Foreword

Physicians have always had an awkward relationship with organizations. From our earliest moments in training, we are told that we bear personal responsibility for our care decisions. We are specifically taught to work independently, not to trust anyone else's history and physical exam, and to make our own judgments about diagnosis and treatment. We don't learn how to work in teams—either with other physicians, or with other professions. And we most certainly do not learn how to partner with administrators and colleagues to improve processes and systems of care. So we come to see ourselves as splendid individual professionals focused heroically on quality. We believe that we achieve results largely because of our own dedication and skills, often despite the efforts of managers, who seem to be focused on costs. We tolerate the organizations in which we find ourselves, as long as they don't get in the way of our work and treat us with appropriate respect.

There have always been a few oddball exceptions, such as military medicine during combat, large multispecialty group practices such as the Mayo Clinic, and some staff-model HMOs. In these organizational settings, physicians recognized that they could be more effective if they worked in partnership with each other, and came to appreciate the value of competent administrators.

Over the last decade, however, these atypical physician–organization relationships have started to become less the exception and more the rule. The majority of physicians now are employed in some sort of hospital or group practice setting. The advent of healthcare reform has accelerated this trend and has spawned new organization forms such as accountable care organizations, with challenging new tasks such as responsibility for the overall costs of care for a population.

The leaders of these new organizations face a fundamentally transformational task. From my perspective, they seem to devote a lot of time and energy to *form*—getting the governance structure right, for example. They also seem to spend great effort on *finances*, making sure the physician compensation system seems fair, equitable, and aligned with external payment models. And they devote considerable technical resources to supporting new *functions,* such as coordination of care.

But, in my view, far too few of the leaders of these new organizations create a fundamentally different *feeling*—specifically, among the physicians who are members, and between those physicians and their administrators and leaders. They cannot possibly implement the massive changes needed without the enthusiastic support and leadership of physicians. As one hospital leader said to me, "All change has to go through 'Doctorland' at some point. And it's a jungle."

If these new organizations are to have any chance of success, physicians and administrators will need to jettison old values and patterns of behavior, and adopt

new ones, as they *intentionally* create a new culture. If they don't, to paraphrase an old saw, "Feelings will eat Form, Finances, and Function for lunch."

That is why this book is so timely, and so important. It shows the leaders of healthcare organizations why it's necessary to create a new culture. Even better, leaders are shown how to go about that task. It isn't easy. The case studies demonstrate that it takes a lot of time and requires persistent, skilled, adaptive leadership. New cultures can't be copied and pasted; they must be internally grown. Most critical is that the new standards must be embedded in the organization's systems, particularly the human resources systems of recruitment, hiring, promotion, performance feedback, retirement, and, as Edgar Schein so aptly puts it, "excommunication."

I cannot imagine how any modern healthcare organization can adapt to a rapidly evolving environment, and succeed in its core mission, without going through the process of creating a new compact. In my view, a new compact is absolutely essential as a platform for transformational change. Leaders who proceed into the new world without one do so at their own peril.

Why should physicians care about compacts? I would suggest to physicians that they read this book with two compacts in mind—organizational and societal. Just as there has always been an implicit organizational compact characterized by autonomy, protection, and entitlement, there has also been a larger compact between our profession and our society, framed similarly. The key element in the societal compact has been autonomy—a privilege of self-regulation granted by society, earned in large part by astonishing science-driven advances in care over the past century, and also by society's perception of our altruistic professionalism. But in the past two or three decades that professional autonomy has been eroded. Why? Because society now knows that, because of our attachment to individual autonomy, we don't use scientific advances very systematically or effectively. And many would argue that society has also begun to perceive doctors as driven less by altruism and more by money.

It would be difficult to develop a new, explicit "compact" between physicians and society, practically speaking. But what if hundreds of organizations went through this painful process and achieved transformational change in real partnership with physicians? And what if, as a result, society started to notice the benefits of safer, more effective, better coordinated, less costly, more patient- and family-centered care? *Is it not possible that physicians might regain some lost professional autonomy at the societal level, by giving up some individual autonomy at the organizational level?*

James L. Reinertsen, MD

Foreword

Healthcare in today's world is a complex system of interdependent parts. Whether we are talking about the *overall political system* with its government agencies, lobbies, unions, insurance companies, malpractice lawyers, and suppliers of equipment and drugs; about a given *regional health delivery system* including hospitals and clinics; or about a given *hospital with its multiple microsystems* through which patients move, we always reach the same discouraging answer: It is horrendously complicated and interdependent. One frequently encounters the view that fixing the system is hopeless because it has so many interdependent players, each of whom is motivated to pursue his or her own economic and vocational interests.

On the other hand, the disturbing statistics about unnecessary hospital-induced infections and medical errors that cause a large number of patient deaths make it essential that we somehow get a grip on this complex system by finding a point of intervention that will begin to make a difference. We've learned from family therapy that the point of intervention is not necessarily the point where the most immediate harm is done. Rather, the point of intervention has to be a part of the system that is accessible to those who want to produce change and is tightly connected to the other parts of the system. If the point of intervention changes, the rest of the system will have to respond and change as well.

Where is that point of intervention in healthcare? *The interaction between doctors and administrators is the key point of intervention if change in the total system is to be accomplished*.

From my perspective, the healthcare system is driven by several occupational cultures that have different assumptions and values. At the governance level we have evolved *medical administrators* who may have come from medicine or nursing but who have acquired an administrative point of view that is inevitably concerned with economics and efficiency. These folks exist at the government, regional, and local hospital levels. The problems of administrators are similar; this leads to a similar set of perceptions and practices that can be thought of as the *administrative culture.*

From the administrators' point of view, doctors pose several problems: They want more autonomy, they are not cost-conscious, and they resist standardization and other efficiency and safety measures, even when those are based on clear evidence that such measures are helpful.

The delivery of healthcare, however, falls primarily to the *physicians, nurses, and various support staff* in clinics and hospitals. By virtue of their training and the similarity of their tasks, they also acquire a common culture. On closer examination, however, this group consists of several distinct subcultures, the most notable of which are the *doctor culture* and the *nursing culture.* Furthermore, while these

two cultures are of equal importance to healthcare delivery, they each have a different status within the system. The way healthcare has evolved has given the doctor culture the position of highest status, as manifested in the frequently heard comment that the system is basically designed for the benefit of the doctors. At some level, this elevated status is warranted by the fact that society has charged doctors with the ultimate responsibility for life-and-death decisions and has supported this responsibility by requiring an exceedingly long and demanding education and training period. As anxious patients, we want doctors to have the expertise and sense of responsibility to take good care of us.

From the doctors' point of view, the administrators pose several problems—their cost-cutting, safety, and other efficiency systems not only infringe on doctors' sense of autonomy (which they have been trained to exercise), but the various procedures also require so much administrative work that they interfere with doctors' practice and consequently increase safety problems because they are so time consuming.

As medicine has become more complex and differentiated, these tensions have become increasingly dysfunctional. If administrators and physicians lack the trust to implement needed changes, delivery of healthcare suffers.

For the healthcare system to work better for society, for patient experience and safety to improve, and for costs to be managed, *both* the doctor culture and the administrator culture have to evolve. For this reason, this book is central in showing how such evolution in the physician and administrator cultures has been successfully launched in a variety of healthcare institutions and can be gradually launched elsewhere. By bringing administrators and doctors together to evolve a new compact in the various subsystems such as a given hospital, both the doctors and the administrators evolve new points of view and find new ways of working together for the benefit of the patients and societal health.

Edgar H. Schein