

Practical Idealism: A Blueprint for Caring

Stephen P. Bogdewic, PhD

On August 5, 1949, a crew of 15 smoke jumpers stepped into the sky above a remote forest fire in the Montana wilderness, an area called Mann Gulch. Less than 2 hours after their jump, all but three of them had perished. For 14 years, Norman Maclean, author of *A River Runs Through It*, studied what happened that day, and eventually his work was published in 1992 in the book *Young Men and Fire*.¹ What happened that day at Mann Gulch has captured the interest of many people over the past 50 years.² The lessons that have been learned are highly relevant to academic family medicine.

On August 4, lightning set a small fire in a dead tree. A lookout 30 miles away spotted the fire the next day, and 15 smoke jumpers were sent from Missoula, Mont, in a C-47 transport plane to fight what they believed was a "10 o'clock fire," which in firefighter parlance meant that the crew would have it under control by 10 am the next morning. A forest ranger, Jim Harrison, was on the scene fighting the fire on his own. Due to windy conditions that day, the smoke jumpers were dropped from 2,000 feet instead of their normal 1,200 feet. The parachute containing their radio failed to open, and the radio was destroyed

on impact. While the crew stopped to eat, their foreman, Wagner Dodge, left to meet with Ranger Harrison to scout the fire. Concerned that the thick forest they were in could become a death trap, Wagner Dodge ordered his second in command, William Hellman, to take the men across to the north side of the gulch and head toward the river.

Meanwhile, Dodge and Harrison ate a quick bite, then caught up with the other men. Dodge took his position at the head of the line heading toward the river. Soon Dodge saw that the fire had crossed the gulch and was heading toward them. He ordered his men to turn and run from the fire. They began angling up a steep hill toward a ridge of bare rock. The steep hill was covered with grass more than 2 feet high, and they were losing ground to the flames. At that point, Dodge ordered the men to drop the heavy packs and shovels they carried. Minutes later, to the amazement of everyone, Dodge lit a fire in front of the men and motioned to them to lie down in the area that had burned. None of them did. They kept running for the ridge. Two men made it over the ridge, Dodge survived in the escape fire he lit, and the other 13 men perished.³

At face value, one might conclude that maybe this was just bad luck for these smoke jumpers. But on closer examination, what happened at Mann Gulch was not your typical forest fire. A host of variables conspired to create a wholly

new phenomenon for these firefighters. Consider the following variables:

Mindset

They thought they were encountering a far less serious situation—a 10 o'clock fire.

Entry

Because of wind conditions, they had to jump at a higher altitude than normal.

Communications

The radio, their primary form of communication, was destroyed.

Leadership

The foreman left to scout fire and left them in the hands of someone more used to following orders than giving them.

Invisible Threat

Due to thick smoke, probably no one but Dodge actually saw the fire jump the canyon.

Loss of Meaning

When Dodge ordered the men to drop their tools, the moment became very existential. After all, their tools defined what they were there to do.

The Unknown

The foreman lights a fire in the middle of the only escape route people can see.

(Fam Med 2000;32(6):372-5.)

The Unexpected

Later examination showed that the wind conditions that day created a “blow up,” an explosive acceleration that provided an enormous fanning effect on the fire. This condition had rarely been encountered and little understood at the time and was certainly not a condition with which these smoke jumpers had any prior experience.

The phenomenon these firefighters experienced can accurately be labeled discontinuous change. To understand discontinuous change, contrast it with the type of change with which most people are familiar, incremental change. In incremental change, there is continuity to the ongoing pattern of change. Each initiative attempts to build on the work that has already been accomplished. Incremental change can be thought of as changes “within the frame.”

By contrast, in discontinuous change, the ongoing pattern of change is disrupted by a major set of new variables that occur simultaneously. The challenge in discontinuous change is not to improve fit within a given frame but to change the frame itself—to build a whole new configuration with a new strategy for dealing with a radically changing environment.⁴

The precursors that led to discontinuous change at Mann Gulch have already been described. These included such things as a belief that they were facing a 10 o'clock fire, a breakdown in communications, and the loss of meaning brought about by the order to drop their tools. These variables create a significant destabilization of the status quo and set the stage for discontinuous or transformational change.

It does not appear that we are jumping into a 10 o'clock fire in medicine today. I think we have landed in the midst of a discontinuous or transformational change. Just like the Mann Gulch fire, we are experiencing a radical departure

from anything we have ever known. This has created a feeling of discontinuity in many of us. Some of the main categories of precursors for the discontinuous change we are encountering include:⁴

- Shifts in industry structure (Managed care, shift to ambulatory-based procedures)
- Technological innovation (Electronic medical records, electronic prescribing, hand-held computers)
- Macroeconomic trends and crises (health care as percentage of GDP, growth in pharmaceutical costs)
- Regulatory or legal changes (HEDIS, Medicare reimbursement changes)
- Market and competitive forces (Mergers, acquisition of practices, expanded use of mid-level providers)
- Growth (Complementary and alternative medicine, gene therapy, explosion in medical knowledge)

How Should We Respond?

Given this transformation, medicine will not ever be the same—which means that we will need to put down some of the tools that have served us well in previous times. So, how do we respond to such change?

Contrary to popular wisdom, the first proper response to a changing world is not to ask, “How should we change?” but rather to ask, “What do we stand for and why do we exist?”⁵

I believe we do know what we stand for. We know the principles that lie at the heart of family medicine, and we share a core value of teaching these principles to the next generation of physicians. So, does that mean that our job is to clarify and reaffirm the values that lie at the heart of family medicine? Yes and no.

Ludmerer recently published a remarkable book that traces the history of US medical education—*Time to Heal: American Medical Education From the Turn of the Century to the Era of Managed Care*.⁶ In discussing his research with faculty and medical students around the country, Dr Ludmerer asks the purpose of an academic medical center. In various forms, the answer comes out something like “to cure disease and ease suffering.” He then asks those same faculty and students for a show of hands indicating whether they have heard their dean articulate these values. No hands go up. Then he asks whether the dean has emphasized the importance of the medical center capturing its share of the marketplace. All hands go up. This illustrates a confusion that is central to the challenge we each face today—a confusion between core values and strategic actions. Going back to my question, does this mean all that we need to do is articulate our core values?

Combining Core Values and Strategic Actions

Let's return to Wagner Dodge for a moment to answer that question. He knew what he stood for and why he existed. He was a firefighter, an experienced woodsman, and he understood well the basic principles of fire and firefighting. He had some basic core values that he trusted would enable him to find a way to survive. But, that is only half of what enabled him to survive.

What ultimately enabled him to survive was that he invented, or improvised if you will, something that was called for, given the unique and complex set of changes he was facing. The escape fire that he lit was, as far as can be determined, something about which neither he nor any of his crew had any knowledge. What Dodge did was not react, or panic, or run away, but, rather, he got creative—real fast.

While Dodge's core values were his foundation, it was the strategic action he took that saved his life. This challenges the belief that by simply articulating our core values we can make a difference, regardless of what strategic actions we take to deal with discontinuous change. Just how important is this combination of core values and innovative, progressive strategic actions? Extremely important!

In 1997, Collins and Porras published a remarkable piece of research in their book *Built to Last: Successful Habits of Visionary Companies*.⁵ In a 6-year research project, they set out to examine how a set of exemplary organizations differed from a carefully selected set of high-quality comparison companies (gold medal organizations versus silver or bronze). Their quest was to discover the underlying factors that accounted for the exemplary organizations' extraordinary long-term success. They found that what separated the truly outstanding organizations from the comparison set was the extent to which the visionary companies had defined and believed in a core set of values—values that exist for a purpose beyond just making money.

That, however, was only half of what they found. They also found institutions that stand the test of time by virtue of their ability to continually renew themselves from within, to continually respond to the needs of their customers without ever straying from their core values. What Collins and Porras emphasize is that the most successful organizations distinguish their timeless core values, which should never change, from their strategic actions, which should change constantly in response to a changing world.

Practical Idealism

For STFM, this means that beyond espousing our core values, we will also need to take new and appropriate action on behalf of those we serve to demonstrate our core values. It is this combination of core

values and strategic intent, this coupling of our idealism with practical ways of meeting the evolving needs of patients and learners, that can serve as our blueprint for tomorrow. Or, if you will, "*practical idealism*."

Is there an opportunity here for STFM? Absolutely! There will be few times in any of our lives when a major institution, such as medicine, will be in such a state of disarray. Such a situation presents a golden opportunity for someone, some group, to step forward and lead the way. Our future is not foreordained. The challenge we face is not one of choosing the right path but, rather, designing the right path. I think there are three elements to guide us down the right path: perspective, courage, and a collective focus.

Perspective

First, we need perspective. Does anyone smell smoke? If we look at what is happening as if we are victims of a system gone awry, then we are no different from the smoke jumpers who thought they were heading into a 10 o'clock fire. Is there any question that after 6 years of steady increase, we have now experienced a 3-year trend in decline in the number of students electing a career in family practice? Is there any question that the regulatory impact on our clinical work and teaching has created more distance between us and our patients and learners? Is there any question that the remarkably higher demand for revenue generation that faculty now experience has resulted in less time for scholarship—not only in terms of research productivity but also in the scholarship of our teaching.

We cannot let our past success block our view of seeing the possibilities for the future. Nor can we let our frustration with the present keep us wedded to the past. It takes gaining perspective—being able to actually see the challenge and to envision the future—that will enable us to avoid feelings of discour-

agement or fear. Gaining perspective can help strengthen our resolve and give us courage.

Courage

For us, courage is needed so we will declare that the core values we represent cannot be compromised. We must make clear to ourselves, our learners, our patients, our leaders, and our corporate partners just what those core values are, and we must know how to, and be willing to, see that they are not compromised. Rationality will not return to US health care—our values will not be honored—unless we are willing to repeatedly make perfectly clear what quality care means.

From where do we find courage? From each other, from our learners, from our patients, and from the noble aspirations that laid the groundwork for our discipline. I have spent more than 20 years of my life working with family medicine faculty. I was drawn here because of the character of the men and women who comprise it. But, the daily grind in many settings can take the shine off of our noble aspirations. That is why STFM is so important. Both courage and perspective can be attained through gathering with like-minded people. Gatherings such as our Society meetings allow values to be reaffirmed and new opportunities for doing the right thing to emerge. These meetings can also permit us to develop a collective focus.

Collective Focus

There is a myth that permeates much of academic life—that organizational excellence is a product of individual excellence. It is not. Therefore, our challenge is not one of having everyone—every residency or every department—develop their own strategic action plan to navigate this period of transformational change. Instead, we must adopt a collective focus. That's not easy. It is much easier to get people to agree on core values. But, imagine where we would be if 30 years

ago, each of us took the core values of family medicine and developed our own idiosyncratic curriculum for training residents. The discipline would not have survived.

We are at a turning point in US medicine, and if we do not develop a collective focus, we run the risk of placing the discipline in jeopardy. STFM can play the key role in our ability to develop a collective focus—a *shared strategic action* that is appropriate and called for given the times in which we live.

I think that an appropriate collective focus is out there begging for us to embrace it! Many of our systems have allowed themselves to become preoccupied with the agenda of insurance payers, hospital CEOs, and corporate benefits officers. As a result, the public has begun to lose faith in all of medicine. On top of this, the Institute of Medicine has shown that errors abound in medicine in numbers greater than anyone imagined.

How can we recapture the trust that has been lost? More importantly, what strategic action can STFM take now to ensure that the core values of family medicine will be around forever? I suggest to you that the best action we can take is to demonstrate our commitment to measurably improving the quality of the care we provide. I envision a day when every resident, student, and faculty member takes for granted that the ability to measure

the care they provide, and use that knowledge to continually improve what they do, is as much of a core act in family medicine as is continuity or comprehensive care. This would allow us to achieve true *practical idealism* by both declaring and demonstrating the value of what we do.

There is a body of knowledge out there—knowledge about how to examine and continually improve care—that we must master. I am not talking about quality assurance, or even continuous quality improvement for that matter. I am talking about the science of improvement. I am talking about critical thinking, reflection in action, and scholarship.

STFM, meaning the collective membership of the Society, can take the lead for the entire discipline in ensuring that family medicine's expertise in this area is second to none. If we combine our deeply held values with a focus on meeting or exceeding the needs of our patients in measurable fashion, we won't be writing just the next chapter in family medicine but the next chapter for all of medicine.

Doing so will no doubt be good for the business of medicine. It will allow us to establish ourselves as quite different from all those who claim to do primary care or who even claim to have the same core values we do. But, it will be even better for those we serve. Who bet-

ter to do this than the "heirs of general practice"⁷—the discipline that brought the citizens of this country health care that was grounded in personal relationships and committed to providing people with comprehensive care throughout their entire lives.

I smell smoke. With your help, we can light a fire that can lead our discipline into its brightest place ever within all of medicine.

Correspondence: Address correspondence to Dr Bogdewic, Indiana University, 1110 West Michigan Street, Room C-264, Indianapolis, IN 46202. 317-278-0300. Fax: 317-274-4444. E-mail: bogdewic@iupui.edu.

REFERENCES

1. Maclean N. Young men and fire. Chicago: The University of Chicago Press, 1992.
2. Weick KE. The collapse of the sensemaking in organizations: the Mann Gulch disaster. *Adm Sci Q* 1993;Dec:628-52.
3. Weick K. Prepare your organization to fight fires. *Harvard Business Review* 1996;May-June:143-8.
4. Nadler DA, Shaw RB, Walton AE. Discontinuous change: leading organizational transformation. San Francisco: Jossey-Bass, 1995.
5. Collins JC, Porras JI. Built to last: successful habits of visionary companies. New York: Harper Business, 1994.
6. Ludmerer KM. Time to heal: American medical education from the turn of the century to the era of managed care. New York: Oxford University Press, 1999.
7. McPhee J. Heirs of general practice. New York: Farrar Straus Giroux, 1984.