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# The Tectonic Plates Are Shifting: Cultural Change vs. Mural Dyslexia

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KENNETH COHN, M.D., LEONARD H. FRIEDMAN, PH.D.,  
AND THOMAS R. ALLYN, M.D.

**SUMMARY** • In response to a rapidly changing healthcare marketplace, a variety of new business models have arisen, including new specialties (hospitalists), selective care (concierge medicine), and joint ventures (ambulatory surgical centers, specialty hospitals), some with hospitals and others with independent vendors. Since both hospitals and physicians are feeling the squeeze of rising expenses, burdensome regulations, heightened consumer expectations, and stagnant or decreasing reimbursement, the response to global economic competition and the need to improve clinical and financial outcomes can bring physicians and hospitals together rather than drive them farther apart.

In response to perceived threats, physicians and hospital executives can engage in defensive reasoning that may feel protective but can also lead to mural dyslexia, the inability or unwillingness to see the handwriting on the wall. The strategies of positive deviance (finding solutions that already exist in the community rather than importing best practices), appreciative inquiry (building on success rather than relying solely on root-cause analyses of problems), and structured dialogue (allowing practicing physicians to articulate clinical priorities rather than assuming they lack the maturity and will to come to consensus) are field-tested approaches that allow hospital leaders to engage practicing physicians and that can help both parties work more interdependently to improve patient care in a dynamically changing environment. Physician-hospital collaboration based on transparency, active listening, and prompt implementation can offer sustainable competitive advantage to those willing to embark on a lifetime learning journey.

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Kenneth Cohn, M.D., FACS, is a practicing general surgeon and director at Cambridge Management Group; Leonard H. Friedman, Ph.D., is professor of public health at Oregon State University in Corvallis; and Thomas R. Allyn, M.D., FACP is chief of nephrology at Santa Barbara Cottage Hospital and chief executive officer of the Santa Barbara Artificial Kidney Center, LLC, in California.

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*“If you don't like change, you're going to like irrelevance a whole lot less”*

—Erik Shinseki, Retired U.S. Army  
Chief of Staff

When leaders fail to appreciate what is happening in their environment, their misperception can originate from fatigue, information overload, conflicting priorities, unwillingness to listen, preexisting mental models, subconscious biases, and unclear communication (Cohn and Barker 2006). A significant barrier to environmental awareness comes from

**Healthcare leaders must be able to differentiate significant signals of environmental change from background noise.**

defensive reasoning: when confronted with a potential threat or embarrassment, people protect themselves by blaming others (Argyris 1994).

A consequence of defensive reasoning is mural dyslexia, the unwillingness or inability to read the handwriting on the wall (Zinkham 1999). Because the healthcare landscape is rapidly changing, healthcare leaders must be able to differentiate significant signals of environmental change from background noise. The tectonic plates on which healthcare delivery currently rests (both the business and mental models) are in motion, and the rumbling is increasing. An unwillingness or inability to see what is going on can have serious consequences for healthcare leaders, their organizations, and most importantly, their patients and communities (Cohn 2005, 39–45).

Healthcare leaders need to discern the handwriting on the wall relating to the economic implications of the evolving relationship between hospitals and physicians and to embrace cultural change as

an opportunity rather than a threat. This article will help leaders apply different frameworks, even though increasing influence and sense of control by admitting uncertainty and welcoming new insights and collaborators may seem counterintuitive. In the article, we briefly analyze forces promoting this rift from a historical perspective and then discuss retail, wholesale, and collaborative strategies to offer a perspective that can reduce defensive reasoning and mural dyslexia. With each collaborative strategy, a brief case presentation shows how theory can play out in the real world.

## ENABLING FORCES

In the 1990s, as payers moved financial decision making from physicians to third-party intermediaries, control shifted from providers to payers. Today physicians and hospitals compete with one another for patients and their associated reimbursement and collaborate on joint projects, resulting in a number of new alliances.

Some of the enabling forces that have exacerbated rifts between physicians and hospital leaders include:

- *Global economic pressure for heightened operational efficiency.* Forced to compete in a global market in industries where the wage and benefit structure is much lower than in the United States, U.S. firms are driven by the rising cost of healthcare to relocate their production capacity overseas (Friedman 2005). Hospital executives, who change jobs every three to five years, may see the effects of globalization in a variety of settings, but physicians, who tend to remain localized, attribute economic deterioration to local incompetence (Cohn and Peetz 2003).

- *Outpatient migration.* The shift of care from inpatient to outpatient settings is one of the most dramatic ways that healthcare has changed over the past two decades. This shift results from a number of factors, including cost pressures, changes in Medicare reimbursement, consumerism, minimally invasive procedures, and improved drugs and home monitoring devices (Galloro 2001). Because patients are rarely admitted to the hospital the day before elective procedures, process inefficiency becomes more readily apparent and less easy to correct in time to avoid disrupting physicians', patients', and families' schedules. In many states, especially those in which new construction does not require a certificate of need, physicians have invested in and developed focused factories (Herzlinger 1999). These specialty hospitals and ambulatory surgery centers improve physicians' ability to see and treat patients and increase revenue at a time when reimbursement has been stagnant and office expenses have been increasing. However, these facilities have siphoned off low-cost patients from hospitals, leaving hospitals with inpatients with multiple medical comorbidities requiring higher staffing ratios and additional resources. Such specialty centers also draw valued operating room staff from the hospital, as these providers are eager to be freed of the burden of night and weekend call (Cohn, Gill, and Schwartz 2005).
- *Changing sociology.* An effect of the outpatient migration process is that fewer physicians spend time in the hospital, which can undermine the

sense of community that once existed with physicians as well as administrators. With the use of hospitalists, key internists and family practitioners no longer come to the hospital and, in many communities, have resigned their hospital privileges. Without proactive programs to involve community physicians, those physicians' feelings of ownership and responsibility for community hospitals will diminish (Cohn, Litten, and Allyn 2006). This situation may intensify as the concept of hospitalists extends to trauma surgery, orthopedics, obstetrics, and neurology (*HealthLeaders Leadership Review* 2007).

- *Regulation and the burden of uncompensated care.* Many of the complex and conflicting healthcare regulations make hospitals enforcers, essentially pitting hospital leaders against physicians. For example, although the Emergency Management Treatment and Labor Act (EMTALA) was revised in 2003, it still puts hospitals in the middle between federal law and physicians who are pushing back against the burdens of providing emergency care (Griffen 2007). The rising burden of unreimbursed care has led physicians to push for pay-for-call stipends, which limits the ability of hospitals to fund replacement of aging equipment and facilities (Griffen 2007). Uncompensated care is never free (Weissman 2005).
- *The expanding oversight of the federal government.* Medicare, for example, which initially increased physicians' incomes when first established, has decreased reimbursement and added complexity that requires specialized

assistance to avoid criminal penalties (Cohn and Peetz 2003). Complex regulations and their attendant bureaucracy increase physicians' feelings of being over-monitored and underpaid and limit their willingness to collaborate with hospital leaders, even though hospital executives are not responsible for the regulations.

- *Evolving work models.* As imaging has become digital and transmission of large quantities of data has become more rapid, analysis has become globalized, for example, the nighttime reading of imaging studies. Cardiologists, vascular surgeons, and radiologists compete for minimally invasive vascular procedures; radiologists' reliance on physician and hospital

***We recommend a proactive strategy, based on dialogue, collaborative conflict to attack problems rather than people, and containment.***

patient referrals make them vulnerable to disruptive innovation (Christensen et al. 2006). As radiologists attempt to negotiate exclusive agreements for vascular procedures, maintain high wages and long vacations, and have the hospital pay for night coverage, one can expect radiologists' relations to the hospital and to other physicians to come under pressure.

## **NEW BUSINESS MODELS**

Clearly, complexity has increased for physicians and job satisfaction has decreased because of increased workload, decreased reimbursement, and feelings of powerlessness and disenfranchisement. The physician's role as captain of the team has diminished. Furthermore, physicians feel that administrators trained in bottom-line management have treated their services as undifferentiated commodities and

have trampled a sacred trust among physicians, patients, and families (Zuger 2004). In a survey of 1,205 physicians (Steiger 2006), the top causes for low physician morale were declining reimbursement, loss of autonomy, red tape, patient overload, and loss of respect perceived as devaluation of physician services and time. Nearly 60 percent considered leaving the practice of medicine because of discouragement with practice environment, and nearly 70 percent know at least one person who has stopped practicing as a result of low morale. The consequences of low morale were fatigue (77 percent), burnout (66 percent), marital discord (32 percent), depression (32 percent), and suicidal ideation (4 percent).

Thorough training in technique and judgment has not prepared most physicians to deal with the challenges of working in rapidly changing institutions, building consensus, and resolving conflict (Cohn and Peetz 2003). The word "administration" serves as a lightning rod for their multifactorial discontent and leads some to work outside hospital boundaries to gain control of schedules, personnel, and operations affecting their time.

As no taxonomy neatly fits the rapidly changing healthcare setting, we offer the following caveats to the discussion that follows:

- We have focused on new business models rather than new physician roles because some business models, like retail mall clinics, do not use physicians but may affect the income of primary care physicians, either positively by allowing them to spend more time with patients and bill for more complex evaluation and management, or negatively by taking away lucrative

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sources of income, like school physical examinations.

- We have arbitrarily divided new business models into wholesale and retail strategies, admitting that the two categories may overlap.

### Wholesale Strategies

As healthcare professionals feel the squeeze of rising expenses amid stagnant reimbursement, one strategy that physicians have used is to invest in ventures that will allow them to bill for the technical as well as the professional component of services delivered. Such “wholesale strategies” take the form of ambulatory surgical centers, outpatient imaging centers, and specialty hospitals. Not-for-profit hospitals can be at a disadvantage compared with outside vendors because of the complex regulations governing charities and the laws governing financial interactions between physicians and hospitals, such as the Stark Laws, which prohibit enrichment from self-referral in designated health services, and antikickback laws, which generally prohibit rewards for referrals. Where feasible, we recommend a proactive strategy, based on dialogue, collaborative conflict to attack problems rather than people, and containment, that is, agreeing to table the issue for later discussion rather than allowing a stressful situation to lead to blaming (Cohn 2005, 17–23). The rationale for this unconventional approach is outlined in the section entitled “The Dance of the Blind Reflex.”

### Retail Strategies

Business models that entrepreneurs have chosen in response to new trends include the following categories; each category includes a brief assessment of its impact on hospitals and physician-hospital relations

(admittedly, the effects may vary according to the response of individual people, organizations, and local and state regulatory agencies).

### *Concierge Medicine*

Concierge medicine is based on annual membership fees that allow primary care physicians (PCPs) the opportunity to reduce their number of patients, dependence on insurance, and economic uncertainty. Although concierge medicine can decrease the number of PCPs available to care for unassigned patients after they leave the hospital setting, concierge physicians visit the hospital to care for their inpatients and thus can remain an active part of the hospital community.

### *Hospitalists*

Hospitalists are physicians who specialize in caring for inpatients, and thus they free PCPs to focus on their office patients. The number of hospitalists is expected to grow to 20,000 by 2010 (Williams 2004). The freeing of PCPs puts pressure on the hospital to link to its base of PCPs by using hospitalists as ambassadors and by offering continuing education programs, Internet-based conferencing, and even financial collaboration projects such as medical office building and equipment leasing co-investment projects (Cohn, Litten, and Allyn 2006).

This is an incredibly important development. How the hospital relates to community physicians who no longer come to the hospital is crucial to capturing and retaining market share. Poor hospitalist-PCP communication, particularly at the time of discharge, leads to suboptimal clinical outcomes and undermines PCP-hospital relations (Kripalani et al. 2007).

### Retail Mall Clinics

At storefront clinics, patients can shop while waiting for nurse practitioners who can perform basic services, such as administering vaccinations or diagnosing sore throats, bladder infections, and earaches (Christensen et al. 2006). The level of competition remains dynamic, with PCPs potentially caught in the middle between territorial specialists and clinics that offer convenience and quick turnaround times. It may be too early to predict the effect on physician-hospital relations; however, storefront clinics offer an opportunity to decrease emergency room congestion and thus allow ERs to

**Both physicians and non-physician healthcare leaders focus on the part of the system that is directly in front of them; the other parts rest outside their consciousnesses.**

provide better service to patients truly in need of emergency care. The question remains as to where patients will go for care beyond the scope of the clinic—hospitals and physicians need to develop strategic, proactive alliances with the owners and healthcare

providers of these services. Alternatively, hospital leaders can develop community-based resources, such as their own mall clinics, to take the pressure off their ER facilities.

### Telephone Medicine

Companies such as TelaDoc offer 24/7 telephone access to family practitioners, on-call specialists, and emergency physicians. TelaDoc also maintains a patient's medical record electronically (*HealthLeaders Physician Compensation Report 2007*). These services offer new employment models for physicians who want or need to work in predictable shifts, for example, in order to care for young children. As with the mall clinics, hospitals

would be well served to partner with rather than compete with these providers to increase patients' likelihood of seeking out a particular physician or hospital for subsequent care.

### Health Tourism

Health tourism is another developing retail strategy. As an example, prices in India average 10 to 33 percent of surgical fees in the United States, and approximately 200,000 foreigners traveled to India for care in 2005 (Mannan 2006). This figure is expected to grow 15 percent per year. Any loss of income can be expected to strain relations further between physicians and hospital leaders, as each group points fingers at the other without understanding the context.

### The Dance of the Blind Reflex

Both physicians and nonphysician healthcare leaders focus on the part of the system that is directly in front of them; the other parts rest outside their consciousnesses (Cohn, Gill, and Schwartz 2005). Members of a section or a department have limited or no knowledge about what is going on in the rest of the system or nonsystem of fragmented care. Therefore, these participants do not see the enabling role they play in the conditions that they deplore. This inability to see the whole system results in what Oshry (1996) refers to as the "dance of blind reflex," which is made up of five interlocking parts:

1. People at the top of the organization feel *burdened* by unmanageable complexity.
2. Those at the bottom of the organization feel *oppressed* by insensitive higher-ups.

3. People in the middle feel *torn* and become weak, confused, and fractionated.
4. Physicians, patients, and families feel *righteously done-to* by an unresponsive nonsystem of fragmented care, which irritates hospital leaders who feel that their efforts are underappreciated.
5. Nobody sees his or her part in creating and sustaining any of the above conditions.

In this dance, blame is freely shared. To call a halt to the dance of blind reflex, we must first work to see the systems that we occupy. Not only do we have systems (i.e., a collection of component parts acting interdependently [Cohn 2005, 30–38]), but the systems also have us.

**Making Sense of Systems**

Our ability to see and make sense of systems encounters three obstacles—“how to,” “want to,” and “able to” (Friedman, King, and Bella 2007). All three of these obstacles are connected through “defensive reasoning” (Argyris 1994), which kicks in when we perceive others are attempting to blame us or when we sense that we are part of the problem. We revert to defensive reasoning when we feel embarrassed, threatened, incompetent, or under scrutiny. We then seek to shift the blame elsewhere and hide that we are defending ourselves (Friedman, King, and Bella 2007). The field-tested frameworks described below offer an alternative to the status quo that improves the practice environment and decreases physician-hospital tensions.

**ALTERNATIVES TO THE SYSTEMS THAT HAVE US**

The remainder of this article explores the use of frameworks and associated case

presentations to work smarter rather than harder, act more interdependently than independently, and create an environment that supports learning and improving clinical outcomes rather than assessing blame. Engaging practicing physicians is key to the economic performance of hospital leaders and their organizations (Cohn 2005, 17–23).

**Dealing with Physician-Hospital Competition**

To work with the systems that have us, break the dance of the blind reflex, and reduce defensive reasoning, we recommend a proactive strategy based on dialogue, mutual respect, and collaborative conflict to attack problems rather than people (Figure 1). For example, if the goal of physician-hospital financial collaboration is to create something of value that benefits patients, physicians, and the hospital, collaboration requires win-win agreements that enlarge the economic pie rather than divide decreasing shares. Both parties gain if physicians act as owners rather than clients, increasing admissions and revenue and pointing out ways to improve processes and outcomes. A spectrum of collaboration opportunities, from service contracts to medical office building/real estate to joint ventures is possible for parties (Cohn 2005, 12–16) if they:

- share information widely to build transparency and trust;
- work proactively to develop a shared vision of care that will benefit physicians, patients, and the hospital; and
- rapidly identify and remove system roadblocks to effective and efficient care, which is key to retaining physician loyalty.

**FIGURE 1** Field-Tested Strategies for Dealing with Physician-Hospital Competition

- ❑ Appeal to physician champions to discuss with colleagues the advantages of reinvesting profits within the community rather than losing them to out-of-town investors.
- ❑ Build on known hospital strengths, such as familiarity and comfort to patients; experience with regulatory agencies; access to capital and land; participation advantages in purchase of expensive, rapidly obsolescing high-tech equipment; and market power to obtain bundled reimbursement from payers for cutting-edge services.
- ❑ Come to know the most valuable physicians proactively by visiting them at least quarterly and learning what hospital executives can do to add value, especially regarding improving processes.
- ❑ Use collaborative conflict to attack problems rather than one another; avoid hot-button words, such as “you,” “always,” “never,” “but,” “why,” “just,” “cost,” and “I disagree.”
- ❑ Engage in active listening by giving the other party full attention, being aware of the importance of body language and tone of voice, suspending judgment, and empathizing to understand the other person’s point of view.
- ❑ Practice a five-step approach during difficult negotiations (Ury 1991):
  1. Go to the balcony, where you can escape mentally to clarify thoughts about both parties’ interests and reflect on the next steps.
  2. Step aside—emotional jujitsu—to enable you to listen, acknowledge, defuse anger, and find areas of agreement on which to build.
  3. Reframe, letting the problem be the teacher to foster a team-based approach, with phrases such as, “What would you recommend to help us solve this problem?”
  4. Build bridges, which allows both sides to save face and satisfy mutual interests.
  5. Make it difficult to say no, which helps to decrease the risk of failure and reassures both parties that the goal is mutual satisfaction rather than unilateral victory.
- ❑ When negotiations break down, agree to meet again in several weeks rather than blame the other side for failure.

### Positive Deviance

One way to overcome system roadblocks involves using positive deviance (PD), a bottom-up approach to organizational change based on the premise that solutions to problems already exist within the community. It encompasses intentional behaviors that depart from the norms of a group *in honorable ways* (Weber 2005a). Positive deviance seeks to identify and

optimize existing resources and solutions rather than obtain external resources to meet those needs. Keys to the PD method include (Weber 2005a):

- self-identification as a community by members of the community; that is, people see themselves as working toward the same goal;
- mutual designation of a problem by

- community members, rather than identification through a top-down approach;
- inclusion of community members on the leading edge who have managed to surmount a problem;
- an analysis of meritorious behaviors that enable outliers (positive deviants) to achieve success; and

- the introduction and adoption of meritorious behaviors elsewhere in the organization.

The following case study shows how a community hospital applied the principles of PD to improve communication and collaboration (Weber 2005b).

## CASE STUDY: WRESTLING WITH READMISSIONS

Waterbury Hospital Health Center is a 234-bed Connecticut community teaching hospital that invited Jerry Sternin, the founder of the positive deviance approach, to speak at grand rounds in autumn of 2004. As the staff discussed the application of PD to healthcare settings, they identified communication as their most pervasive challenge. Dr. Anthony Cusano and nurse Bonnie Sturtevant designed a telephone survey to learn whether recently discharged patients were following their prescribed regimens successfully.

To their surprise, 80 percent of patients were taking their medications incorrectly. For example, one patient, told to take a pill every other day, took it only Tuesday and Thursday, incorrectly assuming that weekends did not count. Another patient, sent home with a variety of new prescriptions, did not take a necessary medication he already had at home because he did not receive a new prescription for it. Some patients did not fill a prescription because of expense, but did not inform their physicians and thus never learned of more affordable alternatives.

The investigators analyzed the 20 percent who exhibited no medication errors and learned that patients who were taking their medications correctly had received

an educational call from a nurse shortly after discharge. Nurses who were making the phone calls found the results so startling and the corrective process so satisfying that they told colleagues, who volunteered to make phone calls to recently discharged patients. Within a few months, they had reached over 150 patients and had expanded the calling process to include new interns and residents (Weber 2005b).

### Case Analysis

Prior to the intervention, Waterbury Hospital readmitted two patients per month on average for failure to adhere to postdischarge medication plans (Weber 2005b). Dr. Cusano noted,

*The patients getting the calls love to know that someone cares about them, and it makes the staff feel good about what they are doing. We realized that people who were getting the calls were close to 100 percent on doing the right things. It turns out that the phone call itself is the solution. So we had to find a way of getting it done for everyone: If everyone on staff makes one phone call a month, we can contact every discharged patient. If communication is the issue, positive deviance showed us that it is also the answer.*

The power of PD lies in its bottom-up process. Frontline care providers, rather than the CEO, determine where to direct their efforts. They invest effort in figuring out which approaches will yield the best results. Sternin felt that organizational resistance to

identifying and following other institutions' best practices was similar to transplant rejection in that it stimulated more conflict than collaboration (Pascale and Sternin 2005). What healthcare professionals discover for themselves, they own (Weber 2005b).

*Note:* This case study and analysis were also discussed in Cohn, K. 2006. *Collaborate for Success! Breakthrough Strategies for Engaging Physicians, Nurses, and Hospital Executives*. Chicago: Health Administration Press, 117–19.

### **Appreciative Inquiry**

Appreciative inquiry (AI) is a technique that focuses on building on success (Ludema et al. 2003). It is based on the premises that people respond favorably to positive reinforcement and that sharing stories of past successes generates more energy and less defensiveness than analyzing problems and attributing blame. We encourage hospital executives to apply AI especially when root-cause analysis becomes mired in defensive reasoning. Healthcare leaders can incorporate AI into their daily practice in the following ways (Studer 2003):

- making rounds and giving positive reinforcement to physicians, nurses, and allied healthcare professionals when patients express satisfaction or delight;
- asking people, “What is going well for you?” rather than making problems the focus of rounds;
- during evaluations, asking, “Would you like to write a note to anyone who was particularly helpful to you?” and having notecards and envelopes in the room.

The following case study demonstrates the relevance of AI in a healthcare setting.

### **CASE STUDY: PHYSICIANS AND HOSPITAL LEADERS BUILD ON SUCCESSFUL CRISIS MANAGEMENT**

While the CEO was out of town, contamination of a Northeastern community teaching hospital's water supply was discovered. Routine testing showed small quantities of a microorganism capable of causing systemic illness in immunocompromised patients arising from an old shower head. Rapid repeat testing confirmed that the contamination was not a result of laboratory artifact and raised the question that the hospital water supply might be contaminated. Physicians and

management representing infectious diseases, oncology, pediatrics, and the offices of the vice president of medical affairs, patient care services, operations, and public relations cleared their schedules and formed a command post from which to receive and communicate information rapidly and often. They shut off the existing water supply and made arrangements for emergent resupply of fresh water while they researched ways to determine the extent of the contamination, remove the

source(s), and purify their water delivery system. They calmly briefed the CEO and board of directors and then the medical staff, employees, press, and local community agencies to offer assurance that they had identified a problem and were in the process of remedying it. In addition, they stepped up monitoring of susceptible patients. Within three days, the team had replaced the old shower heads and purified the water system. No patient morbidity or mortality occurred as a result of the contamination.

In discussion of the situation afterward, some participants felt that the departmental culture created silos that made it difficult to obtain interdepartmental cooperation except in times of crisis; however, all agreed that the shared values, camaraderie, and pride they felt from their rapid and effective handling of a poten-

tially life-threatening contamination episode gave them a sense of accomplishment upon which they built during future challenges.

### Case Analysis

Physicians and hospital leaders can use AI to overcome defensiveness, turf battles, negativism, change fatigue, and slow response time. Professionals prefer being inspired to being supervised. Generally, it is quicker and easier to build on wins than to try to persuade people to abandon established approaches to perceived problems (Weick 1984). Storytelling, which is an integral part of AI, decreases the inhibiting effects of hierarchy on an organization, uses metaphors to summarize important points and make them vivid, and provides vignettes that are remembered more readily than facts.

*Note:* This case study was also discussed in K.H. Cohn, M.D. Araujo, and S.L. Gill. 2005. "Appreciative Inquiry." In *Better Communication for Better Care: Mastering Physician-Administrator Collaboration*, by Cohn, K., 25–27. Chicago, Health Administration Press.

### Structured Dialogue

Structured dialogue is a process that helps a group of practicing physicians articulate their collective, patient-centered self-interest and feel a sense of shared ownership in improving physician-hospital relations. For example, structured dialogue can help physicians improve physician-physician communication, understand more fully the complexity of hospital operations, and articulate clinical priorities for their communities and their practices (Cohn, Gill, and Schwartz 2005).

Unlike hospital-centric change efforts, the structured dialogue process is led by a medical advisory panel (MAP)

of high-performing, well-respected clinicians who review and recommend clinical priorities based on presentations by the major clinical sections and departments. Contrary to the apprehensions of some hospital executives, the recommendations generally include performance improvements and minor expenditures that support these improvements, rather than a list of capital-intensive budget items. In return for giving physicians a say in clinical priority setting, the hospital is able to enlist physicians to attend meetings and outline their priorities. We encourage hospital executives to use this method when they tire of clinicians

shooting down hospital executives' suggestions for reform and want to focus the mirror on physicians' efforts to set clinical

priorities. Benefits of effective physician-administrator dialogue are illustrated below.

## CASE STUDY: WHAT TO DO NEXT?

George (a pseudonym) was an industrial engineer by training. He used a precise, step-by-step approach that his direct reports mirrored, and he had always been known as a turnaround CEO who came in, stopped the bleeding, and left the hospital in much better shape within five years.

Eight years after becoming the CEO of a community teaching hospital, however, he felt stuck. He had tried the latest theories, including reengineering and rapid-sequence change processes, without success. Deficits increased, staffing decreased, and morale plummeted. With the encouragement of his senior vice president of marketing who had witnessed a successful structured dialogue process at her previous job, and with the approval of physician leaders, he appointed two clinically talented and highly regarded physicians to be cochairs of a 13-member MAP. The cochairs, not administration, picked the remaining members to represent outstanding medical staff practitioners from other departments.

The charge to the MAP was to engage physicians to analyze and recommend priorities to improve care for the community, physician-physician communication, and physician-administrator collaboration. Over the next six months, they heard recommendations from all major clinical areas on how to improve care for the community over the next three to five years. The MAP chose a time span of three to five years to stretch

participants' imagination and encourage them to think about the future rather than the past. The panel's report listed approximately 100 recommendations from physician presenters that fell within four overarching themes:

1. Improve service to patients and their families.
2. Enhance physician-physician communication.
3. Implement clinical protocols in all major diagnosis-related groups to save money, limit variation, and improve quality and safety.
4. Develop coordinated diagnostic and treatment centers.

Although these recommendations seem conventional to outsiders, the structured dialogue process represented the first time that the hospital administration had obtained a consensus report from its most talented clinicians. Furthermore, each recommendation derived from issues and opportunities raised in clinical section presentations. Previously, hospital leaders received feedback mainly from their "squeaky wheels."

Over the next two years, physicians, nurses, and administrators worked together to implement over 90 percent of the panel's recommendations. The remaining 10 percent were no longer relevant because of rapidly changing marketplace conditions.

**FIGURE 2** The Role of Physician Champions

- Create a safe environment for learning
- Present and discuss clinical data with practicing physicians
- Increase institutional transparency by sharing information
- Minimize physician-hospital battles
- Help to build trust
- Through the process of discovery, act like an owner
- Leave a lasting legacy

**FIGURE 3** Ways to Cultivate and Nurture Physician Champions

- Make effective communication a high priority, using face-to-face communication to build trust
- Share information for mutual advantage in a customized manner
- Be proactive and get to know the champion in noncrisis settings
- Find common perspectives inside and outside the hospital
- Show that you value the champion's time
- Focus on achieving large goals in small, measurable steps
- Celebrate victories as a team
- Move from disagreement to creative abrasion to become an organization that fosters learning (Cohn et al. 2006)

The structured dialogue process improved patient and employee satisfaction; increased surgical volume, market share, and operating margins; and groomed new medical staff leadership. George is now a sought-after speaker who explains how collaboration with practicing physicians was key to his hospital's turnaround.

**Case Analysis**

During the structured dialogue process, physicians engage in face-to-face dialogue with one another and with hospital leaders and learn to view their individual practices within a larger context, thus abandoning the dance of the blind reflex described earlier (Oshry 1996). A physician wrote:

*Our report represented the first time that the hospital received a consensus report from practicing physicians about what the hospital should do in the future. Before, the process involved squeaky wheels pursuing individual agendas.*

*We evolved from a self-interested view of what the hospital should do for us as physicians to a more empowered view of how the hospital could employ limited resources to improve care for our community. Through the process of discovery, we began to think and act more as long-term partners and co-owners than short-term customers and renters.*

Hospitals of varying size have used the time-tested, structured dialogue

process successfully by meeting the following three prerequisites:

1. Physicians and hospital executives must be interested in exploring how they can improve care for their community.
2. Practicing physicians must recognize the benefit of making time to prepare for and attend meetings based on their need to use their time better, increase
3. Hospital administrators and the board must agree a priori to make every effort to implement the physicians' carefully thought-out recommendations, even if the physicians' suggestions represent a change in the hospital's business model.

*Note:* This case study and analysis were also discussed in Cohn, K. 2006. *Collaborate for Success! Breakthrough Strategies for Engaging Physicians, Nurses, and Hospital Executives*. Chicago: Health Administration Press, 117–19.

## CONCLUSION AND RECOMMENDATIONS

Ironically, the forces that are pushing physicians and hospital executives apart may be what ultimately reunite them (Cohn, Gill, and Schwartz 2005). Both are experiencing rapid change and uncertainty, being squeezed by the disparity between reimbursement and rising expenses, and receiving pressure from a variety of experts to collaborate to improve quality and safety. As Waldman and colleagues (2006) point out, both groups agree on the “who,” since they live in the same communities and share the same patients; they also generally agree on the “why,” as they are both attracted to healthcare careers to make a difference in the lives of patients and their families. The “how” is the basis of dynamic interchange between physicians and hospital executives. Despite the shifting tectonic plates, the mission of most doctors and hospitals remains to provide compassionate care for patients.

The silo mentality embodied in “Let the docs deal with patient care and leave finance and operations to the administrators,” is destined for failure in a rapidly

changing environment. A more suitable approach is embodied in the report by Malcolm and colleagues (2003) on cultural convergence. They wrote that a key reason that New Zealand had improved healthcare outcomes was that integrated district health boards have encouraged managers to shift from a preoccupation with resource management to improving clinical outcomes and allowing physicians to embrace a clear role in stewarding resources to achieve the board's goals. That both groups have minimized the gap between physician and managerial cultures and moved to a more Copernican view that puts patients and families at the center of the universe should give us hope that cultural change is possible, with dividends for physicians, administrators, hospital employees, and especially patients and families.

Sternin wrote that it is often easier for people to change their viewpoints by implementing reforms than to change their actions by changing their viewpoints (Dorsey 2000). To that end, we offer ten steps to take now to engage physicians and improve patient care:

1. Encourage practicing physicians to articulate future clinical priorities, as discussed in the structured dialogue section, to increase their sense of shared ownership, and to improve clinical outcomes.
2. Include doctors who are users of radiology, anesthesiology, pathology, and emergency services when drawing up contract specifications and monitoring performance to improve service; physicians may pay lip service to administrators but listen to other physicians who refer patients to them.
3. Establish a hotline for process improvement issues that is tracked at least monthly in senior management meetings to make sure that the communication loop is closed (Stubblefield 2005).
4. Treat the top 20 percent of physicians as partners, and visit them at least quarterly, regardless of their irascibility (Cohn, Gill, and Schwartz 2005).
5. Ask “go-to” docs, “What can we take off your plate?” at least semiannually to monitor and reduce burnout (Cohn, Panasuk, and Holland 2005).
6. Map out steps of policies and procedures to improve effectiveness and refine hand-offs especially when people complain that they need more workers to accomplish tasks. Many times, staff creep is a result of work-arounds created by inefficient processes that can be identified and improved by putting each step on a post-it note and asking members of a group to remedy the gap between what could and should be happening compared with what is actually occurring.
7. Have the chief information officer and programmers participate in rounds periodically with physicians to see how physicians struggle with information technology and how they could use their time more productively.
8. Develop a hospitalist surgical service to off-load call burdens for physicians and diminish the need to pay stipends to physicians for carrying a beeper.
9. Celebrate and reward all healthcare professionals who exceed their job descriptions to care for patients; if culture trumps strategy, stories of such professionals can become the basis of a positive culture that strives to improve outcomes and service to patients and their families (Ludema et al. 2003).
10. Establish a pool with fines for using hot-button words (such as “you,” “always,” “never,” “but,”) and killer phrases (such as “Let’s appoint a committee to study that some more”) and use the money collected to support a worthwhile service or celebration (Cohn 2005, 17–23).

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