Physicians’ engagement: qualitative studies exploring physicians’ experiences of engaging in improving clinical services and processes.

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Why is physician engagement important?

• Good solutions to healthcare challenges need interaction between the complete care team to be clinically robust and functional
• The position as medically responsible renders physicians a position to support or hinder initiatives

“Clearly all members of the health care team need to be engaged if leaders are to succeed in making quality and safety improvements.

So why single out physicians? …whereas physicians themselves cannot bring about system-level performance improvement, they are in a powerful position to stop it from moving forward, and therefore their engagement is critical.

Simply stated, leaders are not likely to achieve system-level improvement without the enthusiasm, knowledge, cultural clout and personal leadership of physicians.”

• (Reinertsen et al. 2008, p. 23)
What is "clinical services and processes"?

• Developing the hospital ward round is an empirical example of a clinical process where physicians’ engagement is very important.

• Clinical “microsystem” is another potential expression.

“We need to stop regarding ward rounds as ‘ordinary and unremarkable’ but in need of our focused attention just as much as the most expensive technology or complex drug treatment. The benefits to quality, safety, effectiveness, efficiency and staff satisfaction would be enormous, and patients would be hugely happier as well.”

• (Caldwell 2013)

Background

• Physicians’ are engaged in the bio-medical and technical development of health care. But it is well documented that physicians’ engagement in developing clinical services and processes often is limited or missing.
  – (Berwick and Nolan -98; Davies mfl 2007; Tingle 2011; Lee and Cosgrove 2014)

• Very few empirical research studies focusing physicians experiences about hinders and enablers for engaging in development work.
  – (Snell et al. 2011; Kaissi 2014)

• Scientific knowledge gap about physicians’ own experiences engaging (or not) in improving clinical services and processes.
Aim of the phd thesis

To explore physicians’ experiences of engagement in improving clinical services and processes, in order to gain more understanding about why such initiatives have problems engaging physicians.

– Two specific aims:
  ▪ 1. To explore how physicians’ experienced their engagement in healthcare development
     – Paper I: To gain a deeper understanding of how physicians experience their engagement in healthcare development.
     – Paper II: Based on empirical findings how physicians experienced their engagement use theory to better understand the mindset of physicians and managers, and by basis of that suggest management considerations to facilitate physicians’ engagement.
  ▪ 2. To explore physician experiences after changing to a patient-centered and team-based ward round
     – Paper III: To explore physician experiences after changing to a patient-centered and team-based ward round, in an internal medicine department at a Swedish mid-size hospital.
     – Paper IV: To uncover paradoxes emerging from physicians’ experiences of a patient-centered and team-based ward round, and relate empirical findings to the theory of complex responsive processes to further understanding.

Brief overview…more depth in the thesis/papers


Methods

- Qualitative and explorative studies
- Semi-structured physician interviews (25 + 13 physicians)
- Particular analytical approaches used to pay close attention to individual physician’s experiences, while at the same time analytically striving towards finding an empirically grounded conceptualization of physicians’ experiences
  - Grounded Theory - Glaser and Strauss 1967; Charmaz 2006
  - Qualitative analysis - Miles and Huberman 1994
  - Abductive analysis – Coffey and Atkinson 1996; Alvesson and Sköldberg 2008
  - Complex responsive processes – Stacey 2011, Stacey and Mowles 2016

Interactive research process
outlining relevant areas for both science and practice by engaging clinically

Ellström et al. 1999
Different views about change and learning

Mechanistic view – linear causality (simple and complicated)

Organic perspective – non linear causality (complex)

Nuläge Nytt läge

Findings from Paper I and II:
How physicians experienced their engagement in healthcare development

• Striving for professional fulfillment was found to be a central motivator affecting physicians’ engagement for both clinical and development work.
  – Conceptual model built on two dimensions: being useful and making progress/developing
• Physician engagement was reinforced if the task at hand was experienced as being useful and making progress…contributing to professional fulfillment.
• Organizational conditions that reinforced engagement for improvement work:
  – recognition (gensvar)
  – continuity
  – task clarity and role clarity
Findings from Paper I and II, continued:
How physicians experienced their engagement in healthcare development

- Which tasks contributed to professional fulfillment was related to how medical practice was understood.
- Two alternative understandings emerged:
  - The traditional doctor role: high autonomy in relation to organization and management, patient work as the source for professional fulfillment.
  - The employeeship role: in addition to patient work, participation in development work also contributed towards professional fulfillment.
- Physician and manager paradox:
  - have different mindsets, due to difference in socialization, training and everyday practice. This hinders cooperation and negatively impact physicians’ engagement.
  - In order to improve the situation managers need to be appreciative of the mindset of physicians, and physicians need to better understand the mindset of managers.
Findings from paper III and IV:
Physician experiences after changing to a patient-centered and team-based ward round

• Fruitful physician experiences from the new ward round:
  – the less hierarchical positions improved the relation, interactive communication more possible
  – contributed to better informed clinical decisions
  – fewer follow-up questions from patients
  – increased professional fulfillment (“return of joy in medicine”)

• Challenging experiences for physicians from the new ward round:
  – reduced autonomy – follow the defined round structure
  – lack of functional communication strategies to manage time
  – exposing potential knowledge gaps in front of others.

Findings paper III and IV continued
Physician experiences after changing to a patient-centered and team-based ward round

• Different ways to understand medical practice were found and named according to physicians’ focal points during ward rounding;
  – the We-perspective adhered to a more comprehensive and patient-centered practice
  – the I-perspective adhered to a more bio-medical and doctor-centered medical practice
  – When the new round principles were in line with individual physician’s professional identity, the new round was appreciated (We-perspective),
  – When the new round principles challenged individual physician’s identity, the new round was not appreciated (I-perspective)

• Change processes impacting professional identity, need to acknowledge and organize to facilitate epistemological and ontological development:
  – what knowledge or activities “I need to learn and manage”, in the new ward round (epistemological)
  – who ” I am becoming”, working in this new way in the new round (ontological)
Reflections about methodological choices

Reflexivity, relevance, validity: foundational criteria’s for scientific knowledge (Malterud 2001; 2014)

- **Reflexivity**: being aware of own voice and perspective…not overpowering the interviewees
  - All pre-understandings contribute with advantages and disadvantages
    - choice to engage with hospital where I had no management relation to facilitate for myself to embrace the role as researcher and not ex-manager
    - management experience from the nearby university hospital enabled a good understanding of national and regional requirements and initiatives
  - Multifaceted and balanced interpretation of the empirical data by engaging a trans-disciplinary team of researchers with complementary experiences to my own (Research group triangulation Patton 2002)
    - experienced physician and associated professor in medicine
    - experienced nurse and professor in healthcare leadership and pedagogics
    - manager and senior lecturer in healthcare pedagogics
    - professor in business administration with experience in healthcare research

...methodological choices, continued.

Reflexivity, relevance, validity: foundational criteria’s for scientific knowledge (Malterud 2001; 2014)

- **Relevance**: is this a piece of research that is needed and matters
  - Interacting with local practitioners drives relevance (Greenhalgh et al. 2004)
  - Building on previously identified gaps in scientific knowledge
  - Focusing aspect that is considered societal grappling and clinical frustration

- **Validity**
  - Internal=do the methodological choices provide a valid understanding of the phenomena explored
    - explorative qualitative studies since limited knowledge and complex phenomenon
    - interviews to understand the world as experienced by the physicians
    - face-to face individual interview to be able to probe deep and ask for examples
    - well-established qualitative analytical methods used
    - preliminary findings presented to and appreciated by the local practitioners
    - using complex responsive processes, a theory that caters to complex phenomena
    - interpretation of empirical material by a trans-disciplinary team of researchers
  - External=transferability, are findings valid outside the specific context
    - Previous research in other context, with parallel findings, suggests transferability
    - Awareness of contextual perspectives, no claim of “definitive truth” but “temporal clarity”
    - Complex responsive processes argue “meaning” created in local interaction (Stacey 2011)
    - Degree of commonality amongst physicians…community of praxis (Wenger 2000)
    - Usage of research a dynamic act, completed if, and only if someone can make better sense of a situation or a process with the help from research texts (Larsson 2009)
Conclusions

• Physicians were engaged, in an abstract general sense, in improving clinical services and processes
  – the relatively quick contribution from clinical work towards professional fulfillment, compete with the more long-term, complex, difficult to measure development work
  – the conceptual model outlined organizing principles to support physician engagement
  – “looking for engagement – finding identity”

• Which tasks contributed to professional fulfillment was related to individual physician’s understanding of medical practice.
• The We-perspective (also the employeehip role)…
  – a more comprehensive and patient-centered understanding of medical practice,
• …co-existed with the I-perspective (also the traditional doctor role)
  – a less comprehensive bio-medically focused and doctor-centered medical practice.
• Societal demands for increased patient-centeredness calls forward physician capabilities not fully within the bio-medical model.

Implications and practical concerns forward

• The societal expressed need and demands for patient-centered healthcare could be experienced as a challenge for physicians’ professional identity
  – Primarily for physicians with a bio-medical, more doctor-centered I-perspective
  – This implication needs to be acknowledged by politicians and managers (and physicians)

• Evolving physician professional identity – it’s not about “just doing it!”
  – A more comprehensive bio-psycho-social medical curricula suggested by “World Federation of Medical Education”
  – Junior physicians identity highly influenced by encounters with senior physicians
  – Suggested that faculty and senior physicians need support to evolve their professional identity to the revised comprehensive understanding of medical practice
    ▪ scaffolding structures to enable experiential learning in “safe” settings
    ▪ time scheduled for collegial reflection about individual experiences (including doubts, anxiety…and increased joy from medical practice)

• Without structures to support the challenge to identity, resistance towards the societal demand for patient-centered healthcare is likely to follow!
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Thank you!
Questions and comments welcome

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EXTRA MATERIAL...

...taken from the thesis and relating to professional identity and the ongoing transformation of medical education.

Ongoing recalibration of the medical curricula towards an integrative approach

• Combining bio-medical knowledge with social and psychological aspect of care and disease
  – Lancet global commission of postsecondary education in health towards the 21th century healthcare (Frenk et al 2010)
  – World federation for Medical Education (Gordon and Karle 2012; Gordon 2014)
• From a bio-medical focus towards a more comprehensive bio-psycho-social medical curricula.
  – towards a broader inclusiveness in the understanding of medical practise going forward.

• From the more transactional understanding focusing what the physician consider the patient need to be informed about, towards a more inter-relational understanding where the physician also consider how to support patients to integrate new situations into a quality of life (Dall’Allba 2004)
Professional identity and medical education

- There has been an unbalance in favor of bio-medical knowledge, facts and skills which now is being reconsidered by medical educators (Wald et al 2015)

- Recently educators have started to consider the teaching of professionalism as a means to an end, with the actual end seen as individuals developing a professional identity as physician (Creuss et al 2015)

- The professional identity of physicians is critical to the practice of medicine, in the service to societal and individual patients’ needs, as well as for the well beings of physicians themselves (Holden et al 2015)

Professionalism vs. Professional identity

- Professionalism another construct than professional identity
- Definitions according to Wilson et al (2013)
  - Professional identity is how an individual conceives of him or herself as a doctor
  - Professionalism involves being and displaying the behavior of a professional
Focus forward

- Striving towards more comprehensive understanding of medical practice is a way to respond to the societal demands for more patient-centered healthcare
  - in line with the new legal requirements in Sweden
  - for the benefit of patients...but equally important
  - potential for increased professional fulfillment for physicians themselves
- Increased care for the patients also requires increased care for the providers (Bodenheimer and Sinsky 2014)

The risk with the hidden curricula...and the cure

- The culture of medicine in hospitals does not support young physicians in their strivings towards becoming good doctors
- It is thus hard for them to reconcile the official education curricula with the clinical, hidden, curricula (Coulehan 2005)
- In order to facilitate junior physicians updated curricula to become manifest in their professional identity, there seem to be a parallel need to also consider how to evolve senior physician professional identity towards the same converging goal, i.e. 21th century healthcare.