

Physician-Hospital Competition and Collaboration: The New C-suite—Sailing the Seven Cs

WHITE PAPER



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Let's begin with the end in mind. The questions to consider are "Where do you want your organization to be?" and "Where is it now?" To help determine the weather in your organization, consider the following three scenarios and ask whether your facility members are capitulating or collaborating. Is your organization on the bleeding edge, the trailing edge, or the leading edge?

Health System A

It's been a busy year for Harry. He and several of his general surgery colleagues opened a state-of-the-art four-room ambulatory surgery center. As the leader of the initiative, Harry was targeted by the local hospital CEO as a traitor interested only in financial gain to the detriment of healthcare in the community. Many medical staff members thought the CEO crossed the line when he published a letter vilifying Harry in the local paper. At the annual medical staff meeting, Harry was nominated from the floor to be the chief of staff (COS). The medical staff bylaws did not preclude this and did not address issues such as leadership qualifications and succession. Harry was elected COS to serve as the loyal opposition to hospital administration. Since the COS has a seat on the hospital board, the board chair was apoplectic about the result and threatened not to seat Harry. Absent a conflict-of-interest policy or an economic credentialing process, the board is seeking legal counsel to explore options. Harry already has an attorney on retainer. At a minimum, this scenario is unmanaged competition. At a maximum, it could represent open warfare. Bleeding edge, trailing edge, or leading edge?

Health System B

The five orthopedic surgeons on staff have just hand-delivered a letter to the hospital CEO informing her that they will stop taking emergency department call two weeks from today unless they are paid a handsome stipend to carry a beeper and be available. There had been rumblings about this for a while, and the CEO had been aware of national trends in this direction. However, she did not expect the ultimatum. The medical staff bylaws do not clearly address this issue, and the hospital has no policies in this area. The board is astonished that the doctors are asking for this. Do you capitulate? At a minimum, this scenario represents saber rattling. At a maximum, it represents extortion. Bleeding edge, trailing edge, or leading edge?

Health System C

The medical staff, hospital administration, board members, and community donors received beautiful red velvet engraved invitations to a local hotel ballroom to celebrate the opening of the hospital's cardiovascular institute. Being a tough certificate-of-need state, they were able to bring together diverse factions of the hospital medical staff and community to obtain permission to perform full cardiac services, including surgery. Further, they brought together cardiologists, cardiac surgeons, radiologists, and vascular surgeons and formed a cardiovascular and endovascular service line. Appropriate medical directors to lead the enterprise were hired after the team developed job descriptions, and candidates went through a selection process. The institute offers cardiac surgery, full cardiac services, electrophysiology studies, and cardiac imaging, including a 64-slice CT scan and a hybrid room for endovascular procedures, where anybody who has the requisite objective criteria to perform endovascular procedures may do so. Is everybody happy? No. But they put together the cardiovascular institute, and now they are celebrating. Bleeding edge, trailing edge, or leading edge?

Where do you want your organization to be and where are you today?

- We return to the opening questions: Where do you want your organization to be and where are you today? Health Systems A and B are bleeding edge and trailing edge, respectively, dealing with unmanaged competition and the necessity to capitulate. Health System C was able to collaborate and create some services across specialty lines that traditionally don't get along. It also accomplished physician and hospital successes that healthcare professionals would define as leading edge, an organization that's on its way to a successful future.

The new C-suite

Another question is "Do we continue to do the same thing over and over hoping that the outcome will be different, or do we try something new?" In other words, how do we avoid the repetition compulsion?

First of all, we probably have to invent a new C-suite for the hospital. Currently, we have CEOs, CFOs, COOs, CNOs, CMOs, and so forth, but is this sufficient? In addition to, or in place of the above, what we really need now are the following:

- Chief change officer
- Chief collaboration officer
- Chief communication officer
- Chief competition officer
- Chief conflict officer
- Chief culture officer
- Chief cultivating influence officer

Regardless of the titles used in your organization, the point to consider is that a new set of leadership and management competencies is required to lead contemporary healthcare organizations. If people are going to assume

leadership positions in healthcare today, they need to obtain education, training, and proficiency in this new set of competencies. This applies to leaders and managers at every level of the organization: medical staff, C-suite, and board. The following section describes the highlights of the core competencies, the seven Cs, to help navigate these new waters. They are:

1. Embracing change
2. Seeking collaboration
3. Increasing communication
4. Handling competition
5. Managing conflict
6. Influencing culture
7. Cultivating influence

Embracing change

It is well recognized that many people resist change unless they have initiated it.

The only sure thing is change. Change is inevitable. It is well recognized that many people resist change unless they have initiated it. In healthcare, we are facing change at an unprecedented rate. The job of leadership is to strike a balance between stability and change while continually leading the organization forward. In the polarity between stability and change, there is a positive pole and a negative pole. The positive pole of stability is a sense of consistency and familiarity: a comfort zone. The negative pole of too much stability is stagnation and lack of adaptation to a changing external environment. The positive pole of change is new energy in an organization. The negative pole of too much change is chaos. Leadership needs to recognize and diagnose where the organization sits and lead it to maximizing the positives of both poles. In the book *Built to Last*, Jim Collins studied organizations at the top of their fields for a protracted time period. His findings included a balance of stable core values that did not change over time, but the ability to appropriately react to change occurred on the edges and interfaces of the organizations and their external environments. Great models for emulation can be found in these successful organizations.

Change inevitably causes stress, and different primary personality types respond to stress differently. A working knowledge of primary personality preferences and their reactions under stress can help leaders diagnose and treat roadblocks in the process of embracing change. Tools such as the Myers-Briggs Type Indicator (MBTI) or the Dominance-Influence-Steadiness-Conscientiousness Profile provide insights into seemingly inexplicable behavior. For example, many physicians using the MBTI show the following patterns:

- Sensing, which is characterized by attention to immediate details and practical applications. When stressed, this style might have difficulty seeing the implications of the big picture and recognizing culture and trends.
- Thinking, which is characterized by a rational and objective approach to decision-making. Under pressure, this style overlooks the effect of decisions on others and values product first and process second (if at all).

- Judgment, which is characterized by focusing on a product that can be implemented and used. Under stress, this style is uncomfortable with uncertainty and might revert to controlling behaviors.

It is ultimately all about effective leadership. In his seminal work, *Leading Change*, John Kotter describes a step-by-step process that includes creating a sense of urgency, establishing a compelling vision for the future, establishing the coalitions to lead change, removing organizational barriers, and celebrating successes along the journey. This is a core set of competencies for today's healthcare leaders.

Seeking collaboration

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- It is important for leaders to understand that how they respond to conflict is a matter of their conflict style. The recognition of your primary tendency identifies your comfort zone. Knowledge of other responses allows you to understand the styles of others. Learning to move from one style to a more appropriate style is a competency for contemporary healthcare leaders to develop.

There are two primary responses to conflict. The first is assertiveness, in which you seek to satisfy your own concerns. The second is cooperativeness, in which you seek to satisfy the concerns of others. Within these two primary responses, several outcomes are possible. These include:

- Avoidance, by which neither party satisfies its concerns.
- Competition, in which you seek to satisfy your concerns at the expense of others.
- Capitulation or accommodation, in which you satisfy another's concerns at your expense. This certainly would be the case in Health System B if the demands for payment are met without due consideration of other factors.
- Compromise, in which each party gives up some of its concerns to satisfy the other. Although many people view this as the highest form of negotiation, it often leaves both parties feeling dissatisfied or manipulated, as when involved in a high-low pricing negotiation in which you arrive at some middle point as part of a game or foregone conclusion.
- Collaboration, a preferred method of negotiation in which both parties appreciate the conflict as a mutual problem to be solved. This allows the parties to discover new, expanded, or increased alternatives to satisfy their concerns.

A further outgrowth of this thinking is that there are different methods for actual negotiation, not all of which will result in collaboration. These include:

- Positional-based negotiation, in which the bargaining occurs around positions. The danger is a tendency to lock in to these positions. For example, the more you clarify your position and defend it, the more committed you might become to it. Bargaining about positions is inefficient and can endanger good relationships. It is particularly worse when there are more than two parties and multiple positions, as is

often the case in emergency department call compensation conflict involving several physician specialties, the hospital, and the community. Bargaining does not lend itself to seeking collaboration.

- Power-based negotiation, in which one party holds a dominant position over the other either by authority, positional power, or leverage. A threatened pullout of emergency department call within two weeks by your surgical staff when there are seemingly no other alternatives is an example of leverage. This style of negotiation does not lead to seeking collaboration.
- Principle-based negotiation, which is described by Roger Fisher and William Ury in *Getting to Yes*. This method involves four steps:
 - Separate people from the problem
 - Focus on interests and not positions
 - Invent options for mutual gain
 - Insist on using objective criteria

This method of bargaining is designed to facilitate and increase collaboration and should be part of every healthcare leader's toolkit.

We have dealt with the individual insights and knowledge of techniques to be used in seeking collaboration. In a similar fashion, there are organizational responses to conflict depending on the culture of the organization. This will be addressed in the fifth step, managing conflict.

Increasing communication

Communication is the glue that holds everything together. The challenge is even more acute because Peter Drucker, one of the world's experts on organizations, has said, "During times of change, leaders should treble their efforts at communication." We are definitely living through a period of unprecedented change in healthcare. All leaders should devote extra effort to communicate with each other in an open, two-way exchange. There are two facets to this. The first is the actual method of sending communications. The second is a toolkit of communication skills.

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- Medical staff members and hospital leaders need to communicate with several stakeholders (e.g., the medical staff, hospital administration, board, and community). A comprehensive communication plan must include multiple modalities, approaches, and channels to communication. Communication, especially in this 24/7 age of instantaneous news, needs to be timely, accurate, and transparent. Constantly trying new methods of communication insures freshness, vitality, and interest.

Effective multichannel communication includes:

- A monthly physician and/or internal hospital newsletter distributed in the medical staff lounge and sent to all physicians' office staff members by e-mail, fax, or mail.
- A medical staff Web site continuously updated with news, items of interest, and other matters pertinent to the medical staff.

- A letter, fax, or e-mail sent regularly to key stakeholders, informing them of important issues and decisions.
- A “quick flash” briefing letter to address timely issues that need immediate input from medical staff or hospital members. Print the letter on brightly colored paper to get their attention. If faxed or e-mailed, label it as a high-priority item. Text messaging and instant messaging are useful adjuncts for this purpose.
- Webcasts, podcasts, or CDs for informing physicians and hospital members about important issues and decisions.
- A medical staff telephone hotline for physicians to call with comments, complaints, or suggestions. This is a useful method for physicians to voice their concerns in a nonthreatening environment.
- Scheduled office hours for medical staff leaders so physicians can discuss suggestions and concerns in private. There is sometimes no substitution for face-to-face communication.
- Effective committee and development meetings, with minutes distributed to the appropriate staff members. However, do not fall into the trap of believing that because an issue was discussed at a meeting, further communication is not necessary.
- An idea board at all meetings, which can include a flip chart with several markers so that questions, issues, and suggestions can be solicited, recorded, and researched prior to the next meeting.
- Opportunities for social interaction to increase the social capital of the organization. Multiple opportunities exist, including:
 - An off-site one-day retreat with the medical staff, board, and administration.
 - Regularly scheduled breakfast or lunch with medical staff leaders and hospital administration.
 - Informal quarterly socials with hors d’oeuvres. Invite the medical staff, administration, and board.

Hospitals that train board members, administrators, and medical staff leaders in effective communication techniques will see benefits throughout the organization.

- An effective communication toolkit must be developed. Healthcare leaders, including physicians, must become proficient in the development of effective personal communication skills. Hospitals that train board members, administrators, and medical staff leaders in effective communication techniques will see benefits throughout the organization. Hospitals might choose to implement in-house training or arrange external educational programs for physicians in these areas. Several techniques and resources are available to develop communication skills, including:
 - Style assessments. These identify medical staff leaders’ personal strengths and weaknesses. By way of example, style assessments might identify passive-aggressive communication patterns or a need for skill training in assertive communication.
 - Role-playing. This method allows leaders to practice responding to realistic case scenarios in a low-risk environment. This technique can be invaluable in equipping medical staff leaders to deal with the inevitable conflicts that arise.

- Personal coaching. Some physicians and other leaders might benefit from personal coaching that develops communication skills through individualized instruction.
- Formal education programs. Many on- and off-site seminars, classes, and retreats are available to organizations.
- Video- or audiotaped scenarios. Medical staff leaders might be able to identify useful communication strategies by viewing taped scenarios that are similar to situations they might encounter. Also invaluable is for medical staff leaders to view video or listen to audio recordings of themselves. Great insights into their verbal and nonverbal communication can be gleaned in this manner.
- Good listening skills. Effective listening is one of the most important skills of effective communication. It promotes trust, builds relationships, and leads to increased understanding. Good listening is fueled by curiosity and empathy, traits possessed by many physicians.
- Books on writing styles. These are readily available and help hone the development of clear and crisp written communication by explaining how to use the right words, avoid jargon, and steer clear of antagonistic words. Succinct communication is well received by physicians and other hospital members.

Handling competition

It is almost inevitable that there will be some level of competition between physicians and hospitals.

Given the lack of economic alignments, shrinking or flat reimbursements, and the emergence of new technologies, it is almost inevitable that there will be some level of competition between physicians and hospitals. The real challenge for physicians and hospitals is figuring out a way to successfully and simultaneously collaborate and compete. Physician-hospital competition is a nationwide issue that affects how hospitals and physicians relate to one another. This is further compounded by numerous examples of physician-physician competition. A process and supporting policies can help your organization handle these competition scenarios when they occur. Without a clear basis on which to proceed, your organization will flounder and shudder in the face of unmanaged competition. The following are strategies and tools to employ in this potentially volatile arena:

- A solid conflict-of-interest policy that encourages full disclosure goes a long way in helping medical staffs and hospitals achieve the goal of figuring out how to collaborate and compete. A good starting point is to understand the myriad ways in which conflicts of interest can occur. Some of these include:
 - Physician-physician conflict
 - Competitors performing peer review
 - Credentialing/privileging disputes
 - Physician-hospital conflict
 - Leadership position at a competing hospital
 - Competing ambulatory services
 - Physicians in joint ventures with other hospitals
 - Physicians who are loyal to other hospital staffs

- Medical staff leadership roles (e.g., vice president of medical affairs and paid chairs)
- Physicians as governing board members
- Physician group conflict
 - Employed physicians
 - Exclusive contracts
 - Medical directors
 - CEO's "kitchen cabinet"
 - Joint-venture partners
 - Contracted services
- Physician's personal conflict
 - Personal relationships
 - Religious issues
 - Families/relatives with related or competitive interests
 - Physicians involved in competing or similar research
 - Ethnicity issues
 - Ownership or interests in device manufacturers

One thing is certain: As healthcare becomes more complex and competitive, these conflicts of interest will surely increase. Because of the ever-increasing focus on physician interests and hospital-physician competition, facilities should require all medical staff members who are board members, officers, and chairs, as well as those who serve on committees such as the pharmacy and therapeutic committees, to complete an annual conflict-of-interest disclosure. Disclosure forms should be done annually and gather the following information:

- Financial arrangements (including ownership, investment, or compensation) between the hospital and the physician, family members, or group practice or business
- Relationships with suppliers, pharmaceutical companies, durable medical equipment suppliers, and other vendors
- Ownership or other interest in any entities that provide healthcare services or supplies
- Loans from the hospital or its affiliates or an organization that does business with or competes with the hospital
- Gifts, entertainment, or other benefits received by the individual or family member from any organization doing business with the hospital
- Other interests in, relationships with, or benefits received that could influence decision-making on behalf of the hospital

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In recent years, hospitals have developed myriad strategies for handling competition from physicians. Some have pursued joint ventures for ambulatory services or opted to build service lines to try to force competitors

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- out of the marketplace. Hospitals that pursue these options often deny medical staff membership to physicians with competing interests. Other hospitals prohibit physicians with competing interests from serving in leadership capacities. This is generally addressed in an economic credentialing policy adopted by the board. More information can be obtained in the books *Economic Credentialing: How to Balance Competition, Compliance and Collegiality to Resolve Conflicts of Interest* and *The Medical Staff Leader's Practical Guide*, Sixth Edition, published by HCPro, Inc. It is important to recognize that hospitals should not necessarily deny membership or leadership roles to physicians with potential conflicts. Hospitals should try to find areas in which hospital and physician interests align. Physicians must fully disclose where their interests are in areas of conflict such as the following:

- **Loss of high-profit services.** Hospitals often perceive physicians' interests in working with or investing in ambulatory facilities as a blow to their bottom line. Niche facilities typically provide high-profit services that community hospitals rely on to fund the emergency department and other mission-related community services considered to be on a downward trend or marginal. On the other hand, some hospitals recruit well-known expert physicians or superstars to promote certain high-margin specialty lines, which creates resentment among other physicians who admit patients to the hospital and suddenly feel at a disadvantage. The medical staff can grow to resent the privileged position of physicians who are considered revenue generators. It is important when navigating this challenge to fully understand the polarity of intent and effect. What one intends might have an entirely different effect on another party. Sensitivity to this dynamic can promote understanding of a competing position.

- **The case for payment reforms.** Although medical staff organizations can adopt policies that aim to reduce disruptions and tensions caused by conflicts of interest, and boards can adopt economic credentialing policies to deal with harmful competition, some industry experts say national payment policy reform is imperative to reduce the stratification of hospitals and physicians into camps of winners and losers. Factors contributing to this misalignment of economic incentives include the diagnostic-related group hospital payment system, the physician procedural versus cognitive payment system, and the uninsured/underinsured issue. Economic issues are at the source of much of the competition over lucrative services and the exodus away from low- or no-reimbursement services. There is a great deal of money to be made in certain areas because of distorted payments, so there is an incentive for physicians and hospitals to engage in certain activities that are as much about income generation as about patient care. Being able to explain these economic issues clearly can help promote understanding of legitimately held economic incentives and encourage conversation to seek mutually beneficial business and strategic objectives.

Don't forget the five Ps. It bears repeating that the way out of many quagmires is to have a clearly articulated policy developed before conflict occurs to help guide all parties to a principled level. It comes back to the five Ps:

“If you have a policy, follow your policy. In the absence of a policy, it is our policy to develop a policy.”

Managing conflict

The way an organization handles conflict is often determined by its culture. Some cultures view every conflict as an opportunity to crush the competition through belligerence and bullying. Others are characterized by thoughtful responsiveness, sensitive to the feelings and concerns of others. A good starting point is to know your organization’s style and then objectively analyze whether the strategic results are what you wish them to be.

Many organizations have little self-knowledge or recognition of their style. If we accept that conflict is a huge growth line in contemporary healthcare, then best practice is to design and implement a conflict management system. The ideal time to do this is when no immediate or pressing conflict is present. After all, it wasn’t raining when Noah built the ark.

In their book *Designing Conflict Management Systems*, Cathy A. Costantino and Christina Sickles Merchant state that there is a spectrum of alternative dispute resolution (ADR) options that range from least invasive (those that allow disputants the most control over the process and outcome, such as negotiation) to most invasive (those that allow disputants the least control over the process and outcome, such as binding arbitration). What might such a progressive system look like for a medical staff and hospital?

Elements to consider, in ascending order of invasiveness, are:

- Prevention, which includes partnering, joint venturing, consensus building, setting expectations and rules, and joint problem solving. The physician-hospital compact, defining the give-and-take between physicians and hospital, is an excellent practice in this space.
- Principled negotiation to seek collaboration by separating people from the problem, focusing on interests and not positions, inventing options for mutual gain, and insisting on using objective criteria.
- Facilitation by using mediation, principled negotiation, and conciliation.
- Fact-finding mediation using a neutral expert.
- Advisory ADR using results of early neutral evaluation and non-binding arbitration.
- Imposed settlement, such as binding arbitration.
- Legal remedies (only if all else fails).

Influencing culture

Culture is extraordinarily powerful and has the potential to undermine any leadership efforts and improvement.

There is a saying in healthcare today that “culture eats strategy for lunch.” Culture is extraordinarily powerful and has the potential to undermine any leadership efforts and improvement. This is because culture is not merely an expression of an organization’s espoused values; it is a combination of espoused values, personal attitudes and beliefs, and actual behavior. In fact, it can be said that culture drives behavior, and behavior drives results.

Therefore, to achieve a truly effective medical staff, physician leaders must proactively mold and lead the medical staff culture so that it simultaneously drives the desired results of physician and hospital success. Recent literature addressing organizational culture has recognized that truly effective cultures must simultaneously embrace and balance interdependent opposites, sometimes called polarities.

Common polarities seen in contemporary medical staffs include:

■ **Collegiality and excellence.** Simply by completing medical school, residency, and fellowship and by becoming a member of the medical staff, your fellow physician should have your unconditional respect as a colleague. This is the so-called social grease of physician-to-physician relationships.

We all want to work in an environment that is high on collegiality. Physicians appreciate working within a medical staff in which their fellow physicians work and play well together. They treat each other as valued colleagues. They trust each other and enjoy each other's company. Collegiality helps increase the social capital of a group or organization. This social capital is critical for providing the grease that allows smooth relationships and interactions within the medical staffs. In short, people who play together have a more difficult time fighting.

Although collegiality is an important aspect of a strong medical staff culture, it must be balanced by the medical staff asking and answering the question, "How good is good enough?" Is our medical staff culture one that expects excellence of its members, or are we aiming simply to be average (i.e., mediocre)?

What does a culture of mediocrity look like? Do staff members say, "Look, we're at the 50th percentile, so we don't have to work on this?" Is our culture one that simply says, "No news is good news?" This translates to mean that as long as none of our physicians are practicing egregiously poor care, then we are good enough. If we are only concerned with collegiality, with greasing the social wheels in our medical staff, then we cannot hold each other to a level of excellence. Therefore, to achieve a truly effective medical staff, we must have a culture that embraces, supports, and expects collegiality and excellence from all physicians.

Consider peer review in a culture characterized by excessive collegiality. Doctor A reviews a case of Doctor B. Things were not done well by Doctor B. In a culture of collegiality, will the case be glossed over because next month the roles might be reversed? Compare this with a culture dominant in excellence. Will the case be discussed in a forthright but impersonal manner such that the element of collegiality is lost?

An effective medical staff is not either collegial or excellent, but both.

● The takeaway message is that the answer to an effective medical staff is not either collegial or excellent, but both. How do we capture the best of both and manage this dynamic tension?

Physicians need the freedom to make choices about how to spend their time—on their practice, with their families, and on personal pursuits.

- ■ **Freedom and commitment.** Physicians need the freedom to make choices about how to spend their time—on their practice, with their families, and on personal pursuits. This creates a dynamic tension that applies to physician participation in the organized medical staff. In this context, freedom means each physician's right to make individual choices concerning how to balance their practice, home, leisure time, and medical staff responsibilities. Each physician is autonomous and free to make these choices as he or she sees fit. Increasingly, medical staff members are opting to spend less time involved in medical staff activities or carrying out the board-delegated responsibilities of contemporary medical staffs. In many organizations, this absence of commitment and leadership has led to a crisis situation.

Yet physicians want to be relevant to hospital discussions. They want to have a voice at the table and influence over their interests. They need to show up at meetings, get involved in solving problems, and take their turn in medical staff leadership. However, in a democratically organized medical staff, we must depend on voluntary activities from medical staff members. This can only arise from medical staff members' commitment to participate in these activities. If there is no commitment, the organized medical staff cannot carry out its activities effectively. This will result in fulfilling the prophecy of those who have predicted the death of the organized medical staff and its replacement by professional physician managers. Therefore, an effective democratically organized medical staff must embody a healthy balance between members' freedom to make personal choices and physician commitment to sustain itself.

- **Appropriate independence and mutual accountability.** Appropriate independence is critical for the practice of good medicine. All physicians value the right to provide care to their patients as they deem appropriate for each case. Appropriate physician independence in the practice of medicine is an absolute requirement for physicians to exercise their clinical judgment and skills in the best interests of patient care. By virtue of training, experience, board certification, and undergoing rigorous and ongoing determination of current competency, physicians exercise their privileges to ensure quality patient care. This is consistent with the fiduciary responsibility of the physician to his or her patient.

However, physicians are accountable to the governing board of the hospital for their activities and actions within the hospital. This accountability is exercised through the democratically self-governed medical staff. If we are democratically self-governed, the corollary is that physicians on the medical staff are mutually accountable to each other for the quality of care we provide. The most pragmatic measure of a medical staff concerning mutual accountability would be that a physician brings a loved one to the emergency department for some condition. Does it matter who is on call that day for medicine, orthopedics, ENT, or any other specialty? The on-call physician is far less of an issue in a medical staff with high mutual accountability. Although this ideal state is not often realized, an effective medical staff cul-

ture balances appropriate physician independence with a high level of mutual accountability. Balancing this tension is a challenge for medical staffs.

■ **Appreciation and continuous performance improvement.** Healthcare has adopted continuous performance improvement as a mantra in promoting improved processes that result in efficiency and improved measurable patient outcomes.

Who is saying “thank you”
in your hospital?

- But we often fail to appreciate the excellent care physicians are providing already and the sacrifices they are making—attending patients in the middle of the night, dealing with angry patients who threaten to sue, and then coming in the next morning and doing it again. Who is saying “thank you” in your hospital? If physicians only hear from their medical staff about how they can improve, without being appreciated for the hard work and excellent care they are already providing, you won’t have a healthy balance between appreciation and continuous performance improvement.

Although there is no doubt that healthcare has embraced the principle of continuous performance improvement, initially espoused by W. Edwards Deming, Joseph Juran, and others, physicians have often resisted efforts at continuous performance improvement when it requires physicians to change how they take care of patients. Medical staff leaders who continually push their fellow physicians to improve their patient care often meet resistance. One source of this resistance is that most physicians truly believe they already provide high-quality care; therefore, a prerequisite for physicians embracing a culture of continuous performance improvement is a culture that expresses appreciation for the quality of care, the personal commitment, and the sacrifices already manifested by the physicians on the medical staff.

Once physicians feel appreciated and honored for the excellent quality of care they already provide, they are far more likely to accept constructive feedback and improve their care over time. In this sense, a medical staff culture that embraces appreciation and continuous performance improvement is more likely to be an effective medical staff.

■ **Stability and change.** If medical staff leaders are to fulfill their responsibilities of helping the hospital and physicians succeed in these challenging times, they must embrace and implement change. For today’s medical staffs, this includes new pressures to adopt evidence-based medicine in a timely and effective manner to ensure optimal patient care. Medical staff leaders must address disruptive physician behavior to ensure a safe and effective working environment. Physicians and hospitals increasingly operate under public accountability for quality measures and concerns about costs of patient care. The adaptation of new electronic technologies for recordkeeping and computerized physician order entry is necessary to provide safer and accurate documentation of care. It also involves managing physician-physician and physician-hospital conflicts of interest

in thoughtful ways, simultaneously supporting the success of the physician and the hospital—all while providing good care for the community. The very survival of hospitals and their medical staffs depends upon their ability to respond to these changes in a timely and effective manner.

Yet any organization requires a measure of stability or it risks lurching from one fad to the next. The upside of change is new energy; the downside is chaos. Medicine is inherently a conservative profession dealing with patients' lives, in which decisions should not be made on a whim. We are dealing with patients' lives every day, and we don't want to fall victim to fads and unproven treatments. We want to preserve the autonomous practice of medicine as a noble profession. We want to help our fellow physicians, not penalize them. We don't want to do anything that undermines a peer's ability to earn a living, and we hesitate to tell our peers how to treat patients or run their practices.

This conservatism has served our patients well in some ways, but not in others. Studies have documented the excessively slow adoption of evidence-based best practices by physicians. This can lead to unnecessary harm to patients. The upside of stability is consistency; the downside is stagnation. Thus, an effective medical staff is one that balances stability and change well.

Leaders must walk the talk and lead by example.

- Culture is not changed easily and requires strong leadership. Leaders must espouse new beliefs and values, often in mission, vision, and value statements. Leaders must walk the talk and lead by example. They must be great communicators and reach out to fellow physicians to communicate about the new culture and the reasons for change. Leaders must also build strong social capital and respect to facilitate the necessary culture changes.

In addition, leaders must hold others accountable for not complying with the new culture when faced with the inevitable resistance that arises when leaders try to change a culture. But with strong and effective leadership, slowly the change will come. This is a key competency of the new C-suite.

Cultivating influence

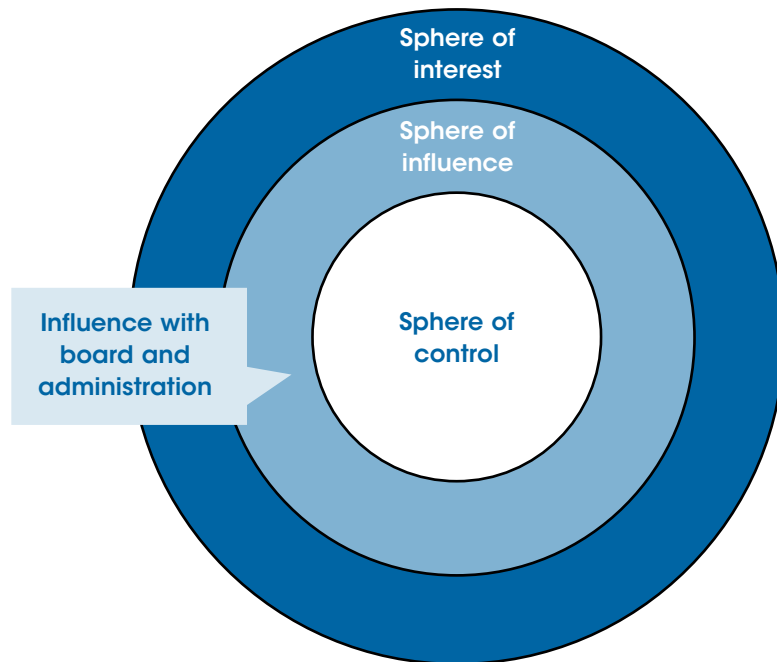
A fundamental principle underlying cultivating influence is that we are often interested in far more than we actually control; however, if we do well with what we control, we are able to increase our influence on things in which we have an interest but no control. Medical staff leaders should understand this dual role and responsibility of the medical staff. This principle applies to all parties. What is the sphere of control of the organized medical staff? First and foremost, it is their board-designated responsibility to monitor and improve the quality of care that is primarily dependent on the performance of individuals' granted privileges.

Because of this, physicians on your medical staff are accountable to each other for the quality of care they provide. This is a given. This is the sphere

of control of the medical staff, namely how credentialing, privileging, and peer review are conducted in the organization.

But the medical staff is interested in many other things, including hospital operations (e.g., staffing, cleanliness, timeliness, availability of services, and competency of staff members) and the board-directed strategic development and initiatives of the hospital. This sphere of interest is not in the control of the medical staff; however, it is an area in which the advocacy role for the medical staff comes into play. So to have effective influence with the board and administration, here is the lesson of the story: To expand our influence, we must begin by doing what is in our sphere of control. Do what is in your sphere of control well, and your influence will expand. Don't do what is in your sphere of control well, and your influence will shrink.

This is depicted in the following graphic.



If you achieve excellent hospital outcomes in these areas, your sphere of influence with the medical staff will increase.

- In a similar fashion, the hospital has an interest in working with the medical staff to keep quality at the center and ensure physician and hospital success. But it does not control the medical staff; it controls hospital operations, finances, and safety. If you achieve excellent hospital outcomes in these areas, your sphere of influence with the medical staff will increase.

Conclusion

This paper began with keeping the end in mind. Will your organization be characterized by unmanaged competition and war or extortion and capitulation, or will it be an organization dedicated to collaboration and ensuring physician and hospital success? Sailing the seven Cs offers a step-by-step approach to realizing the latter. ■

