

In Christensen's book, "Competing Against Luck," he lays out the "jobs theory" — what job did you ask a product or service to do? As I've previously written, the Affordable Care Act did exactly the job we asked it to do: It gave a lot more people access to a fundamentally broken, expensive, fragmented, inequitable, and occasionally unsafe healthcare delivery system, then hoped the system would disrupt itself.

Physicians will need to lead the shift to value, whether through ACOs or something else. But if they aren't eager to embrace innovative disruption, ready to compete in an ever-changing medical landscape, value-based care will never become a sustainable reality. We can blame Obama. We can blame Trump. Or we can look in the mirror.

If we want to create a delivery system that ends "amenable mortality," provides access, and is focused on outcomes for populations, then we have to stop playing victim.

Medical education for the future

My passionate belief is that the future depends on changing the DNA of healthcare one physician at a time. We cannot continue to create doctors who fit in to the autonomous, competitive, hierarchical world of the past. We need to promote team-enabled healthcare and the creation of "teams of leaders."

It has been clear for years that team-based care is the wave of the future — and is the norm in virtually all ACOs and other organizations focused on population health. So we need to select and educate a new breed of creative, passionate, and flexible physicians.

The accrediting bodies and establishment need to get over their obsession with multiple-choice tests and fragmented episodic education. Instead, we need to work toward a continuum of healthcare education that embraces not only the science, but the business and social aspects of healthcare, with a heavy dose of cultural diversity and compassion.

Forcing students to memorize material they can look up instantly deprives them of time spent learning to be creative, communicative, and especially, human. And we have to stop tinkering with interprofessional education like it is some lab experiment, and make this collaborative team approach the standard for all healthcare professionals.

The duty of mid-career physicians

As "older" members of the profession, our responsibility is to stop telling kids not to be doctors. Instead, we must help create a healthcare workforce that selects and educates professionals who embrace change. We need physicians who can advance an academic and entrepreneurial model, who understand that creativity is key to our success, and who can be leaders as opposed to followers of healthcare transformation.

It is amazing and distressing to me that 20 years after that encounter in the OR lounge, I could still have a similar conversation today. And yet, I repeatedly find that middle and later-career clinicians can "get it." At Jefferson we have instituted a very successful program called JOLT (for Jefferson Onboarding and Leadership Transformation), which instills the communication, tolerance of ambiguity, and organizational skills into a cohort of increasingly creative and optimistic physicians and nurses.

Physicians are not unintelligent. Very few would prefer paper charts and chickens for payment. But we have to understand that we've been selected, trained, and programmed to see change as threatening.

We have to be willing to adjust our thinking. We must see creativity as a solution to change. That's the only way provider-driven, value-based care will move from philosophy to reality.

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