

Leadership Development for the Future of Family Medicine: Training Essential Leaders for Health Care

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(*Fam Med.* 2021;53(7):650-3.)

doi: 10.22454/FamMed.2021.125016

Published Online First June 21, 2021

A key goal of residency redesign should be to include development of the future leaders of medical schools and health systems. To improve health and health care, we need to work toward having family physicians leading institutional implementation of Accreditation Council for Graduate Medical Education (ACGME) guidelines, integrating family medicine residency graduates into the workforce, and leading the changes in education, research, clinical care, and community engagement necessary to adapt and thrive in the rapidly changing world of health care.

How do we get there? The professional lifetime of family medicine residency graduates will span three to four decades. As we look that far into the future, many things are already known. The current model of US health care is economically unsustainable, intolerably inequitable, and rapidly burning out the health care workforce. The COVID-19 pandemic has shown a bright spotlight on these harsh realities and there is growing political pressure to change this unsustainable model. Because the decades ahead will present many unknowns, family medicine needs physician leaders with the vision, knowledge, leadership qualities, and skills to anticipate and navigate these unknown challenges. Future leaders will need better preparation than ever before. Leadership development must start in residency with formal leadership training, and be inspired by leaders in health care systems, community organizations, government, as well as academia.

Family medicine has traditionally focused on developing leadership for academic

departments and programs.²⁻⁵ Nationally, 15-20 department chair positions are open each year.² Academic family medicine is undergoing generational change in senior leadership, concurrent with increased demand for physician leaders in both academic and non-academic settings. In responding to upcoming ACGME revisions, we must embrace the role and responsibility of residency education in developing family medicine leaders for an evolving health system characterized by mergers and acquisitions, changing payment models, technology-enabled innovation in care delivery, changing patient needs and preferences, increasing emphasis on population health management and community-based care (vs hospital acute care system), and the imperative to control health care costs. We also need family physicians who are prepared and interested in shaping how academic medicine responds to health care industry changes, such as new partnerships and governance structures, hospital-owned medical groups competing with private practice, and weakening financial commitment to support residency education.

Why be concerned with preparing family physicians for leadership roles beyond academia? The current model of federal graduate medical education funding ensures that residency programs are inextricably intertwined

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with the perspectives and decisions of hospital and health system executives. Traditional academic department leadership is evolving toward new roles and responsibilities that increasingly are hybrids of academic and health system leadership (eg, department chairs and service-line leaders). Health system and health plan leaders want innovation to reduce cost of care and improve health outcomes, but often have little awareness of how family physicians can further these goals. Moreover, as health systems focus more attention on social determinants of health, there is an important role for family physicians to build partnerships between communities and health systems. We must ensure that training and paths to leadership are open to underrepresented minorities and women so that family medicine leaders reflect the diversity of our discipline and the communities we serve.^{6,7}

Family medicine residency education, with its distinctive biopsychosocial perspective of caring for patients within the context of family and community and experience across the spectrum of care, uniquely prepares family physicians for multidisciplinary and system-level leadership roles. Our training also extends beyond the walls of clinical facilities and out into the community—necessary for complex system thinking, understanding social determinants of health, impacting the health of whole populations, and effective community-based approaches to health care. Future family medicine leaders also will need competencies in information science and use of new digital assistive technologies to bridge the gap between office visits and patients in their homes.

One example of thinking broadly about family medicine leadership for the future has emerged from the Association of Departments of Family Medicine (ADFM) fellowship, Leadership Education for Academic Development and Success (LEADS Fellowship), visioning and planning summit held in November 2019.² Stakeholders determined a need to embrace a view of family medicine leadership that extends beyond academia to encompass leadership of multidisciplinary service lines; codeveloping and coleading interdisciplinary education, research, and clinical programs; chief medical officers and other executive leaders of multispecialty medical groups, health systems, government agencies, community organizations, and advocacy groups.

Development of leadership skills in medical school and residency are increasingly recognized as essential to delivering

interdisciplinary team-based care.⁸⁻¹⁰ Leadership curricula must also include collaboration skills as vital for team-based patient care, and interdisciplinary team-based research and education.^{11,12} Others assert the need for leadership development customized for academic medicine.¹³ In response, family medicine residencies have begun to incorporate leadership development into residency curricula, but these efforts have yet to achieve a clear model for preparing residents to become leaders at the highest levels. Leadership training in residency must be reenvisioned with the goal of graduating family physicians who are also pluripotent physician leaders aware of and prepared to pursue the full range of health care industry leadership roles early in their careers.

Expanding leadership training does not require adding more didactic teaching. Robust quality improvement (QI) projects serve as experiential learning opportunities for teaching leadership skills as well as meeting ACGME requirements and milestones.^{14,15} Accessing and using data for QI can be a hands-on introduction to health informatics and data analytics, skills also applicable in research and scholarly projects. Collectively, these learning opportunities can all be woven together in learning population health management. Collaborating with health plans, medical groups, hospital and health system leaders can help expose residents to those in senior leadership positions. The health care industry, including academic medicine, has acknowledged social determinates of health (SDH) significantly impact health care outcomes and total cost of care. There is growing realization that physician engagement and collaboration with communities is necessary to find community-based solutions to address SDH.¹⁶ Integrating leadership training into experiential longitudinal community-based projects can make community medicine and hands on advocacy curricula come alive.¹⁷ These opportunities could be integrated with other advocacy, legislative, and governance activities such as participation in organized medicine at the state or national level. Finally, the practice management curriculum can teach leadership skills while meeting ACGME Milestones. Engaging residents to help lead clinical process improvement and primary care practice transformation can provide practice in applying these leadership skills in tangible ways, applicable in their own residency practice.

How should all this fit together? The future will require a longitudinal and developmental

perspective on leadership training in residency that posits a core curriculum of fundamental leadership skills most applicable to residents' stages of development and training. Interns should be members of interdisciplinary teams with opportunities to learn and practice organization and time management, communication, interpersonal and collaboration skills. Senior residents should lead clinical teams and develop skills for leading meetings, managing others, providing feedback, promoting team resilience, working with other clinical service lines, and negotiation and conflict resolution. Chief residents³ typically have administrative roles requiring additional leadership skills such as budgeting, organizational decision-making, preparing and presenting an "ask," and representing constituents to residency and institutional leadership.

Building on a foundation of a leadership core curriculum, residency electives or focused curriculum tracks should address advanced or focused leadership skills. Residency tracks could lead to postresidency fellowship training in topically-focused areas such as health policy, community engagement, primary care research, diversity and health equity, education, clinical informatics, data science, or health care administration. Such tracks are already available in internal medicine and pediatrics. Curriculum tracks or fellowship training can also be coupled with formal education leading to additional credentials or academic degrees. Such credentials can help prepare for later career job opportunities.

Faculty development will be required to integrate such leadership training throughout residency education. To develop innovative and immersive experiential learning, faculty will need their own skills development for engaging and negotiating with health system leaders, community organizations and other external entities to create resident learning opportunities. Skills in stakeholder and conflict management also will be needed to cultivate and manage the organizational relationships surrounding resident activities.

As we contemplate the future of family medicine and re-envision residency education, now

is the time to think broadly, envision creatively, and act boldly to develop physician leaders for the future of family medicine and all of healthcare. In education, family medicine educators in medical schools and residencies can drive curricular innovation to better meet the needs of patients, communities, and society, not just hospitals and healthcare systems. Family medicine researchers can bridge the gap between medical innovation and its implementation in the real world of primary care. In clinical care and administration, family physicians can help drive health system innovation and policy with a more holistic approach to meeting the needs of patients, families, and communities. In community engagement, family medicine leaders can build partnerships with public health and community organizations to find better ways to improve population health. In summary, with their distinctive training and perspective, family physicians bring unique leadership value in all the domains essential to the future of their specialty: clinical care, education, research, and community engagement. Let us inspire and prepare the next generation of family physicians to be at the center of health system change—both as leaders and as change agents.

CONFLICT OF INTEREST STATEMENT: While the authors have no direct conflicts to declare, the perspectives in this commentary are influenced by the authors' collective experiences of having served in a wide range of executive leadership positions in academic family medicine; the private health care sector at local, health system, and regional levels; and the public health sector at local, state, and federal levels.

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