CHAPTER 6

Breaking Down the Power Gradient

On March 27, 1977, the largest air travel disaster in history occurred on Tenerife, one of the Canary Islands off the coasts of Spain and Morocco. Two Boeing 747s collided on a runway blanketed in dense fog, killing 583 people. You might be thinking, *That's horrible, but what does an aviation accident have to do with healthcare?* My answer is that the tragedy teaches a vital lesson about power dynamics and communication that we should *all* take to heart.

Here's what happened that day in 1977: Los Rodeos Airport on Tenerife was severely congested. As a Pan Am 747 slowly taxied the airport's single runway, a Dutch KLM 747 began to take off from the opposite end. The two 747s could not see each other due to the thick fog—and the air traffic controller couldn't see *either* jumbo jet.

Shortly before the crash, Pam Am had radioed to the tower that it was still on the runway, but the communication was inaudible to KLM because of radio interference. In a radio exchange confirming flight instructions, KLM's first officer was told by the tower, "Stand by for takeoff. I will call you." That sparked a fateful miscommunication: Apparently, KLM's Dutch captain focused on the word *takeoff*. (It's worth noting that in 1977, as now, the word *takeoff* would not have been used in the United States until actual permission had been given. This accident prompted international communication guidelines to be standardized.)

"Is Pan Am still on the runway?" asked KLM's second officer, who had correctly heard the tower's message to stand by.

"What did you say?" asked the highly tenured captain.

"Is he not clear [of the runway], that Pan American?"

"Oh yes!" replied the captain. In the wake of that emphatic statement, the second officer was apparently hesitant to challenge his captain again. The aircraft continued to pick up speed. Soon thereafter the Pan Am 747 became visible on the runway through the fog, but it was too late. Despite attempts by both pilots to get clear, the jets collided. Everyone on board the KLM flight was killed. Only 61 individuals on the Pan Am flight (including the captain, first officer, and flight engineer) survived.

Disaster might have been averted had any number of variables been different: no fog, clearer radio transmissions, and standardized terminology among them. But what stands out to me and to many others who've studied this tragedy is the KLM captain's dismissal of his second officer's doubts, and the second officer's unwillingness to speak up again. The power gradient (or amount of authority) between these two men turned out to have deadly consequences.

Tenerife's Legacy

The Tenerife disaster led to a widespread restructuring of cockpit procedures. Instead of emphasizing hierarchy, a team-based approach to decision-making called *crew resource management* (CRM) was developed. Now, more junior crew members are encouraged to question, challenge, and contradict senior pilots if they believe something is amiss. Senior crew members are required to listen to any concerns and reevaluate their decision accordingly. CRM has proven very effective in improving communication, reducing human error, and increasing safety in the cockpit.

KLM's Captain Veldhuyzen van Zanten was one of the airline's most senior pilots. He was also chief of flight training for the entire airline. In other words, Captain van Zanten was a highly respected leader with a great deal of authority. Although we will never know for sure, it is speculated that the second officer was reluctant to continue challenging an esteemed captain who stood well above him in the cockpit hierarchy.

What can we learn from the Tenerife incident? Plenty. We may never sit at the controls of a massive aircraft, but we hold lives in our hands each day. Those we lead should never be afraid to challenge us—and we should never hesitate to listen to their voices of experience and wisdom.

Why *Power Gradient*? A Word About My Terminology

Google the Tenerife disaster and you'll see the phrase *authority gradient* pop up over and over. You may also see the phrase *power distance*. These two phrases are used to describe the difference in perceived superiority between two individuals. Whichever term you use to describe that difference—in terms of how comfortable people are in voicing their thoughts or concerns—the smaller it is, the better it is. This is true for the organization, all of its employees (caregivers), and ultimately the customers (loved ones). As this difference decreases, all metrics will improve: safety, strategy, culture, service, empowerment, engagement, and more.

That said, you may have noticed I use the term *power gradient* throughout this book. It's a hybrid of the two aforementioned terms. In the context of this book, I prefer the word *power* to *authority*. Why? Because *authority* differences

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(or gradients) between levels of leadership *are* valid—not all decisions can be solved by consensus, and someone has to make the final call. That's just reality, and we're not trying to remove anyone's authority.

What we do want to remove is the perception of *superiority*, which, to me at least, the word *power* suggests. If Person A is superior, then person B must be inferior, right? If person B feels inferior, they may keep their mouth shut at times when it would be far better for everyone if they spoke up. So, whichever terminology you prefer, let's work to eliminate the superiority difference between the levels of leadership.

THE POWER GRADIENT IN HEALTHCARE

Historically, healthcare has tended to have a hierarchical culture. In other words, nurses, more junior physicians, and other employees have been reluctant to speak up to senior physicians and leaders due to fear of punishment or other repercussions.

Perception Is Reality

Even among supposed peers, a *perceived* power gradient has long existed in healthcare settings. Here are a few examples of relationships where this might be the case:

- Two team members have the same role or "rank," but one team member has several more years' experience than the other.

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- An employee has experience and qualifications but is new to the organization and thus hasn't "proven" himself to the team.
- One person on a team is more "popular" than another and has more social capital.

Even when someone actively tries to flatten the power gradient, *perception* of that person's authority can still affect her working relationships. For instance, a physician might say, "I am not a medical director (or in another position of authority). Therefore, I am simply a caregiver and would like my team to view me as such." However, because this person *is* a physician on whom others rely for expertise, she is in a position of power and thus part of a power gradient. (This situation can happen with nurses and other caregivers too.)

It is also common for patients to perceive their physicians and other caregivers as being in positions of authority and control, even as we strive to live out our purpose of providing respectful, compassionate service. Too often, patients feel reluctant to speak up, ask for clarification, or disagree with their providers because of the perception that "the doctor knows best."

The point is that power gradients are everywhere. Even when they are only *perceived* as opposed to hierarchical, they can have negative, or even disastrous, consequences—and we should be driven by the same urgency to correct them. Don't just look up and down the organizational chart for perceived power gradients; look horizontally at relationships between peers, and even outside the chart at caregiver–patient dynamics. As the saying goes, "Perception is reality."

The good news is that the power gradient in healthcare (both real and perceived) is gradually being flattened as its negative effects on patient care and organizational culture are more clearly understood. Especially as we move toward a value-based, patient-centric care model, more and more leaders realize it is our responsibility to directly confront this issue. However, despite these efforts the power gradient still exists and still affects performance and patient care from time to time. We are doing better—but there's significant work yet to be done.

In healthcare, as in aviation, the power gradient can directly or indirectly cause any number of adverse outcomes—up to and including loss of life. And in fact, when we talk about the power gradient in healthcare, it's often in the context of safety. We are all aware that tiered levels of power between caregivers (or between providers and patients) can directly contribute to human error, just as in the Tenerife crash.

I also want to be clear that a rigid power gradient sends many other negative ripples throughout the organization. It adversely affects culture, communication, innovation, engagement, morale, and more. It prevents caregivers from aligning with the purpose of their role, their department, and the organization. It drives turnover and contributes to burnout.

First, let's review some of the negative effects the power gradient can have within healthcare systems:

- Junior staff do not speak up when they have safety concerns or do not fully understand confusing information. This can lead to a poor patient outcome or poor project performance. (Note that I use the term *junior* very broadly here. For example, a departmental director, who is very high in the overall organizational hierarchy, is still "junior" in relation to the CEO.)
- Junior staff feel that their voices are not heard and that they are not contributing members of the team, which directly contributes to burnout.

- Leaders do not receive valuable ideas and information from frontline employees. Thus, potential gains in efficiency, productivity, safety, or other areas are never realized.
- Teams are afflicted by a lack of trust, cooperation, engagement, and collaboration.
- Employees feel intimidated, stifled, or suppressed and are much less likely to be aligned with the organization's purpose.
- Patients do not feel that they are valued partners in their own care or that their opinions are respected. This type of disengaged patient may seek care elsewhere. Worse, they may not share a critical piece of information that could affect their clinical outcome.

EVALUATING THE POWER GRADIENT IN YOUR ORGANIZATION

Evaluating the power gradient in your organization isn't always easy. Although policies and procedures related to voicing concerns, shared decision-making, and advocating for patient care may be in place, staff may still feel that they will face consequences for challenging a "superior." Longtime caregivers may find it difficult to break away from old patterns of behavior and power dynamics. Here are some diagnostic questions to ask yourself:

- Do nurses feel comfortable raising concerns with a prominent surgeon? Would they stop a procedure to say, "We've lost a needle" or "We're missing a sponge"?
- Do physicians willingly accept feedback and their team's opinions with gratitude? Or do they feel disrespected and believe they have lost face? Think about relationships between physicians and all other roles: respiratory therapists, pharmacists, radiology

technicians, environmental services personnel, medical students, and so on.

- Does everyone in the organization feel comfortable voicing concerns to the CEO? Would they point out potential flaws in the organization's strategy or say, "I have an issue with the new policy"?
- Does one person within a team, shift, or department tend to make all decisions? Or are decisions reached collaboratively?
- Is the entire leadership team (at all levels) supportive of employees speaking up? Are they willing to have a discussion with anyone in the organization? Do they genuinely listen to others with the intent of understanding?
- Do patients feel comfortable bringing forth concerns about their care, or do they act subordinate to providers?

This list of questions is not exhaustive, but it should get you thinking about the power gradient within your organization. Chances are you will identify several areas in which the power gradient creates a barrier to providing the best care, strengthening teamwork, receiving caregiver input on how to improve the organization, and building a strong culture. Throughout the rest of this chapter, we will look at ways to break down the power gradient.

Use the "Introduce Me" Litmus Test

I once heard another leader say that a quick way to evaluate an ambulatory medical clinic's culture and power gradient is to ask some of the physicians to introduce you to the front desk staff. Afterward, in private, ask the physicians to tell you more about those people: Are they married? Do they have children? What are their hobbies?

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If the physicians don't know the names of front desk caregivers, that is a big issue. It implies a dangerous level of disconnection and disinterest on the physicians' part and indicates a rigid power gradient. If the physicians *can* introduce you to their coworkers at the front desk but don't know much about them, a power gradient that prevents communication is probably still at play. Perhaps the clinic's culture simply doesn't revolve around people talking about their personal lives, but most tight working groups do know these fairly basic details about one other. Higher level staff not knowing personal information about coworkers is a sign that you should keep evaluating the culture.

The same litmus test can be used in a tight unit of a hospital (e.g., Emergency Department, Obstetrical Department, Intensive Care Unit, Cardiac Unit, Operating Room). Do the nurses in the ICU know about the respiratory therapists? Do the respiratory therapists know about the physicians? Do the physicians know about the pharmacists?

You can even use this test to assess the leadership within the same specialty of a certain department. Does the manager of Plant Operations know about his team members? Does the general counsel know about the leaders of Compliance, Risk Management, and Contracting? Do the leaders of Compliance, Risk Management, and Contracting know about their own team members?

BREAKING DOWN THE POWER GRADIENT STARTS WITH YOU

As I've stated before, one of my guiding principles as a healthcare executive has always been to put people first with the knowledge that this will shift the culture and result in improved patient outcomes

and metrics. A big part of my strategy to put people first is breaking down the power gradient. I've learned that leaders *must* be deliberate about this. Good intentions alone won't move the needle.

Leaders must realize that flattening the power gradient needs to start at the top. We must demonstrate through our own behavior what we expect to see from others. Culture isn't changed by telling people how to behave but rather by modeling behaviors to emulate.

With that in mind, the following sections discuss some tactics we can use.

Be More Accessible

The power gradient can be broken down significantly by developing relationships and increasing communication with individuals from all levels, departments, and roles within your organization. Here are some strategies I used when I was president and CEO of Hospital X:

- Throughout my career, I asked everyone in the organization to call me Kevin. I didn't want to be known formally as Dr. Joseph, because a perceived power gradient can easily originate from something as subtle and innocuous as a title. While the name I went by didn't affect how available I was from a "presence" standpoint, it made me *seem* more accessible because it helped caregivers view me as an approachable colleague instead of a person with greater power, simply because of a title.

  Being addressed more informally also conveyed that I didn't consider myself to be "better than" or to have special privileges because of my position. When it comes to carrying out an organization's purpose, I believe that everyone is "in it" together—we just have different roles. (You might recall the story of how my mother taught me this vital lesson, which I shared at the beginning of chapter 1.)

In a similar vein, I know several surgeons who all but demand that the entire operating room team calls them by their first name, and not by "Doctor Smith." The atmosphere in these operating rooms is very collegial. There is great communication, and no one is hesitant to voice concerns if they should arise.

- When I visited a hospital or site within the system, my laptop was my office. If I had free time, I didn't go to an empty office or other private space. Instead, I set up in the cafeteria, break room, or caregiver lounge—wherever people ate or took breaks. I wanted to be visible and approachable. If you adopt this strategy, don't plan on sending many e-mails or getting much project work done, but *do* plan on getting great value for your time. Through the conversations you have, you will learn a tremendous amount about the organization and where to focus your efforts. Opportunities for improvement, small and large, about all aspects of the organization, will be conveyed to you. As I will explain in the next chapter, healthcare is in the service business—and the quality of service we provide depends on the quality of our relationships.
- When Hospital X was under construction, the leadership team asked that there not be a physician dining room. We wanted everyone to eat together in the cafeteria. This broke down the notion that physicians were special and entitled to privileges that the rest of the staff didn't get. However, all departments did have a break room or lounge available—physicians, nurses, and other caregivers simply used the same space. Everyone needs to (and should) take breaks away from frontline activity throughout the day.
- My cell phone number was public knowledge within the organization because I wanted *everyone* to know that I was accessible. If caregivers didn't see me in person during the course of the day, or if seeking me out was difficult because of time constraints or scheduling conflicts, they

could call or text. Over the course of my career as a leader, I have provided thousands of caregivers with my mobile number. It has never been used without good reason. But the impact this action continues to have in breaking down the power gradient is tremendous.

Being accessible is not just about being physically available for a conversation, it is also about being mentally available for a conversation. In other words, an accessible leader takes care to be fully present in the moment. Trust me, I know that when you have a lot of things on your mind, that's easier said than done. Here are a few successful strategies I use:

- When speaking with anyone in the organization, I try to be fully present. That means I not only stop typing or put down my phone; I move away from those devices so that they are not a distraction to the conversation. I try to actively listen instead of thinking about something else. I do not want people to feel like they are bothering me; I want them to walk away from our interactions knowing that I genuinely wanted to hear and understand what they had to say.

  If I'm finishing up an e-mail, a text message, or a conversation, I'll say something like, "Give me two minutes to finish up this e-mail so that I can provide you with all of my attention." Invariably, the person understands why I asked them to wait and is appreciative of my undivided attention once we are able to converse.
- One thing that is helpful for me, and that also demonstrates that I am paying attention, is taking notes during the conversation. I carry around a small notebook and a pen (I have seen other colleagues use note cards). When someone is providing input, I bullet point their thoughts. This helps me remember the items I need to

address (which are all too easy to forget during the course of a busy day), and it also sends a strong message to the other individual that I am taking their concerns seriously. I then use this same list as a reminder to circle back to that person once I have found the answer to their question, resolved their concern, or otherwise addressed their thoughts.

- Being mentally present is important in all interactions, despite how brief or innocuous they may seem. For example, when you are passing someone in the hallway, extend a greeting. Not saying "hello" because you are "on a mission" to get somewhere or do something sends a message that (at best) you have something on your mind that is more important than the person you just passed, or (at worst) the other person is not good enough for you to bother greeting them.

Get Out on the Front Lines

In chapter 1, I first told the story of how I asked the C-suite at Hospital X to work on the front lines. To briefly recap: As CEO, I worked one day a week as a physician in the Emergency Department (ED), and I asked all of my executives to work on the hospital's front lines one day every other week. For instance, the chief nursing officer assisted the nursing staff by taking vital signs and answering call lights. The vice president of Operations worked as a respiratory therapist, as that was his previous occupation and he was still licensed. And the chief financial officer, who didn't have past clinical experience, jumped in by transporting patients and cleaning rooms.

As I had hoped, immersing themselves in the day-to-day, patient-facing work of the hospital helped these

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leaders understand their purpose as well as how their decisions affected the care we delivered. To my delight, another by-product of working on the front lines was a flattening of the power gradient. As frontline caregivers began to develop relationships with the departmental directors and executives, their respect for and trust in these leaders grew. Many times, I heard one of the leaders say, "I am learning so much from the caregivers in my department. I didn't realize how many ideas and concerns I *wasn't* hearing before I spent time on the front lines."

When You Make a Mistake or Bad Decision, Admit It Humbly

When I became CEO of Hospital X, it was struggling in many ways, including financially. One of the calculated changes we made to become more productive was to take a close look at staffing. The hospital had 12-hour nursing shifts, and staffing was the same overnight as it was during the day. After talking to nursing managers and directors, my leadership team and I agreed that since the volume of work at night was less than during the day, we could reduce staffing on that shift.

Just a few weeks later, one of the night nurses approached me directly. (Incidentally, the fact that a nurse felt comfortable coming to the CEO proved that my other efforts to break down the power gradient were working!) This nurse told me that the staffing changes were not sustainable.

"The other nurses and I understand the rationale for having less staff at night, but at the 7 p.m. shift change, work doesn't slow down," she explained. "At that time, patients are still getting imaging studies like X-rays, MRIs, and CT scans. Food trays are still

being provided. Admissions in the ED are at a high volume. Work doesn't really slow down until around 10 p.m., so for the first three hours of the shift, we are really struggling to keep up."

"You're right," I told her. "Thank you for telling me about this." Shortly thereafter, I admitted my error to the entire organization, and we adjusted shifts so that staffing decreased around 10:00 p.m. Although the original decision to reduce staffing at 7:00 p.m. was made by the entire leadership team, I believed that as CEO the proverbial buck stopped with me, and that any mistakes made throughout the organization were ultimately my responsibility.

By making myself vulnerable and publicly admitting fault, I didn't weaken my position or lose the respect of caregivers. Far from it! Instead, I gained their trust and further flattened the power gradient. They now had proof that their CEO would make time for them, listen to their concerns, and make changes when warranted.

Get Input from All Stakeholders Before Making a Decision

Another important lesson I learned from the night shift staffing incident was to always consult with those who will be directly affected. As I mentioned, I *did* consult with the nursing managers and directors, but none of them worked in a frontline setting, and none of them foresaw how staffing reductions would affect nurses' ability to deliver care in the first hours of the night shift.

As I've noted previously, despite having good intentions, leaders may not know what's best or what's needed at the front line. We need to *ask* the front line what they need, prefer, and think in order to end up with the best outcomes. In this case, I failed to do so up front. I'm very grateful to the nurse who helped me learn the lesson that frontline stakeholders need to be engaged before a decision affecting them is made, even if their leadership team is also engaged in the conversation.

The point is, if a decision affects people other than yourself, you should seek their input before moving forward. (This is especially true if systems or procedures for an entire unit, department, shift, or organization will be changing.) When leaders make unilateral decisions and expect all those affected to obediently fall into line, the power gradient is reinforced. But when you involve stakeholders from all levels in the decision-making process, you show that you are committed to flattening the power gradient *and* to achieving the best outcomes for patients and their caregivers.

Bear in mind that as leaders, we sometimes lose sight of how difficult it can be for frontline employees to approach individuals who may be many levels above them in the organization's hierarchy. Thus, we need to be proactive about seeking out caregivers' opinions and suggestions. Leadership can't be everywhere at all times, but collectively, our employees are. Too often the power gradient (real or perceived) ensures that those employees keep their observations to themselves. Remember that we can't fix something that is broken or improve on something that could be made better if we aren't aware that there is an issue.

What If Input Is Hard to Gather?

Knowing that all plans have flaws, risks, and unintended consequences, I always ask for feedback from others. However, there have been times when the room is fairly silent and no feedback is forthcoming. In these situations, I remind myself that despite ongoing efforts to reduce the perceived power gradient, it will never be completely eliminated. (This helps me not take the lack of feedback personally.) Then, I go around the room asking everyone to punch a hole in my plan.

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This strategy not only provides me with valuable feedback on the plan, but it also helps others become more confident in speaking up and demonstrates my own vulnerability and humility. However, know that this tactic can backfire if your inquiry isn't authentic. If you don't genuinely listen to everyone, if you interrupt, if you don't show respect, or if you quickly shut down their thoughts, you will have taken a step backwards—and you may find it doubly difficult to regain the lost ground.

Always Respond to Feedback

Throughout this chapter, I've talked a lot about the importance of leaders listening to employees' concerns, ideas, and observations. Well, here's the second part of that piece of advice: Always, *always* respond. Whether the feedback is valuable, accurate, actionable, or not, thank the other person for sharing and emphasize how much their contribution matters. During your efforts to break down the power gradient, all eyes will be on leadership. Any slip-up will set your progress back, so you do not want to send the message that people who come forward will be ignored.

When you are having a face-to-face conversation with a team member, it's easy to respond. It may not be as easy in other situations. Here are a few things to be mindful of:

- Don't let voicemails, e-mails, or texts fall into a black hole. Send a reply.
- If you provide comment cards or suggestion boxes for employees to utilize, then acknowledge contributions. Even if responses are anonymous, you can still say, "I

understand from submissions to our suggestion box that many of you are concerned about XYZ." I know of some leaders who dedicate a section of their weekly or monthly newsletters to addressing suggestion box comments. They'll share what the solution to the issue was or, just as important, explain why it can't be done.

- If an employee's feedback leads to change, let that person know what action you are taking, and consider celebrating that person for the suggestion or concern that was raised. This will reinforce the importance of speaking up. Plus, others will want to be similarly recognized and will be more willing to come forward.
- If you can't go through with a suggestion, or if you find that a concern is unfounded, provide an explanation. You should always give people the *why,* but it's especially important when your response could be construed as ignoring their feedback or dismissing their concerns.
- Whether the communication is in person or via e-mail or text, restate the person's concerns, suggestions, or message in your own words. This demonstrates that you are listening and striving to understand their message. It also gives them a chance to set the record straight if you *have* misunderstood something.

Remember That the "Little Things" Can Be Very Powerful

Most of the advice in this chapter is focused on "big" things you can do to break down the power gradient, both real and perceived. But even seemingly small behaviors can have a big impact on helping the caregivers in your organization see you and other senior staff as approachable partners (as opposed to high-and-mighty bosses). Here are six subtle tactics to consider:

- **Say goodbye to the power suit.** Who says leaders *have* to dress formally? Consider letting them know that suits, ties, and more formal dresses are not necessary. Formal business attire can set up a subconscious social barrier for many people. They associate it with authority and power. Remember, a *perceived* power gradient can be just as stifling as an actual one.
- **Let seating arrangements work in your favor.** If you call a meeting with someone and choose to sit behind your desk, you have laid the foundation for the conversation to be governed by a traditional power gradient: The person behind the desk is on their "turf" and has the authority; the person sitting across from them is a subordinate. Contrast this to *both* of you sitting together at a small table, or in a pair of armchairs adjacent to one another—perhaps in a neutral, communal location. In these scenarios, your guest is much more likely to feel like an equal partner in the meeting.

  Perhaps don't even sit—have a walking meeting. During nice weather, who doesn't want to be outside? This format is only conducive to more informal and conversational update meetings but is certainly a welcomed change of pace.
- **Be aware of body language.** We all know that what we *don't* say speaks just as loudly as the words that leave our mouths. In fact, research by Dr. Albert Mehrabian suggests that 55 percent of communication is based on body language and facial expressions, 38 percent is via intonation, and just 7 percent is accomplished through spoken words (World of Work Project 2022)! That being the case, avoid using postures that can be off-putting or dismissive, such as crossing your arms or angling your body away from the other person. Make eye contact and try to relax.

Those of us in healthcare should be particularly mindful of how we converse with patients. Assuming the patient is sitting or lying on a bed or exam table, take a seat so that you are at their eye level. Standing above someone is a quick way to subtly establish that you are in a position of power. (Be sure to share this insight with physicians and nurses, who might regularly spend five or ten minutes in discussion with a patient.)

- **Prioritize promptness.** When leaders are late to a meeting or other type of appointment, they can send the message that their time (and therefore their position) is more important than their staff's. This is especially true if tardiness is habitual. Being prompt shows that you respect the other person's presence and time, and that you don't consider your to-do list more important than theirs.
- **Remember that words matter.** The words you use can either reinforce or break down the power gradient. Take, for example, "I have to be at this event" versus "I get to be at this event." The first sentence indicates that you view spending time at the event as a chore; the second makes other attendees feel valued. Here are a few other examples of phrases that either reinforce or break down the power gradient:
  - "What were you thinking?" versus "Help me understand why you made that decision."
  - "As director of this department, I want you do it this way" versus "Let's consider this option too."
  - "That's not going to work" versus "I'm concerned that this is beyond our capabilities. Let's discuss how we might make this option work."
  - "All employees need to make this change" versus "We are all going to work on making this change together."

- **Proactively define medical terminology.** Healthcare has a giant lexicon of obscure words and medical jargon that can unknowingly create a gradient between colleagues or between caregivers and patients. Many people don't feel comfortable asking caregivers for an explanation of unknown terminology, which can lead to dangerous situations. I have found it helpful to proactively define terminology as it is spoken, with a preference toward using the "technical" word *after* I explain the content of the conversation. For example, compare the following:
  - "Your heart condition is idiopathic cardiomyopathy."
  - "Your heart condition is idiopathic cardiomyopathy. *Idiopathic* means that we don't know what is causing it, and *cardiomyopathy* means that your heart isn't pumping as strongly as it should."
  - "We are not sure what is causing your heart condition, but we do know that it is not pumping as strongly as normal. We call this *idiopathic cardiomyopathy*. *Idiopathic* means that we don't know the cause, and *cardiomyopathy* means that your heart isn't pumping as strongly as it should."

  The third option is easiest for the patient to understand and does not set up as much of a power gradient. Explaining the diagnosis prior to using the technical terminology is a subtle but powerful tactic. I have noticed that when patients hear a complex term or medical jargon first, they often get "stuck" trying to figure out what it means instead of focusing on the rest of the caregiver's explanation.

  This same approach can be used in discussions with colleagues when out-of-the-ordinary terms are introduced. The important thing is to never assume that the other person knows the definition of unusual words.

CASCADING YOUR POWER GRADIENT PHILOSOPHY THROUGHOUT THE ORGANIZATION

As we've discussed, breaking down the power gradient in any organization is a top-down process. Clinical and nonclinical caregivers must see their leaders modeling desired behaviors in order for their own habits and behaviors to change. Successfully combating the power gradient requires the buy-in and participation of the whole organization.

You might recall that in chapter 1, I described why the leadership team at Hospital X decided to refer to patients as "loved ones": because each patient *is* someone's loved one. If we treat every patient as if they were our own beloved parent, spouse, child, or friend, then we will make the correct decisions regarding their care and service experience. With that said, I have a question: Would you want your loved one to be treated by a provider who negates input from others? Who sees themselves as "better than" other caregivers—and potentially patients? If the answer is no, then it is your responsibility as a leader to make sure that doesn't happen in your department or organization. Here are a few strategies.

Hire Caregivers Who Share Your Commitment to Flattening the Power Gradient

I once conducted an interview with a gastroenterologist. About ten minutes into the conversation, I asked why he was leaving his current organization. He said, "The nurses have a tendency to pause procedures when they think something isn't right. It's so frustrating! They slow me down with their objections, and it's not their place to speak up."

Yes, this physician actually told me he didn't think it was a nurse's "place" to speak up when something might be amiss. I then said,

"I don't think this organization is the right fit for you. Thank you for your time!" and shook the physician's hand. It was the shortest interview of my life.

Admittedly, this is a pretty extreme example. The physician in question voluntarily made it clear that he was what I call a power gradient enforcer. Most of the time, people won't be that up front in conveying they support and expect tiered levels of power in healthcare. But you should always be on the lookout for these power gradient enforcers, and you should never tolerate their harmful attitudes in your organization.

When hiring new employees, you can ask interview questions designed to uncover how a candidate feels about the power gradient. For instance, if you're interviewing a physician, ask, "Tell me about a time when someone slowed you down while you were doing a procedure because they had a concern. What was your response to the person and situation?"

If you're interviewing a departmental leader, ask, "How do you go about formulating new policies and procedures? Whose opinions do you seek out?" "When is the last time you spoke with someone on the front lines?" "What was your reaction to an incident when you witnessed or learned of someone 'talking down' to someone else? How did you address the situation?" You could even throw out a more open-ended prompt such as, "Describe your thoughts on the relationship between an organizational chart and culture." The candidate's answer to this broad prompt should spark follow-up questions and informative conversation regarding their views on the power gradient.

Ensure That New Hires Are Entering a Culture Where *Everyone* Is Well-Versed on Power Gradients

Once you have identified a candidate who seems to be a good cultural fit for the organization and who is driven to lower the power

gradient, it is time to onboard the new caregiver. At this point, it's important to remember that real and perceived power gradients can span a full 360 degrees, reaching up to the new hire's boss, down to her subordinates, and horizontally to her peers. Therefore, everyone at all levels (not *just* new hires) needs to be trained in the organization's philosophy on flattening the power gradient. I recommend setting a goal for all caregivers to be able to do the following:

- Describe what a power gradient (and *perceived* power gradient) is in healthcare
- Provide examples of superior, subordinate, and peer power gradients
- Detail the consequences of power gradients
- Discuss tactics and methods for breaking down the perceived power gradient
- Describe the organization's philosophy regarding power gradients, and shared standards of behavior that the entire

Flattening the Power Gradient and Pleasing Others Are Not Always the Same Thing

A leader who has broken down the power gradient genuinely seeks out the opinions of others, demonstrates respect for caregivers and their opinions, and builds relationships based on trust, communication, and integrity. This *does not* translate into relinquishing the authority to make final decisions, some of which your organization may not fully support. It is important to contrast authority to superiority. Breaking down the power gradient doesn't break down authority—it breaks down superiority.

It is critical to understand that breaking down the power gradient does not mean that your decisions will always be popular or that they must align with the opinion of

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someone whose input you sought out. As a leader, you will always have to make difficult decisions. And inevitably, some people won't like what you choose. However, if you have genuinely listened to the stakeholders of the final decision and provided the rationale for why your decision is not in alignment with their desires, you have succeeded in lowering the power gradient as much as possible.

organization stands behind. Behavioral standards might include the following:

- "I will treat all colleagues with respect."
- "I will not 'talk down' to anyone."
- "I will not interrupt or silence someone who is sharing a concern."
- "I will provide the 'why' behind my thought process when making a decision."

Give Leaders the Tools to Support and Empower Their Teams

Caregivers need to know that leadership throughout the organization has a zero-tolerance attitude toward power gradients. Leaders can ensure this happens by (1) helping caregivers understand how to escalate a concern or event that enforced a power gradient, and (2) knowing how to address individuals who are power gradient enforcers.

For many caregivers, confronting someone of perceived authority can be an intimidating challenge. It is often helpful to provide suggestions on how the caregiver might approach the situation. For example, I was once approached by a nurse who was concerned that a surgeon was not always washing his hands prior to approaching the

patient. The nurse told me that she didn't feel comfortable bringing up this issue with the surgeon and wasn't sure what to say if she did initiate the conversation.

I suggested that she phrase her feedback in the context of concern for the patient and physician, for example, "Dr. Jones, I don't want one of your patients to get an infection, so please don't forget to wash your hands prior to seeing the patient." In general, I've found that caregivers are most comfortable—and those above them in the organizational hierarchy are more receptive—when feedback is given out of concern for the patient or the caregiver in question, not from a policy standpoint (if possible).

Hold Power Gradient Enforcers Accountable

In large organizations, it is inevitable that there will be individuals who are supportive of a power gradient and who do not agree with breaking it down. These individuals need to be held accountable for their actions. If their actions are not addressed, then the team's efforts to break down the perceived power gradient will quickly fall apart.

You don't want consequences for power gradient enforcement to come out of the blue. Ensure that all caregivers, regardless of their role, know what to expect if they violate standards of behavior. Perhaps a first violation would prompt a verbal warning from the caregiver's supervisor, along with a constructive conversation about how the caregiver's behavior needs to change. A second violation might warrant a written warning. A third might earn the caregiver a suspension, performance improvement plan, and/or probation. And a fourth violation of power gradient standards would mean termination. (This is just an example. Chances are, your organization already has a progressive discipline plan in place that could be applied to power gradient violations.)

Bear in mind that everyone in the organization will be closely watching how power gradient enforcers are addressed, and how far

their behavior will be tolerated (if at all). It's essential for executive leadership to be comfortable providing feedback to these individuals, disciplining them, or perhaps even terminating the relationship between the individual and the organization.

In all of my leadership roles, I have provided my mobile number to the entire organization with a strong emphasis that caregivers should not hesitate to call or text me with any concerns. If the concern was in regard to power gradient–enforcing behavior, I wanted to know about it immediately! The sooner it was addressed, the more effective the feedback and coaching would be.

FINAL THOUGHTS

I'd like to refer to an observation I made in the first chapter in this book: Everyone has a unique contribution to offer. In the daily effort to fulfill your organization's purpose, no one is more important or valuable or special than anyone else. Yes, we will always need hierarchy to provide structure and leadership within our organizations. Some people will always have more seniority, expertise, and experience than others. Some will always be responsible for making a final decision. However, those distinctions should not create barriers to communication and collaboration, and they do not give us permission to treat anyone with less respect.

Instead, we should always remember that it *is* those very differences in our roles and perspectives that combine to create a full, robust healthcare ecosystem. Ego and the traditional power gradient have no place in providing high-quality care or in creating a positive, purpose-driven culture.

The bottom line is this: Breaking down the power gradient—real *or* perceived—requires trust, humility, authentic respect for others, genuine communication, accountability, and diligent relationship-building. Know that even as you make progress, a hierarchy of power is always present. If left unchecked, it is detrimental to patient outcomes and organizational success. Counteracting the power gradient

takes continuous attention. Keep this effort at the forefront of your work every day.

REFERENCE

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