

Commentary: Clinical Faculty, Academic Culture, and the Future of Medical Professionalism

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Editor's Note: The ACGME News and Views section of JGME includes data reports, updates, and perspectives from the ACGME and its review committees. The decision to publish the article is made by the ACGME.

In this issue of JGME Christmas and colleagues¹ present perspectives from highly respected clinicians in academic medical centers' departments of medicine. Their qualitative research methods probe the beliefs of those clinicians related to the advantages and challenges of pursuing a career as an academic expert clinician. The article presents these faculty physicians' perspective on the quality, safety, affordability, or patient-centeredness of clinical care provided in teaching settings. Yet its most intriguing and powerful contribution is insight into the thoughts of the clinical role models of physicians in training. The clinicians studied and their counterparts at other teaching institutions are the role models for the young physicians who will shape the future health care system of the United States. Academic physicians in the study reported they felt distracted by competing obligation and faced bureaucratic obstacles, yet they are activated by the meaning and purpose of their work. In our opinion, these academic clinicians are the foundational elements of health care delivery and redesign, and they need to be recognized and rewarded for clinical excellence.

Culture and Quality

Safe, effective, and service-oriented clinical care is predicated on organizational culture, structure, and processes. These features may require meticulous cultivation in academic medical centers dominated by research agendas. The best care is essential to the best learning and is predicated on mindful aim and design. These qualities should be part of organizational culture, rather than imposed by external requirements or instituted primarily in response to sentinel events.²

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A Culture of Learning

Just as attention to culture is critical to achieving quality and safety outcomes, cultural transformation should precede the educational redesign necessary for assessment and outcome verification in graduate medical education.

We believe that one of the most formidable barriers to educational outcomes in many settings is a largely unmet need for expert clinician educators. These academic practitioners should dedicate their careers to expert knowledge of the components and developmental milestones of clinical competency in their specialty, well-honed assessment skills, and the willingness and ability to invest time in the daily observation of learners, whether at the bedside, in the clinic, or in the operating room. These behaviors will not be within reach of reluctant, unprepared, distracted, or detached clinical educators.

We must incorporate features of the intellectual environment of the university with the practical environment of an integrated care model to achieve balanced agendas for meeting learners', investigators', and patients' needs. A good start would be redeclaring the value of full-time clinical faculty and robust faculty development schema in all our clinical educational settings.^{3,4}

Customer Focus

Clinical educators have multiple stakeholders, each with their own blend of dependence on our Hippocratic, fiduciary duties.

To patients, they owe safe, high-quality, evidence-based humanistic care tailored to their needs and preferences, and the advocacy that may be required to obtain it.

To learners, they owe expert observation, assessment, feedback, evaluation, and teaching, which undergird optimal learning and professional development.

To the community, they owe social justice in efficient and equitable resource distribution, and the preparation of clinical learners to take our place serving the public in the future.

Transforming the outcomes of clinical education will necessitate that every learning environment engage in a courageous and humble inventory:

- Are current clinical care outcomes worthy of emulation by learners?
- Are structures and processes respectful of resources and people—both those served and those who serve?

- Are clinical supervisors and educators supported in, and accountable for, observation, assessment, teaching, and evaluation?
- Are these faculty members organized and managed effectively to balance the tripartite mission of our teaching institutions?
- Are individuals and groups of educators engaged in substantial faculty development programs that assure they are competent clinicians, educators, and evaluators?

Highly functional and effective clinical education is strategically integral to achieving the Institute of Medicine quality goals: safe, effective, efficient, patient-centered, timely, and equitable care.⁵ Clinical education can also become a bridge between the business and professional agendas, and between community and academic teaching centers.

We hope future studies will extend this inquiry longitudinally and horizontally.

Given the age of the cohort (median age likely 50–55 years), clinician educators may be considering retirement to be preferable to reinventing themselves for a transformed health care system. A study of younger clinicians would add to the picture by exploring emerging faculty role models, secular culture shifts, and organizational mission evolution.

Horizontal reproduction in community settings, accountable care organizations (such as Group Health Cooperative of Puget Sound, Kaiser Permanente), and integrated multispecialty clinics (such as the Mayo and Cleveland Clinics and the Geisinger Health System) could shed light on the cultural context demanded for the care that the Institute of Medicine recommends.⁵ Christmas and colleagues are to be commended for a methodologically fresh peek into the culture of academic clinicians. Their effort represents humility, self reflection, and hope in pursuit of “the right ideas and ideals.”

References

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