Introduction to Heartline and Dr. Ramnath

Welcome to Heartline, Changemaking in Healthcare. I'm your host, Dr. Andrea Austin, a board-certified emergency physician, physician development coach, and educator.

After years on the front lines, I've learned that real change in healthcare starts within. Each episode invites you to explore the inner work that unlocks clarity and bold leadership, because healing systems through changemaking begins with following our heartlines.

I am so excited today to have Dr. Venkatesh Ramnath with me. He is a health architect. He is also an intensivist who worked during COVID and is still here, which I think that's a special form of human to have worked in an adult ICU during COVID and to still be doing it.

Not only that, but to really be a fellow changemaker and somebody that I look to for inspiration. and really camaraderie along this change-making and health architect arc that we're both on.

So Vintesh, welcome to the podcast. Thanks so much, Andrea. It's a real pleasure to be here and I'm a real fan of your podcast and I'm glad we connected because I do think change-making and health architecting have a lot of similarities.

Yes. Well, let's start with that. Tell the audience about when you first realized that you were a changemaker or health architect. It was something that wasn't really premeditated.

It sort of came upon me as I know it resonates with your journey as well. So I was cruising along after finishing my training for several years as a practicing intensivist.

Becoming a Health Architect

And I ended up running into some conflicts that were not really expected, whether it was politics in the workplace or just running up against how maybe the sciences I had learned it wasn't being practiced the way I had been used to, at least hearing about it during training.

There were some communication challenges, there were just practical realities of coding and billing and those things that I wasn't prepared to talk to administrators about.

And so after a series of difficulties where my solution at the time was to sort of look for a different place where a fit might be a little bit more seamless.

So I moved to different positions. I even moved across the country. But I ended up sort of running into similar, but different challenges that all had sort of a common theme, which was, I don't know, I didn't really know how to work in the modern medicine reality that I was placed.

And so in about, I would say 2015, I kind of hit rock bottom and I really faced an existential question, which is, do I really want to be a doctor today?

when it's so different from what I thought it was going to be. And so as I climbed my way back sort of brick by brick, I realized that, well, actually, there are things that I can learn about the craft, but also myself.

And I started seeing doors open in ways that I wasn't really expecting to at all. And those surprises sort of built upon themselves and led me to a path that now I call being a health architect in my situation because it was kind of like building a house from the foundations up to the roof deck.

And as I've moved through that, that's where being a healthcare leader in this way was, it was a novel sort of experience to me. And so I wanted to kind of share that.

And I see that, you know, at this time, especially reading about your change making work, this is a theme that is not unique to me. And I wanted to sort of.

create a community, join that community. I think that's how you and I connected because the people that I had been sharing this with locally put us together.

And so I think there's a broader community out there and thrilled that we're even talking about this. So that's kind of my sort of atypical move from the traditional practitioner to this new way of trying to make change in formative ways.

Yeah. I want to take the listeners back to where you were when you realized that something needed to change because I think sometimes people listen to this podcast or they see our social media posts and they're like, Oh, Venkatesh and Andrea, what are they doing?

Like they're kind of weird. They're kind of out there and maybe they're privileged or resourced to do something that I can't. Is there an example of a friction, a pain point that you were experiencing before 2015 that really was burning you out and started you on this path to become a health architect.

Yeah, totally. So I'll give two examples. One is that my first job out of training was part of an academic practice in the Boston area. And I was never trained or even coached how to do coding and billing, which is such a Core aspect of our livelihood and I was kind of thrown into it and my partners at the time sort of gave me a sheet of paper that said oh dude if you see this do this.

It was a very, very linear connect the dots kind of thing. Which I took at face value and I think they meant it in good faith and that was all fine. But when I met my provider educator from the hospital, I realized that it was exaggerated in a way that wasn't really compliant.

And so as I worked with two different people in sort of two different worlds, I realized that there was a disconnect that I could not bridge. there was no way to figure out how to make them both work fit, that the pieces just didn't fit.

And what ended up happening was it actually led to a Medicare audit that we had to really give back a bunch of money from the hospital to CMS in order to basically demonstrate our good faith that we really didn't mean to violate the rules in the ways that I guess we found that we were.

Leadership, Trust, and Team-Based Care

And so that was one example of how someone or some entity, somebody could have created a set of expectations or even communicated with me right up front, hey look, this is what you'll need to do and this is why and here are some resources for you and that's something that is going to help you.

It's going to help you today but it's going to help you tomorrow. That's something that now I do instinctively for my group. Because it's the same thing.

There are not a lot of resources or time that practicing physicians have to look on their own time and personal time being very, very restricted in this time and day to find those.

And so I've created a role for myself where I can be that bridge. I can be that resource that wasn't there. Another example is I was running up against communication issues, even with the clinical staff.

So there were. the ways of doing clinical work in the ICU that I had been taught in the places that I trained. And when I went to community hospitals, rural hospitals, where they just weren't used to that kind of academic approach to things, there was a need to communicate in a different way.

And so I remember this hospital in Texas where The nurses were just not used to hearing me say, hey, look, we need to do this in a certain way because of this study that shown this X, Y, and Z.

And what I had to do. Eventually, the way I made it through that was I completely changed. how I approached the communication. I did not say, Hey, look, we're going to do this and ignoring their own position about it.

I invited them to share their own thoughts about why a person needed a diuretic or a person needed fluids, for example. And instead of just saying, I understand that, but we're going to do this anyway.

I said, you know what, let's figure this out together. Maybe there's a way that. We can try your way first. And if that doesn't work, let's check back in two hours and maybe try my way.

If the circumstance allowed that, yeah, I couldn't do that in every situation, but in places where I didn't have to be mandating something, if the clinical care could just bend a little bit.

then I realized that if I yielded my rigidity a tiny bit that I could actually gain a lot more trust. And so I think that trust is one of those things that you read about it more and more where patients and even other providers don't have the same trust of physicians as we used to.

And that is something that I ran up against for years without really knowing how to navigate it until I just tried something new. And that time it was sort of a trial and error thing, but now there are tons written about it.

People are podcasting about it. You podcast about it. It's all over the place. And so I think that we still need to lean into that and not just know the science, which is really important, but we need to know these ways of navigating through the real practical space of medicine.

Yeah. I mean, I think that there's so much for the listeners to really reflect on there because Sheree talks about it all the time and Sheree's a frequent guest on the podcast that, you know, really the through line that I'm hearing and I'm interested to see how this lands with you.

I think a lot of what you're talking about is leadership. And, you know, when you think back, at least to my medical school, there was no overt leadership curriculum.

It was a lot of apprenticeship. It was just assumed that because you're the physician, you're the head of the medical team, that you would know how to be a leader.

And again, going back to the story when you started in that first ICU, that's about onboarding. And I can tell a lot about a place with how onboarding is approached.

What are your reflections on how leadership, you know, is that the underpinning to draw a line and we're going to define more what a health architect is and what change making is.

But I really feel like it's this leadership of team, leadership of the organization. And, you know, that's really what you're describing in both of those examples.

Yeah, I think you're right. I think that leadership isn't something that's intuitive. I think it is a teachable, learnable skill. And in a way, it's kind of funny because we all learn certain parts of leadership when we're in training.

We go through a PGY one, two, three, four. When we start at the bottom at PGY one, let's say, we don't know much about leadership. And yet we still do because we're still leading our patients, we're leading certain types, the other paramedical personnel, right?

Just to get something done.

What Health Architecture Means

Like you have your task list, you still have to get them done. So you have to lead in certain ways. And then as we move through the upper years of our residency training and into fellowship, we do gain a hierarchical understanding of what leadership is, but we don't really have the experiential component that is emphasized.

What does it feel like to be a leader where you have people who are on the quote unquote same level as you. We don't see them in a non-hierarchical way.

And so even when we have multidisciplinary teams where we have specialists who are dietitians and pharmacists and social workers, we are still leaders, but we have to be leaders in a different way.

And so that stuff is neither emphasized nor really taught. And I think that's kind of the vacuum that I was placed into when I left my training, because I'm being asked to be a leader in a way that I just wasn't prepared to be.

So I think you're totally right. One example of how leadership overlaps with mentorship, and I know you talk about this and it's been meaningful on your own journey, Is from the other day I mean literally last week a junior faculty colleague called me and said hey look I have a patient that I really feel strong at that antibiotics should be this the infectious disease consultant is saying he wants it that and I don't know what to do with this communication I don't want to lose this consultant because he's sort of saying, well, I'm going to just sign off if you just act this way.

And yet I can't give up my beliefs and what I think the science is directing me to. How do I navigate that? And so I give him complete credit to be, first of all, self-aware because part of leadership is being self-aware.

A part of it also to reach out and need help. Yeah, a big part of it. And to reach out for help and to admit when and just be compassionate with yourself when you don't know the answer and you need someone else's input.

And so we talked through the case and I gave him some things to think about. I didn't give him the answer because there really wasn't an answer that I could give him, but I gave him some things to promote his own reflective thought process.

And at the end of the day, he was able to maintain that trust with that consultant. The consultant did not sign off. And yet they were closer to a therapeutic strategy that was okay for both of them.

And I think the patient ultimately benefited also because we were leading that patient to a team-based approach as opposed to a solitary You know, she said one consultant versus another kind of scenario where the trust just erodes.

So I think leadership has various aspects to it. It doesn't come in one form. It's not intuitive. It is learnable. It is teachable. It is guidable. And yet you have to start with self-awareness.

And none of this stuff is really taught to us in the way that we really need to when we're out in the real world, fending for ourselves, so to speak. Yeah.

Well, let's turn to your framework. What is a healthcare architect? The reason I came up with the idea of architect being the sort of paradigm for what we do is that I saw a lot of parallels between architecture and medicine.

First of all, they're ancient practices that involve humans and they combine art and science. They combine what we do in the world and how we think about the world because, you know, we spend Basically 90% of our time indoors and of course we spend 100% of our time in our bodies and the architecture just like medicine requires many different people coming together and to create not just things of utility but things of beauty as well.

And so I saw a lot of parallels and I thought just like an architect will build a constructive building that has a foundation and various levels of, again, combining form and function, utility and beauty.

So does a physician. We build a foundation that has combined science and ethics. We have different levels of diagnostic approaches and therapeutic approaches.

And finally, we get on what I call the roof deck, which is where we shift a little bit away from health, as a removal of disease and towards wellness, which is this aspirational pursuit to our full potential.

And so I saw a lot of parallels between them and I thought, you know, this is kind of what I do every day. I bring different sort of focus, putting our own health and wellness at the center as opposed to the periphery of what we do.

We want to lead with that, lead our patients and their families through it, but also lead ourselves personally and professionally in our own journeys through our careers and our lives.

So that's where I feel like this health architect paradigm and model analogy, metaphor, whatever you want to call it, has a lot of meaning for me. And it is something that I wanted to share with the broader world.

I love it. I think the imagery is brilliant and the more frameworks, you know, whether it's changemaking or health architecture, you know, to me, we're all pointing towards a similar destination that healthcare has to be better, number one, for our patients and for the people working in it.

Yeah, and I sort of thought what was meaningful to me also about this metaphor is something that draws upon my interest that is growing in cognitive science.

Skills for Modern Physicians

You know, John Vervecky is a professor of cognitive psychology at University of Toronto and For anyone who's interested in his work, it is really, I think, groundbreaking stuff, which if you want to see a masterwork on the history of purpose and meaning in human beings, you can see on YouTube his awakening from the meaning crisis.

It's a 50 part, really just a masterwork of description. The first half is about the history of thought around meaning and purpose, going back to the Axial Revolution through really modern times and philosophies.

But then the second half is really looking at cognitive science and how it has shaped how we look and create meaning in our lives. And so having listened to that and read his works and the works that he cites, it's a really academic sort of treatise.

It made me reflect upon medicine and how really we're trying to bring meaning into medicine like A lot of people are looking for meaning at different places in their lives and different industries.

And the architect, again, analogy or metaphor is something that spoke to me that incorporates some of the core concepts that he talks about. And again, he's part of a group of psychologists who talk about the 4P3R model of cognitive science, which is the 4Ps are different types of knowledge, which are participatory, propositional, perspectival, and procedural.

And then the three R's are recursive relevance realization. And I'm not going to go into it here, but the point is that how do we all create meaning? How do our brains create meaning and purpose moving away from just knowledge?

and into wisdom. And that is where I think, again, my model is trying to help us in medicine get back to our understanding of medicine as a form of wisdom and not just a collection of facts and just like telling people, this is a disease and this is what you're gonna take.

It's about really understanding what's the process of medicine. What is the journey of medicine? And like you said, Andrea earlier, how do we lead ourselves and our patients and families on individual terms, but also collectively towards health and wellness.

Yeah. I want to get a bit granular. I've listened to many of your podcasts and read articles that have been in some great publications, by the way. So our listeners should definitely check out.

You're popping out everywhere from the LA Times and very exciting places. Can you talk about the behaviors in skill sets that define a health architect?

And that I think at the core of who I am, I can't remove the educator in me. And I have a vested interest as a program director. And what are the observable behaviors and what's the curriculum that we could do to support shortening that learning curve?

Because I'm going to be a bit dramatic here, but I'm not being dramatic. When you and I talk about hitting rock bottom and burning out, thank God we're still here.

Physicians have a huge suicide rate. And I know there are colleagues that had similar thoughts and feelings and experiences to us that didn't live, that just didn't survive it.

Like we came out of things and we were able to construct meaning from it and revitalize our own careers. But I truly believe what you and I are doing is saving lives, saving our colleagues lives through this work.

So how can we shorten the learning curve? What are the behaviors and skillsets people need to know? So hopefully they don't have to end up where we did in a pretty dark spot where we were questioning whether we even wanted to do this thing that we spent most of our twenties learning how to do.

Yeah, that is a sobering set of things you bring up. You're right. COVID really brought this into relief, right? We saw the impact upon not just the population and the people we serve, but ourselves.

And it showed how health and wellness can really just lead to devastating consequences. So I completely agree with you. Let me try to keep this brief.

There are many things that we can do. And I think that the starting point is to understand that there are two drivers that I feel are essential to be aware of.

One is that we all need a feeling of having agency. We want to be in control to some degree. We don't need to take over the world, but we have to have some control over what we're doing and why, right?

We want the purpose to be there. The other driver is a sense of human connection. We want to be doing this with other people. We're not, we don't want to do this in a silo.

We don't want to do this in a vacuum. And so when I've seen my own journey through burnout, I see it in the lens of those two drivers, which I want them to be moving me towards health and wellness.

That's what health and wellness means to me in the workplace. And not just it has ripple effects throughout my personal life, too. But when I can focus on my agency and my sense of human connection, that will help me in my own framework.

and that framework is associated with those two drivers, then I can move forward. And one other thing I'll say is those two drivers are linked to what I call the new oath.

In fact, if I can get my book published, that is what it's called. It's a new oath. We need to make a new oath to a health and wellness. And it's because we can do so because we're going to now focus on creating our sense of agency and human connection.

Now, how do we practically do that? There are four drivers that I feel are sort of neglected in what we do today as modern physicians. One is that we don't really look at the information overload and misinformation overload that we're basically grappling with every day.

Second thing is there are all these different types of technology from sensors to telemedicine to AI that we don't really have a great purchase on. Third thing is that we don't understand as physicians how much we mean to

patients in terms of their own care journey through different networks, whether they're in urgent cares or hospitals of primary, secondary, tertiary, quaternary, rehab facilities, wherever these patients are going, we don't really have a great understanding of that journey and to be a shepherd for those patients going through that journey.

Nor do we really sit very squarely with all the different people who touch a patient in terms of their care, whether it's dietitians or pharmacists or social workers or nurse practitioners or whoever.

And so those are some of the, what I call the horizontal and the vertical networks that we need to understand better. And then finally, there's a financial backdrop to this entire thing that we as physicians have been ingrained with this idea that it shouldn't touch the doctor patient relationship.

It should not touch the bedside. And so the reason I bring out these four points is that these are essential, you would argue quintessential aspects of what the modern physician needs to understand and be aware of, but also find ways to have agency and human connection with.

So for example, we can regain a sense of agency by just educating ourselves on what care networks are, who are all these different people that a patient may see.

Teaching Health Architecture in Training

We can educate ourselves about what kinds of technology are available, when technology is needed and when it is not needed, how to see it as a coach and not just a replacement, which a lot of people are worrying about.

In fact, Robert Wachter just wrote a piece in the New York Times yesterday about how AI can be used as a coach and a curbside consult in ways, not just for patients, but for us.

and that's gaining in traction, but we have to use it in certain ways. So that's technology. We can really create a better way of fostering what Lee McIntyre calls a scientific attitude, which is putting the evidence at a higher echelon that maybe we have been doing and also being open to new evidence.

And I can give examples around all these things. And finally, financial literacy. You know, we cannot just say, well, you know, it's not my job to worry about whether this clinical program is financially solvent.

We have to be savvy. We not just need to be facile, but we need to be savvy about what keeps the lights on. Whether it's coding and billing rules, whether it's payer mixes, it doesn't mean we have to get an MBA in this and be able to sit in board meetings all day.

But we have to be able to be aware and educated enough to have really cogent conversations with administrators. And when you can do that, not only going back to the two drivers, not only do we feel a sense of agency there because now we are competent and we can actually make some decisions around some of these things, but we'll also foster our sense of human connection because we can have conversations with administrators and executives in ways that invite us to the conversation rather than being told after the fact, hey, by the way, your program needs to cut by 20% because and you'd had no idea.

No, you're going to be now part of those conversations upfront to engineer a solution. So anyway, this is a sort of condensed version of what I feel the health architect framework provides is it marries a philosophy of bringing purpose and meaning back to what we're doing in the form of this oath that impinges on these two drivers of agency and human connection, but it marries it with a framework that's practical, that leads to those four issues that are facing modern physicians.

It doesn't mean we don't know the science or we shouldn't lean into that, but it means that we have to complement it and admit that there are other aspects being a physician that we just can't ignore anymore, lest we run into being considered irrelevant.

We are not irrelevant. We will never be irrelevant, but the need for us is changing. The need for us is changing and

we have to adapt to it. And we have to embrace that adaptation.

We have to embrace the change. We can't say, well, the system is so terrible and I can't do anything about it. Enough with the learn helplessness. There are things we can do about it.

It's not going to solve everything. But to wait for Godot and think that it's all going to work out in the end, if we just say enough in complaints or just wait in time, I think is a fool's errand.

Yeah, a hundred percent. You know, I look back now I can't cause I'm no longer on Twitter, but if you read my tweets during the pandemic, it was a lot of screaming into the void.

And I think that's a phase, but again, we can't stay in that phase for long. And what you're saying makes complete sense. Hey friends, Andrea here. There are moments in a doctor's life that mark you forever, and for me, they often involve travel.

It's where I connect with awe and wonder that help me see my life and my career differently. The heart of medicine in Uluru, Australia, July 29th through 31st, 2026, is a retreat that is an immersive soul-level experience at one of the world's most sacred landscapes.

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Learn more and register at coachingfordoctors.net.au or you can email me at andrea at andreaaustinmd.com. I'd like to spend a few minutes brainstorming about how we could reshape medical curriculum, because my stance is that this should really start happening in medical school.

I think a lot of medical school, and again, it's done from a benevolent place. I think medical student deans, for the most part have worked in academia.

And I even think back when I was going into medicine, I grew up Catholic and there was a lot of parallels between going to medical school and becoming a nun or a priest.

People may laugh at that, but you're joining this group of people with their own rituals. And there's a lot of things that you don't get to do in your twenties because you go to medical school.

I still had a lot of fun, but there's a lot of things in your life that you sacrifice. And at the time I was like, well, this is a sacrifice that I'm willing to make because I just have this calling.

to do it, but that kind of high priest, high priestesses that go into this, you know, special building with these weird clothes that we wear and all the other accoutrements of becoming a high priest of medicine, it doesn't effing work anymore.

And then what you do is you graduate somebody that is full to the brim of altruism, although studies are now showing that by third year medical school, that's gone.

And so now you've got this person that came in altruistic, but they don't have the skills to understand the RVUs, how, you know, the bills actually get paid.

So if you got to become Dean of a medical school and shake up a curriculum, what would you do? Would this be one class? Would it be just little tweaks on every class?

Would it be kind of like if you added social determinants of health to a curriculum, you would just sprinkle it in?

along the way. So Dean Romoff, what's your prescription?

Well, I love your analogy to the religious world because the idea of rituals and let's say myths, you know, it goes back millennia, right? And it is part of my framework too, because, you know, if you look back at medicine, we have oaths and we have rituals in medicine.

Right? I mean, going back to Hippocratico, everybody knows that. But we have other myths, which are really sacred stories that give us meaning and purpose on how we should aspire to, right?

They're not concrete. They're something that leads us forward, just like the Christian faith or the ancient Greeks or the Hindu mythology, whatever. tradition you want to follow, they have myths and they have rituals that are associated with those myths.

So in medicine, we have things like the body-mind omniscience, you know, that comes from Galen. That's a myth. I mean, it's not real, but it's something that has meaning, right?

We have the doctor-patient relationship, which came from William Osler. You know, it's taken on a mythic proportion and he's become sort of mythic in himself, right?

Florence Nightingale sort of embodies compassion. That's also something that has a lot of meaning of purpose. And all of these things have rituals associated with them.

And what I am arguing for is that today, the same is true. We have to hold on to the rituals that still have meaning and purpose for us.

Financial Literacy and Healthcare Reality

That includes. tending to patients, treating them with compassion and empathy and care. But it also involves adopting a scientific attitude and seeing that through.

It also involves understanding, sadly, let's just say, but coding and billing rules and financial literacy. Another ritual is understanding this complex maze of healthcare locations and personnel that we are working within.

and how to deal with information overload and misinformation and technology. All of these things are different rituals that we're adding to some of the old ones that we're holding on to because they still have meaning and purpose today.

So that idea of rituals and myths, it resonates with me 100%. As a dean, to answer your question more directly, I think we have to sort of re-engineer the entire ethos of what we do.

And it's not just one course, okay? It's going to be something like, okay, today we learn medicine from basic physiologic principles, right? And we also incorporate societal and public health attitudes and trends and themes and so on.

We should be adding a financial literacy aspect to that. We should be adding an epistemological aspect, meaning how do we adopt the scientific attitude?

We should add a communicative aspect to this. How do you communicate these things to each other? How do we understand the care networks and the infrastructure of health care?

All of these things should be adopted really for every type of disease pathway that we're really thinking about. So to me it's not just a seminar or lecture here and there, it's something that gets embedded.

Now how do we start this process? Well we have to start maybe a little bit more thoughtfully. So as we speak, I'm trying to put together a lecture series or a mentorship program for medical students where I am at UC San Diego.

And so I'm starting to walk before I run. But I think that's the idea is when you want to change a mindset, you have to bring awareness to it and you have to introduce it as a non-threatening kind of thing.

And then eventually you can embed it in all the different aspects, just like we do with everything else. I mean, there was a time, remember, where science and evidence-based medicine really wasn't a real thing.

I mean, going back to the 1800s, but even in the middle of the last century, evidence-based medicine became a moniker only since I think around the 1980s or maybe just after that, maybe the 1990s.

right or wrong, it has recalibrated the focus of how we think about what we're doing. And so what I'm asking for the health architect framework is, and from your standpoint, the changemaker framework is, let's reorient how we're thinking about what we're doing.

And when we can do that, then I think some interesting things can happen. I guess the next question I'd like to do is talking about how you approach weaving in health architecture during your clinical work and teaching residents.

Do you have some examples that you can use? You mean for residents in particular? Yeah, like you're on rounds in the ICU. Is there moments where, you know, you're able to weave in any of the concepts that we're talking about and make it practical?

and use that health architecture. It's a little hard with the residents because there are different levels. All right. Well, now that we've fixed undergraduate medical education and clearly, you know, they need to get Dean Austin and Dean Ramnath in the seats.

I'll take the East coast. You can have the West coast and we'll just meet in the middle. Now that we've got that fixed, now let's move into a graduate medical education now where I spend all of my time.

So working with residents and for you, you work with a lot of fellows. And, you know, it's interesting now when I interact with a medical student, you know, just the stark difference.

And I think the Pitt does a great job of showing that altruism And I guess for a seasoned clinician, how refreshing it can be spending time with medical students.

And then you go to the resident or the fellow that sometimes are kind of the most burnt out people in the system because they're working in a lot of cases the most, and they're also the least paid of the people working in the system.

So when you're dealing with that resident that's at the end of their 24 hour call, You're in the ICU, your list is exploded. Thanks, Lucy's in. How do you practically weave in some of these concepts?

Yeah, that's a great question. I think it depends on the situation and it depends on the person. So part of this is again, that leadership thing to be able to really surveil the right opportunity for the right experience.

So for example, in the moment, let's say I'm on rounds, And I have residents of various levels, PJY 1, 2, and 3. I have a fellow as well. So there's a broad range of experience and knowledge base.

I may restrict my comments on rounds themselves to, how do we adopt a scientific attitude? This has come up many times. So someone will say, oh, yeah, you know what?

I think we should give mitadrine, mitadrine being a medication to raise blood pressure. Well, I say, okay, well, can you help me understand why you feel that way?

Are there pieces in findings in the literature that you can cite to support that? And usually I'll get silence. And I'll say, Hey, no, this is a great opportunity for us to find some of that literature and let's come back.

And so the next day or later on in the morning, we'll have a chance to go over that literature. And I make a point to lead by example. So at the end of my week on service, I will send people probably five to 10 papers based on all various things, whether we discuss them on rounds or not.

Around the evidence behind what i'm saying and why the decisions that we made so that's one sort of concrete example that is probably familiar to many people in the academic environment.

Another one, which I like to do more of is the one-on-one. So especially with fellows, as they're getting to, let's say, even in their early years, but particularly in their, let's say, second year, we have a three-year fellowship for pulmonary and critical care.

So let's say in the second year, if the opportunity avails itself, I'll say, Hey, you know, what are your career plans? What are you thinking about? Where are you thinking of working?

And opening up the discussion to more than just clinical medicine, more than just research. Are you thinking about education? Are you thinking about innovation work?

Are you thinking about administrative pathways? What does that look like? What do you know? What have you heard? Because my background has gone from academic tertiary care places to rural non-academic, not even community, very rural practices, let's say along the US-Mexico border and everything in between.

I've worked in Texas, I've worked in several different states across the country in all kinds of contexts, even outside of the country. So part of my ability to open a pathway towards what I would call being a health architect is to kind of move to the roof deck first and see what's your one, two, five, 10 year plan in your mind, where does that lead to?

What have you thought about professionally? What have you thought about personally? And what does that look like? And where are your questions around that?

If it's around, let's just say there's a patient with a certain type of difficulty, Let's say it's an end of life situation.

Books, Self-Care, and Creativity

I will then move to say level two of my framework and say, how do we think about prognostication? How do we think about quality of life and quality of death?

These are things that are part of what I call the workrooms on that level. but they don't get the same kind of emphasis that I think the traditional medical education has.

It doesn't mean that ignores it, but it doesn't put it front and center in intensive care in particular, but I would say medicine in general, we just don't do a great job of talking about quality of death.

or quality of life, but certainly quality of end of life. We just don't, we don't like to talk about it. And I put that at the center and I say, hey, let's talk about this.

What do we know about this patient's story? What do we know about what's important to this patient now? And I've led family meetings with fellows and really opened doors for their own understanding.

So again, these are just two small examples of how the situation and the approach can vary quite widely, but they do still fit into a larger recalibration of how we think about the entire craft that we do, our vocation.

It just looks at it a different way. And I haven't even talked about, you know, different things about coding and billing and stuff like that, which again is a little bit more tangential to the trainee.

But I introduced these concepts. I'll give one last example. I'll say, Hey, look, let's stop using the term mental status

change or altered mental status.

Why? Because when you actually have to code it and bill it, you're going to get a lot more clarity and also importance placed on acute encephalopathy.

And you can even be more specific, acute metabolic encephalopathy, acute toxic encephalopathy. You're not going to get the queries from your CDI folks as much if you're going to be more specific.

Don't see acute kidney injury, see acute tubular necrosis. I mean, these are small little things that in the moment I might coach my trainees, maybe not the residents because they're a little bit further away, but certainly the fellows to be able to get them closer to as they're getting to the end of their training.

These are the things that are going to be more and more important to keep in mind. Yeah, nobody listening to this podcast would think this, but, you know, I think there's a caricature of physicians being wealthy, maybe being in it for money, you know, some of the horrible things that were said about our profession, especially during the pandemic.

I mean, at this point, a lot of us are trying to keep the lights on. And, you know, I'm the article that I'm working on now about the emergency department funding and thinking about how we can do that more.

Creatively, when I actually went to the most recent RAND report and crunched the numbers, it still blows my mind. So I have to say some of these numbers for people.

Only about 30% of people that come to an emergency department have insurance that will actually pay the fair market value approximation of what my professional charges should be for that visit.

And 50% of people are using Medicare or Medicaid, which is paying significantly less than what is fair market value. And then 20% of people coming to an emergency department can't pay.

They're not paying at all. And so that means 70% of people coming to an emergency department are not paying for my physician services. And, you know, just thinking from a business standpoint, if you're trying to open a business, you went to a bank and said, I got this great idea.

The community really needs it. It's going to be lifesaving and critical infrastructure for this community. But 70% of my clients won't be able to pay their bill or all of their bill.

you'd be laughed right out of the bank. But that's literally what we're dealing with in emergency medicine. And I know it's not much different for critical care.

And so when we're trying to teach trainees or our colleagues how to code something, so we bring home a little bit more of what we actually deserve, there's patient wellbeing and our wellbeing behind that too.

It's not being money hungry. It's simply trying to play by the set of rules and know the rules, which is actually part of the change making work that came out of my research is that is a key skill set that you need to be able to do.

If you want to change a system, you first have to know how the rules work. And in our system, that's medical billing and coding. Yeah, I'm going to take it maybe even one step further.

There are two messages that I think come out of financial literacy. One is to the public, which is that even if you think that physicians make too much money, if you want to have a clinic or a hospital even exist, whether or not that physician gets paid or not, we have to do a better job of understanding the kind of work that we're doing.

If we don't substantiate the work that we're doing, which is coding and billing, and physicians have to get support to do that, then these places just can't function, and they will close.

So I work right now, one of the hospitals I work at is, like you said, it's 70% Medi-Cal, So, you know, lower income folks or Medicare. And unfortunately, just doesn't bring in the same kind of money that can keep the operations going for things that have nothing to do with critical care, let's just say.

So one thing is to the public is, yes, we have a societal need to take care of the infirm. And some of them have more means and some of them have fewer means.

But that if we don't look at the enterprise as a whole, that's a problem. For the physicians, I would say we have to radically accept that medicine is a business in this country.

A lot of countries is not like that, but in the United States of America, it is. And so once we can accept that, then we can move to the next step, which is, like you said, Andrea, how do we educate ourselves on proving the work that we do?

By coding and billing, unfortunately, that is the primary way to do that. Intensive care units almost always lose money. We cannot seek referrals. We see the sickest of the sick.

And when folks, even if they have good insurance, the resources that are required often are more than what some of those support situations come in. But overall, we keep it open because then we can do the surgeries, we can do the other types of therapies that provide the benefit to the large number of folks that thankfully don't need the intensive care unit.

But looking at one physician in one group in one part of the hospital, is not going to give the perspective that is needed to be able to get the care that everybody needs and everybody deserves.

So for our part as physicians, we have to accept that our part of this equation is to code and build as well as we can and also to interface with our administrators as tactfully and strategically and collaboratively as possible so that we can all move the enterprise forward on behalf of our patients and, again, keeping the connection between all of us strong and our sense of agency across the board intact so our own health and wellness is front and center.

I could do this all day, but I know this will be a continued conversation and we'll just keep ping-ponging back and forth between our pods and other venues.

I'm hoping someday we'll be sharing a stage at the AAMC and talking about some of these concepts and how we reshape our medical curriculum to meet the moment.

Because right now I don't think we're meeting the moment and you can look at any health indicator that you choose. But let's pivot to a wrap up. If you had to pick one book that's really informed your health architecture framework.

And I know there's many, but just one book that maybe it's something you've read recently or just one that you always go back to. Actually, one that I read recently is by another physician.

His name is James Turner. It's called Determined. I can't remember the rest of the title, but it is his own journey through burnout.

Closing Thoughts and Where to Connect

And what I liked about it is that while it doesn't give a ton of practical tips, it really talks about how we have to change our mindset about taking ownership for this gauntlet that we're in.

We have to pick up the ball and run with it. And I really liked how he basically asks us to not be helpless and to not sit on the sidelines, but to get up and pick up the baton and start running and not fleeing, but being really mindful and thoughtful about what we're doing and why we're doing it and where we're going.

I do think that is a meaningful message. I love it. I've already written it down. We'll make sure it's in the show note. This work is hard. Well, being a doctor is hard, number one.

And then being on the far end of the innovation curve is hard. So how do you take care of yourself? What's maybe one of your top self-care tips? One of the posts that I put in my own sub stack is on slowing down.

And that is really hard for me. As I imagine, it's hard for you too. I know. Yeah. So one of the things I'm really trying to do is not add too many things to my plate.

It is incredibly hard. I'm trying actually more than I ever have been. to not sign up for more shifts than I absolutely need to. I'm doing a lot more meditating at home.

So just meditation. I'm doing a lot of self-compassion reading. That's another book, not to mention another book, but Kristin Neff and Christopher Germer's self-compassion workbook.

I love that book. I'm constantly going back to it. I'm constantly trying to practice it. And so those are things that I'm just trying to slow down. Yeah, that's a great message.

And you know, that's where creativity for me, not that you need a incentive to slow down, but when you're moving at a supersonic pace, it's really hard to do creative work.

So that's kind of my reminder to myself. And I can now tell when my creativity zapped. And that's kind of like an early indicator that if I don't get a handle on things, then other things are going to start falling away.

Yeah, I think physicians often forget that it took a lot for us to get to where we are. And a lot of that is creativity. We were and have been and still are extremely creative, fertile minded people.

And when we bury it and all the tasks that we learned in internship saying, you know, you got to get the hundred things done. And that becomes our way of being.

Like you said, it just gets buried. And when you unpack that and unload it and sit with ourselves, which actually feels pretty uncomfortable. All of a sudden, there are these sprouts of ideas that sort of come out.

I never thought I'd be doing so much writing in my life. As I just sit with myself or even just if I'm on the bike and I'm just staring off into the clouds, all of a sudden an idea will just come and I'll say, wow, maybe I should write on that.

That'd be kind of cool. And then I start writing and I just sort of sit And then an idea comes. And so what I would just encourage your audience is, and I imagine most if not all of them are physicians or someone connected to health care in some way, is to don't minimize just sitting and being with yourself and listening to what is happening.

So we're all going to have these thoughts that are constantly just batting us around, right? But to actually notice them, and be curious about them and maybe even explore a couple of them calmly without judgment or any of those things, it can be pretty revealing and surprising and maybe even inspiring.

I think those are avenues to creativity that I think that with your changemaking framework and my health architect framework, that's what we're trying to say.

When you move into that realm of Prospective journey making right trailblazing. It's not what you have to do anymore. And that can be pretty scary and uncertain.

But God, it's also invigorating and empowering to to shape your own way forward. And guess what? Your patients and families are along that journey too.

So you can do things for them by opening yourself up as well. So there's a whole world out there. I just feel like we've spent so many years just putting it in a closed door, but when you open that door, heck, there are some cool

things that can happen.

Well, I can't think of a better way to end than that reminder for us to rest and to unlock the creativity to continue to do this important work. With that, how can our audience connect with you, read more of what you're working on, listen to your podcast?

Great, thank you. And I'm thrilled to have been on this podcast. Andrea, I really love your work and I really look forward to continuing this conversation and yes, sharing a stage if we can at some point.

People can find me either on Substack at Be A Health Architect. I'm also on X under my name, Venkatesh R. And I'm also on LinkedIn. So please look me up and connect with me and please give me feedback too.

Thank you so much, Venkatesh. This has been amazing and I can't wait until next time. Thank you for listening to Heartline, Changemaking, and Healthcare.

If this episode sparked something for you, I'd love for you to share it with a friend or colleague who's walking their own changemaker path. If you're interested in coaching, consulting, or speaking engagements, you can find me at andreaaustinmd.com or connect with me on LinkedIn and Instagram.

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Until next time, keep following your heartline.