

## What Is a Compact—and Why Is a New One Needed?

Here are just a few troubling situations in which executives and physicians have found themselves that suggest a new relationship is needed:

- ◆ When they signed on, physicians acquired by an expanding healthcare system were promised they would generally be left alone. However, angered by reports showing they're not sending their referrals to the system's employed specialists and by the healthcare system's demands that they standardize supplies and justify the hiring of support staff, the physicians claim they are victims of a bait and switch. The icing on the cake, as they see it, is the news that they are to take on the system's name—and give up their own—as part of a branding strategy.
- ◆ Due diligence prevents the hospital's CEO from discussing with physicians the details of a potential merger that was reported in the local newspaper. Independent doctors in the community interpret the lack of up-front communication as indicating the CEO intends to “sell them down the river” and sign an affiliation agreement with an integrated system that employs its physicians.
- ◆ Doctors who halfheartedly bought into Lean principles are discouraged from further engagement in the improvement philosophy because of “top-down tactics” calling for guidelines developed at another site to be introduced at their site. They see this action as going against their tradition of distributed leadership. Believing the administration is playing hardball, the physicians reject the applicability of guidelines not invented at their site instead of trying to tailor the guidelines to their local conditions.
- ◆ Administrators see greed and the desire for control as the motives behind a local nonemployed neurology group's decision to build its own sleep medicine

center. The neurologists see the center as necessary for their survival as market conditions shift because it will allow them to remain independent for as long as possible and strengthen their position if they need to integrate with a larger enterprise.

The disconnect between managers and doctors is not exactly news. Much has been written on the divergent worldviews, training, roles and responsibilities, and values orientation of managers and doctors. The dysfunction in this relationship and the consequences of that dysfunction have long been of interest to both academics and practitioners (Davies and Harrison 2003; Degeling et al. 2003; Garelick and Fagin 2005). Amer Kaissi (2005), a professor of healthcare administration, has examined the underlying factors in this relationship from several different perspectives. He concludes that managers and physicians represent different tribes as a result of cultural differences. Nigel Edwards and colleagues (2003, 609), introducing a themed issue of the *British Medical Journal* on doctors and managers, state, “The fundamental problem is a paradox between calls for a common set of values and the need to recognise that doctors and managers do and should think differently.”

Empirical research and theoretical models aren’t needed to make the point that increasing pressure and uncertainty about the future usually chip away at trust and partnership. Instead of serving as catalysts for meaningful doctor–manager partnerships and for obtaining solid trustee support, the trends and pressures now operating to reform healthcare (Chassin 2013; Cutler and Morton 2013; Jost 2014; Moses et al. 2013) have usually instigated anger, insecurity, and misunderstanding between concerned and well-intentioned individuals. We know from our work that such problems can in fact *unite* these parties—so why do they lead to such division and resentment in many institutions?

## THE TRADITIONAL PHYSICIAN–ORGANIZATION COMPACT

One important reason for the tension between physicians and managers is the implicit compact, or psychological contract, that binds both parties—a compact that has gone unchallenged for a long time. The traditional compact is a major source of slow change, failed attempts at change, and strained relationships.

Denise Rousseau has written extensively about psychological contracts in a variety of organizations. She and her colleague Martin Greller offer the following definition, which I have annotated to explore this concept in relation to physicians:

The psychological contract encompasses the actions employees [physicians] believe are expected of them and what response they expect in return from their employer [the organization in which they practice medicine—be they employed, contracted, or independent]. (Rousseau and Greller 1994, 386)

When physicians are asked to make a change—for example, to follow a treatment protocol, input orders via computer, or practice team-based care—and they push back with the comment “I didn’t come here for that,” they are expressing their reality. As far as many doctors are concerned, veering off preferred routines or established patterns at the behest of others isn’t part of the unspoken deal—the traditional, implicit compact—they agreed to when they became physicians, nor is it, in their eyes, an obligation of organizational citizenship. Even when physician leaders request the change, physicians can feel their inherent sense of medical professionalism—and the implicit deal—have been violated. The traditional compact between physicians and organizations looks similar to the one represented in Exhibit 1.1.

The pact that physicians feel is—or should be—operating isn’t a figment of their imagination. It’s rooted in centuries-old traditions and in their training; it’s reinforced by everyday interactions and by the enticements organizations offer to recruit talent. Administration colludes with physicians in many ways to keep elements of the old compact intact. Is the typical hiring discussion designed to entice doctors by offering them what they want and expect to hear? Or does the organization lay out a deal reflecting what behaviors it expects from physicians and what, in turn, physicians are entitled to expect? Does the administration accept antisocial behavior from talented physicians to keep them from taking their business elsewhere?

**Exhibit 1.1 Traditional Physician–Organization Compact**

Physician Responsibilities (Physician “Gives”)	Organization Responsibilities (Physician “Gets”)
<ul style="list-style-type: none"> <li>◆ Treat patients.</li> <li>◆ Provide quality care—as you define it.</li> </ul>	<ul style="list-style-type: none"> <li>◆ Respect physicians’ clinical autonomy.</li> <li>◆ Protect physicians from the business side of the enterprise, from market forces, and from change.</li> <li>◆ Allow entitlements commensurate with physicians’ status (including not holding them accountable in the way that other staff are) and treat them as key customers.</li> </ul>

Or does it make clear that respectful behavior is an expectation of all doctors and administrators?

In short, if expectations are left unsaid in the early days of joining the organization, each doctor will subjectively interpret what he or she owes the organization. If conscious attention is not paid to matching physicians' expectations with the organization's, physicians will by default carry forward unconscious legacy expectations of autonomy, protection, and entitlement.

## **A Barrier to Needed Change**

The traditional physician compact (Exhibit 1.1) is a barrier to engaging doctors in changes that organizations need to implement. When asked to take on responsibilities outside of the implied compact, physicians feel angry or frustrated and are labeled “uncooperative,” which unleashes a cascade of unhelpful interactions. If relationships between doctors and the administration and trustees are in disrepair, the stress brought on by new imperatives intensifies this harmful dynamic. The result is a deepening frustration on all sides.

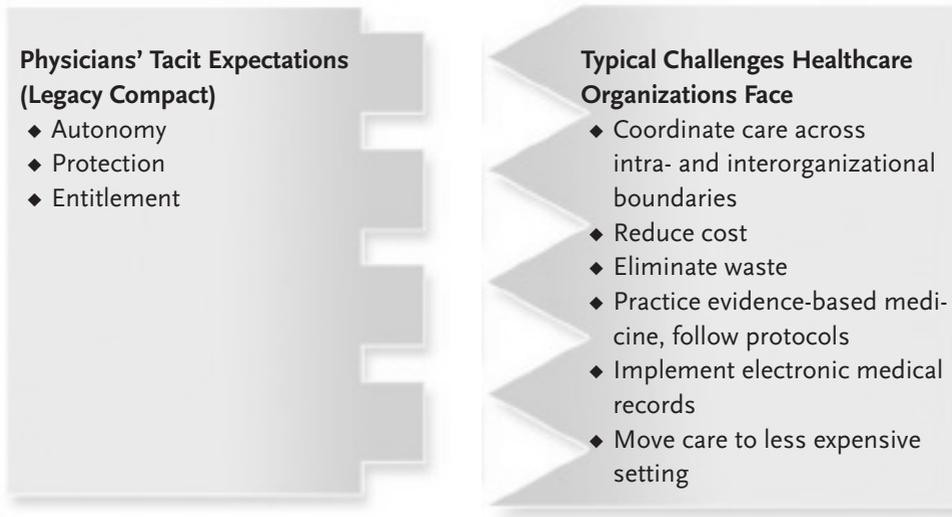
As noted earlier, as credentialed professionals most physicians harbor certain expectations of the “workplace” in which they see patients. These expectations do not vary by employment status or organizational setting—or even national boundaries. What most physicians expect to give is medical care—the best they can. Until recently, good care has been largely determined by “what works in my clinical experience,” locally accepted practices, knowledge gained at professional events, insurance reimbursement, and journal reports of clinical research. In exchange for providing care, doctors tacitly expect respect for their clinical autonomy; protection from changes, market forces, and worries about the cost of care; and entitlements commensurate with their status (e.g., tolerance for behavior unacceptable in other staff, reserved parking).

The way that the unspoken compact bollixes attempts to introduce change becomes clear if one views autonomy, protection, and entitlement alongside typical challenges most healthcare organizations face today. The two columns in Exhibit 1.2 illustrate the mismatch between physicians' expectations and challenges that must be addressed.

If you customize the right-hand column of Exhibit 1.2 to your institution, you'll likely find at least some mismatch between doctors' expectations and what your organization needs from them. When they see the lists side by side, many doctors recognize the lack of synchrony as the source of their internal dissonance and

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## Exhibit 1.2 Mismatch of Physician Expectations and Organizational Imperatives



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say, “Now I know why I feel the way I do.” To the extent this old compact exists, responding to any imperatives is slow and difficult.

### Operating on Parallel Tracks No Longer Works

Imagine two railroad tracks running parallel to each other. One represents the board’s and management’s work: visioning, strategizing, organizing, and executing plans. The other represents the physician’s work: patient care and, in some institutions, research and teaching. This two-track approach worked well for healthcare organizations for decades. The traditional compact allowed physicians to ignore finances, strategy, and personnel management and represented no real barrier to institutional success.

Today, such a two-track orthodoxy greatly undermines the organization’s capacity for change. Physicians need to understand, at some basic level, how their actions affect economic performance and patient satisfaction, which is increasingly linked to reimbursement. If rank-and-file physicians are exempt from having business literacy, they cannot constructively dialogue about needed change. With little understanding of the broader context, physicians see administrators as “the heavies” when they ask the physicians to behave differently. Instead of collectively working

to make continued success more likely, physicians direct their energy toward questioning the need for change.

At the same time, clinical implications attach to almost every decision an administrator makes—thus, administrators must listen closely when physicians question their edicts. How well does each party understand the other’s imperatives? A process to define new mutual commitments, to co-develop an explicit compact, helps both doctors and administrators expand their understanding of life “on the other track.”

## A NEW COMPACT MEANS ADAPTIVE CHANGE

The organizations whose compact journeys you will read about in this book all approached the work as the *adaptive change* it is. Here are two key points about adaptive change relevant to compact work:

1. At the start of a process no predefined solution exists; one has to be created.
2. Those who will be implementing the remedy have to be among those who figure it out.

The term “adaptive change” has been popularized by Ronald Heifetz and his colleagues at Harvard’s Kennedy School of Government (Heifetz 1998; Heifetz and Laurie 1997; Heifetz and Linsky 2002a, 2002b; Heifetz, Linsky, and Grashow 2009). They distinguish adaptive change from what they call “technical change,” in which the problem is well defined and a solution exists. Even if you don’t know the best solution to a technical problem, someone else does. Meeting a technical challenge doesn’t call for anyone to abandon cherished traditions or personal values. Flat tires are fixed, bones are set, injections are given, and diuretics are swallowed—without angst or tension.

But adaptive changes do increase anxiety and stress; for that reason, we would rather avoid them. Typically, such changes evoke loss because they mean giving up a practice that has worked well or a long-held belief. Merging with another entity, reporting to a new department head, and becoming more transparent in reporting errors represent adaptive changes.

Asking physicians to give up or modify deeply held assumptions that are tightly bound to their sense of professionalism is asking them to undergo a profound adaptive change. That process takes a good deal of conversation, venting, and even grieving along the way. If the process to define a new compact resembles a checklist exercise or stifles real conversation, it won’t result in meaningful compact change.

## REPLACE AN AMBIGUOUS, UNARTICULATED COMPACT WITH AN EXPLICIT ONE

Given the strained physician–administrator relationships and demands for change, it may seem an awkward time to discuss something as seemingly ethereal as a “new compact.” However, such discussion is the prescription for easing some of the burden of mistrust and anger and for building resilience in these critical relationships. At this juncture a new compact—one that aligns physicians’ expectations with administrators’ views—is crucial.

What would a new compact look like?

- ◆ *First, a new compact would be explicit and written.* It would identify reciprocal expectations—what physicians are entitled to expect of their organization and what the organization is entitled to expect of them.
- ◆ *Second, the compact would be linked to the organization’s vision.* Administrators and physicians share that vision. At the start, doctors and administrators have to agree that they’re going someplace together. This definition of the future state will be different for each organization. To enable reasoned discussion about a desired future state, administrators may need to present facts and figures to physicians and help them understand what they mean. Without business literacy that allows physicians to translate market conditions into likely financial impact, their views about what is possible for the institution’s future may be unrealistic.
- ◆ *Third, compact change would be recognized for being the adaptive change that it is.* Because developing new expectations involves adjustments to deeply held assumptions and beliefs, the direct involvement of physicians, executives, and administrative leaders is needed. Adopting a compact developed elsewhere, tweaking it in an executive meeting, and announcing, “Here’s our new compact” will only generate cynicism. Everyone who will be required to meet the compact’s expectations must have some voice in what is proposed.



The implicit compact in your institution may already be eroding from the demands that your organization makes of physicians. If physicians’ unarticulated expectations are whittled away—or dashed—and no meaningful substitute is offered, it’s little wonder many physicians feel let down or betrayed. Erasing bits of their old compact without any conversation or substitution for cherished traditions doesn’t

serve anyone well; unhappy doctors are not the most compassionate healers or the most engaged partners to implement strategy or innovate solutions to organizational challenges.

As the cases in this book make clear, the challenge ahead for you and your institution is to identify physicians' and administrators' expectations and disappointments, face them, and help the parties move forward together to build a compact that is a solid foundation for change.