CHAPTER 2

Mending the Gap between Physicians and Hospital Executives

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This chapter explores the relationship between two components of our healthcare system: physicians, representing all providers of direct care, and hospital executives, referring to those with administrative responsibilities, regulatory obligations, and resource control. Currently, there is a wide gulf, or gap, representing an adversarial interaction. Over the past 50 years, there have been dramatic, frankly, revolutionary, changes in the practice of medicine without corresponding or matching adjustments in the healthcare system. As a result, both physicians and healthcare executives are frustrated. The present adversarial tone between healthcare executives and physicians adversely impacts healthcare outcomes.

We discuss data showing differences between physicians and healthcare executives in education, background, work experience, and culture. However, the two share common core values: altruism, service, and love of a challenge. They also have common concerns about the future.

We conclude that the real enemy is not the so-called other—physicians or healthcare executives—but our dysfunctional healthcare system. The common values and concerns shared by physicians and healthcare executives could provide the framework for successful communication leading to a bridge across the gap and a collaborative rather than confrontational relationship. Physicians could teach healthcare executives about clinical priorities, useful new technologies, and scientific methodology, including evidence-based decision making. Healthcare executives could educate physicians about management tools and techniques for planning, implementation, and assessment, especially systems thinking. Together as partners, healthcare executives and physicians could address many of the currently insoluble problems in healthcare.

INTRODUCTION

If you have not used the tube (subway) transit system in London, you have missed a pleasurable experience. In a place where streets are narrow and wind around buildings, where street names change without notice and are routinely mispronounced by tourists, it would be easy to get lost. The tube helps you get where you need to go. There are, however, places where the subway rails are not flat but cantilevered, forcing the train to be tilted away from the platform edge, creating a dangerous gap into which passengers can fall to injury. At each of these places, when the train comes into the station, a stentorian mechanical voice with a British accent warns: "Mind the gap!" In the following discussion of hospital-physician relations, we have stolen and modified the tube-stop clarion call, writing that we need to *mend* the gap.

During the discussion that follows, we use the words hospital, management, and MGT (management) interchangeably to indicate those within a hospital or healthcare system who have administrative functions and resource responsibility. This includes managers, support staff, billing individuals, all the way up to the chief executive officer (CEO) and the board. We intersperse the terms physician, medicine, and provider to represent all who directly provide care, such as doctors, nurses, therapists of all kinds, social workers, and technologists.

Case Report: Local Newspaper Reports 10-Hour Waits in Emergency Room

The following is a dramatization of an actual meeting in a hospital after the major local newspaper printed a front-page story about how long people waited in the emergency room (ER).

Director of public relations:	"You all saw last week headlines. The board is very distressed over the story showing that patients often wait in our ER for 8 to 11 hours. I have called this meeting to see what we can do."
Medical director of ER:	"We have real problems. Yes, people do wait a long time in my ER. We need more resources: nurses, bed spaces, and equipment."
Vice president of operations:	"We have no additional money. The ER ~~hospital~~ is a money-losing facility. How long can it take to see if the patient is bleeding and sew him up or determine what the child's rash is?"
Director of inpatient services:	"We do not have beds to accept patients from the ER, and we frequently are sitting around waiting for the cath lab."
Chief of nursing:	"I cannot recruit enough nurses to fill the vacant positions we have in the ICU or the cath lab."

Chief of cardiology:	"It is malpractice to have a patient with an evolving heart attack waiting around in the ER. This cannot go on!"
Director of fiscal services:	"Too many ER patients have no insurance or are undocumented or refuse to fill out papers. No one has preauthorization. We just do not get paid for what we do."
Chairman of surgery:	"Patients lie in the ICU [intensive care unit] or the wards waiting for surgical times to get into the operating room. We need more rooms and surgeons, or the waiting list just gets longer."
Director of Emergency Transport Services:	"Our hospital is the Level I trauma center for the area. I *have* to bring the patients here, and, oh, we lose money on every uninsured patient. We are mandated to transport them but do not get paid."
Chairman of Pediatrics:	"During epidemic seasons, we have to house dehydrated or asthmatic children in the ER because there is no other place to put them."
Medical Director of the ER:	"We have to do something!"
Director of Public Relations:	"We have to do something!"

Each person was speaking the truth from his or her perspective. No one understood the others' issues. No one was talking *to* anyone else. No one was diagnosing causes of ER flow problems, and no one was suggesting any workable solutions.

PHYSICIAN-HEALTHCARE EXECUTIVE EXCHANGES

Below are some additional examples of communications between physicians, called white coats, and healthcare executives, nicknamed blue suits. As above, they are actual, recent in-hospital verbal exchanges. Even the jocular names—*white coats* and *blue suits*—suggest opposing teams rather than teammates, much less colleagues, and certainly not brothers.

- Doctor (to receptionist): "Please fax this information immediately to Dr. X."
- Hospital receptionist: "I can't. My name is not on the medical release form."

- Provider (doctor): "How can I talk to my patient when there are no translators?"
- Manager (director of translation services): "Do these doctors think I can print money?"

- Provider (doctor): "I should talk to the patient about the complication."
- Manager (risk management director): "You can't. They might sue, and besides, all discussions at morbidity and mortality conferences are confidential."

- Provider (surgeon): "Where is the family of the patient I just operated on?"
- Hospital (receptionist): "Somewhere in the hallways. There are 22 waiting room chairs for a 72-bed ICU."

- Doctor (surgeon in operating room): "I need a 24-mm Carpentier-Edwards heart valve."
- Hospital (operating room [OR] manager): "We only have 20 and 25 Shiley valves. Those were the only ones I was allowed to order."

- Provider (doctor): "Why must this patient wait four days for the surgery she needs?"
- Manager (OR supervisor): "Because we only have three ORs and they are all booked solid."

- Doctor (department chairman): "We need to recruit Dr. Z as soon as possible."
- Hospital (human resources [HR] director): "It will take 6 to 18 months, approximately seven different forms, at least four committee meetings, compliance with EEOC [Equal Employment Opportunity Commission] regulations, and I have no idea how much it will cost. Oops. She has an H-1 visa. Sorry, we cannot hire her."

- Provider (social worker): "I saw in this morning's paper that our CEO got a 4 percent performance bonus. His 'performance' success means we have fewer translators."
- Hospital (CEO): "I saved the hospital $4 million last year and am underpaid by national standards."

- Provider (respiratory therapist): "Why aren't we using the ventilators with the new servo control?"
- Hospital (unit manager): "If I stay within budget, I get my annual bonus."

- Provider (nurse): "I have had it here. I am moving to Hospital X uptown."
- Hospital (HR manager): "I cannot understand why she left. We gave her a signing bonus."

- Both, separately: *"But we meant well!!"*
- In unison: "You won't believe what *they* just did!?!"

Whether the subject at hand is an individual patient, facilities within the hospital, relations with outside agencies, or outcomes—medical or financial, the providers and managers seem to be shouting at each other rather than having collegial discourse. Relations are either silo type, with one side functioning independently of the other, or frank adversaries, where each side sees the other as the source of its problems.

ADVERSARIES

Most physicians and nurses simply want to do their work free of hassle, providing high-quality, patient-sensitive care.[1] They see themselves as doing what society *wants*, and therefore expect society to make it easy, rather than difficult-to-impossible. Unfortunately, most experience the opposite: hindrances and hassles due to the plethora of diverse expectations and restrictions placed by organizations, managerial personnel, regulatory agencies, and patients.[2] Not surprisingly, clinicians tend to direct their anger and frustration on immediately available, easily identifiable individuals, such as their own managers, rather than some faceless insurance entity, an unknown regulator, a distant legislator, or global economic pressures.

Healthcare executives are responsible for creating conditions that enable and promote quality care while overseeing limited resources. Ultimately, their administrative decisions impact medical care delivery. However, the complexity of modern medicine presents serious challenges to anyone in hospital management who seeks to create a milieu free from error, strife, dissatisfaction, and constant turnover.[3–5] As the presumed top of the power pyramid, the hospital CEO has come to symbolize the enemy in the minds of many physicians looking for a convenient scapegoat.[6]

A pejorative view by physicians of those in hospital management does little to resolve problems or improve health care outcomes.[7] Such attitudes only exacerbate an already contentious care delivery setting.[8] Moreover, this tendency to stereotype CEOs is inconsistent with evidence-based practice. In many respects, physicians probably know less about the CEOs who lead their hospitals than they do about the neighbor next door.

Change in Function without Change in System

Consider a hospital in 1950—what was possible, the standards of medical care, roles, and relationships. All these were in the future: heart surgery; drugs affecting specific organs like Viagra, Cardizem, Lipitor, and Zoloft; nonsurgical repairs; CAT (computerized axial tomography) scans; echo studies; computers; and the Internet.

The 1950s hospital was filled with patients convalescing from pneumonia, diarrhea, ear infections, appendectomy, and childbirth (the standard was five days in the hospital postpartum). Almost all modern specialties did not exist, such as cardiology, neonatology, even the ICU. Medicine was incapable of caring for

patients with renal failure or premature babies, and therefore such patients were not hospitalized. Older people with heart failure died at home in bed.

The 1950s hospital consisted of a cadre of nurses, some supply personnel, no lawyers on staff, and a very small group of professional managers. Most doctors were in private practice, and many hospitalized patients had their own private duty nurses. They made rounds in the early morning on their hospitalized patients, possibly taught some students, and then went to their private offices. The doctor and the hospital sent separate bills to the patient, invariably a few lines on a single sheet of paper. People paid their own medical bills in cash.

Most patients in modern hospitals are gravely, not mildly, ill, requiring complex technologies and highly trained, specialized teams. Over 80 percent of all the medical care available in your hospital did not exist in 1950. High-acuity patients are extremely resource intensive in terms of equipment, supplies, expertise, personnel, and liability. The 2006 hospital is typically staffed with full-time physicians and hospital-employed nurses. Private duty nurses are not allowed in hospitals, and most office-based physicians delegate in-patient care to the full-time staff. Interestingly, 55 percent of all the people who work in a hospital never see or physically touch a patient![3] The CEO is responsible for an annual budget ranging from $25 million in a small rural hospital to over $1 billion for major metropolitan institutions. The vast majority of all medical bills are paid by third parties rather than out of a patient's wallet.[9]

In 1950, production efficiency was the key to success in any business. The hospital was, after all, a business owned by a political entity, usually the county or the federal government. Reimbursement was "cost plus," meaning a cost was determined, invariably by allocation and calculation, not direct measurement, and a profit margin or predetermined "plus" was added. The more one did, the more one got. Success, for both hospital and doctor, was effectively having all hospital beds filled all the time. In 2006, most reimbursements are fixed price, based on a diagnosis and contractual arrangements. A detailed bill listing what was done and what was used has become almost irrelevant. Success is achieved by having the right types of patients—both diagnosis and insurer—and getting them in and out the hospital as quickly as possible. Since the pot of healthcare dollars is predetermined and fixed, the less you take out, the more that is left over to be profit. Therefore, providing the least care gives the most money.

The entire healthcare paradigm has been radically altered, from the care possible to the finances, from the definition of success to medical impacts on society. Have the roles of managers and doctors radically changed over the past half century? Of course they have. Have the relationships between managers and doctors adapted correspondingly to the changes in their roles and responsibilities? They have not, and the absence of this adjustment is, in large measure, the genesis of the so-called gap.

The Adversarial Relationship Is Inevitable

Some see the conflict between providers and managers as inevitable, citing the inherent nature of the two sides, somewhat like the Sharks and the Jets in

West Side Story. The *West Side Story* analogy has some real merit in our healthcare system with its unsustainable supply/demand ratio: fixed supply of funds, but uncontrolled and apparently limitless demand for services. How would 10 rats or people behave if you only gave them enough food to feed 7?

Doctors and Healthcare Executives Are Both Frustrated

Both providers and managers feel squeezed and frustrated. For physicians, job satisfaction has decreased because of increased workload, decreased reimbursement, and feelings of powerlessness as well as disenfranchisement.[10] The providers believe that managers belittle, even sometimes distort, what is to them a sacred trust between provider and patient. The physician's role as captain of the team has diminished, and providers, in general, are confused by a system that wants them to do social *good works* but then puts stumbling blocks in their way. They are experiencing "vu jàdé,"[11] where the world itself makes no sense.

Managers are frustrated as well. They were socialized in a collaborative, bottom-line management environment where machines, money, and people (like nurses and doctors) are simply means to an end, generally treated as undifferentiated commodities. They do not understand the doctors' failure to recognize, much less understand, and accept resource constraints. Just as managers are frustrated by their internal environment (and those doctors), so too are they frustrated by the obligations and restrictions placed by the outside world, particularly governmental agencies and insurers. They are required to offer services without adequate resources and follow confusing, often contradictory, rules. Managers, like doctors, feel they are in a no-win position.

An unintended, important, and subtle change in the physician-management relationship has resulted from the intrusion of regulatory and accreditation bodies into the management and delivery of healthcare. Healthcare executives have been forced to become agents of the government, as they are responsible for compliance and for providing mandated services. If their institutions fall out of compliance or fail a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) audit, the hospital loses accreditation and becomes unable to bill Medicare for services. As an agent of government regulations, the healthcare executive comes, by necessity, into conflict with the physicians.

In addition to the dynamic tensions and adversarial interactions that might naturally occur between management and medicine, each has personal and professional frustration that they must vent. Both tend to focus on the nearest convenient target—those egotistical white coats or those bean-counting blue suits. (Amongst doctors, the single word *suits* is used derisively to refer to managers.)

How They Communicate

Providers of healthcare services are trained rigorously in the knowledge base, judgment, and technical skills necessary to be providers. In the past, physicians did

not receive training in communication or in cross-cultural relationships that could improve communication capabilities between medical people and management people. The only *process* that the providers see is their interaction with the patient, rather than a broader process of healthcare. If providers could master process skills, such as communication, team building, and conflict resolution, they could enlist, rather than fight with, their own managers.

Successful communication could improve care processes, change the work environment, and possibly regain the doctors' (lost) leadership role in patient care.[10] Unfortunately, each side tends to see a we-they, adversarial relationship, and they communicate on that basis.

REVIEW OF LITERATURE

Prior Data

While much has been written about medicine-management relations, there is surprisingly little hard data. The lack of such evidence allows people to make definitive and unqualified statements about relations between physicians and hospital executives. Nonetheless, useful insights can be gained from perusal of previous writings.

Most agree that a fundamental disparity exists in the minds of many clinicians about how healthcare managers view the world of medicine and its practitioners.[13-16] Physicians intimately know and relate to the passages doctors endure on their way to becoming licensed practitioners. They intuitively understand, respect, and trust other physicians, even those in management positions, because of sharing a common professional background. Having these career paths in common usually leads to fruitful interactions and philosophical understanding about care delivery issues and problem-resolution methodologies.

In contrast, practicing physicians and hospital CEOs seldom share the same education, professional career path experiences, or organizational perspective.[17] The two can have great difficulty in reaching an agreement about how care should be delivered and resources apportioned. As a result, communication breaks down, suspicion germinates, and a cultural gulf forms that is extremely difficult to bridge.

Recent Data

In an attempt to acquire accurate data about hospital management, we asked U.S. hospitals CEOs to describe: (1) the career path to CEO, (2) why they chose to become a hospital CEO,; and (3) what were their concerns for the future of U.S. healthcare.[18] Six hundred and seventy U.S. hospital CEOs responded to our survey, representing 16 percent of those to whom letters were sent. Eighty-eight percent of the respondents were men, which slightly underrepresented women.[17] The median number of in-patient hospital beds was 229 (mean = 147).

Career Path for CEOs

The educational background of hospital CEOs was highly varied. Ninety percent of the CEOs had advanced degrees (Figure 2.1) beyond bachelors. Seventy-nine percent (*n* = 529) held masters degrees in public health or health administration; business administration; the arts, the sciences or some other field. Nine percent had a second degree such as RN (registered nurse); a different additional masters degree; CPA (certified public accountant); and others. Nine percent (*n* = 63) had doctorates in medicine, philosophy, law, and others. Contrast this diversity to the highly structured, lock-step requirements to obtain an MD (doctor of medicine) degree, specialty, or subspecialty certification. Furthermore, though women are ascending the ladders of both medical and managerial senior positions,[19] still only 12 percent of hospital CEOs were women.
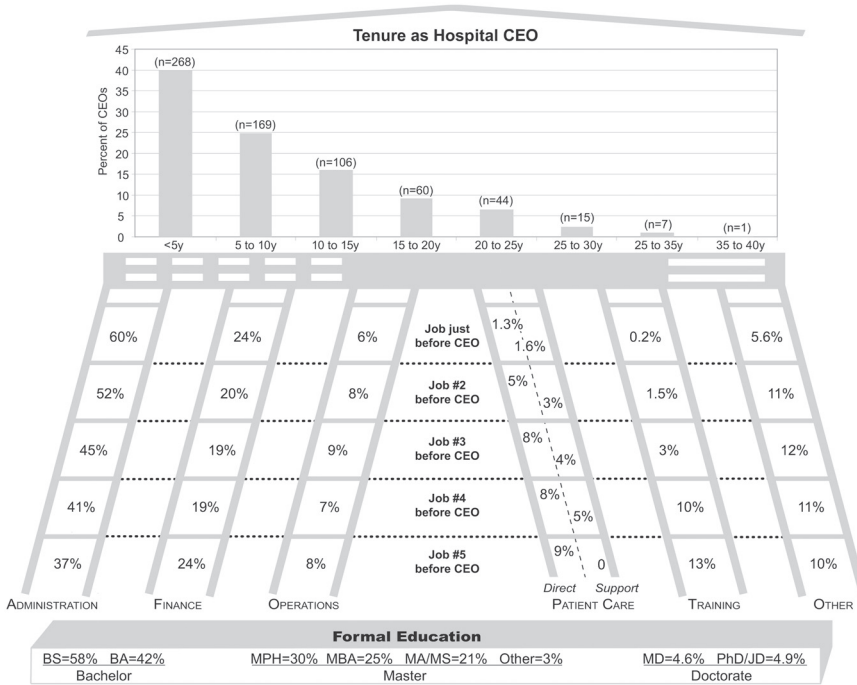
Work positions held by the respondents prior to becoming CEO were categorized as follows (Figure 2.1): administration (or management)—starting at 37 percent, but the number goes up 60 percent before becoming CEO; finance—24 percent; operations—8 percent to 6 percent; 9 percent started in patient care (direct or support), enrolled in formal training, and held other positions (e.g., marketing, human resources, development, consulting, legal, or information technology). Administration or management was the leading career path according to the respondents. Sixty percent of the respondents indicated they moved from an administrative or managerial position to the CEO position. In comparison, 24 percent of the respondents indicated moving from a finance position to CEO. The vast majority of prior jobs held by the respondents (regardless of activity) were in healthcare delivery rather than other occupations.[20] In contrast to many other industries, job crossover is uncommon in healthcare. This may be due to the highly specialized nature of healthcare administration, the contentious environment, the lesser income compared with other industries, or a self-selection process as people enter the workforce.

Tenure as CEO is also displayed in Figure 2.1. Forty percent had been CEO less than five years (*n* = 268) and 25 percent had been in the position 5 to 10 years. In contrast to corporations such as General Electric, only 67 hospital CEOs (10 percent) had been in place for 20 or more years.

CEO Concerns for the Future

The constant expansion of unfunded mandates was by far the most frequent concern voiced by CEOs. Their institutions are required by law to provide services for which they do not have the resources—financial, physical, and human. Seventy-seven percent specifically expressed concern about reimbursement and cost issues (financing), while 66 percent indicated that personnel shortages were their greatest concern. These results are highly comparable to prior survey results.[21,22] The consistency of CEO concerns clearly documents the determinants of stress that CEOs experience trying to meet expectations of their boards of trustees, medical staff members, accreditation bodies, and patients.

Figure 2.1 Ascending the Corporate Ladder to Hospital CEO

Tenure as Hospital CEO

Tenure	Percent bar label
<5y	(n=268)
5 to 10y	(n=169)
10 to 15y	(n=106)
15 to 20y	(n=60)
20 to 25y	(n=44)
25 to 30y	(n=15)
25 to 35y	(n=7)
35 to 40y	(n=1)

Percent of CEOs (y-axis: 0–45)

	Administration	Finance	Operations	Direct Patient Care	Support Patient Care	Training	Other
Job just before CEO	60%	24%	6%	1.3%	1.6%	0.2%	5.6%
Job #2 before CEO	52%	20%	8%	5%	3%	1.5%	11%
Job #3 before CEO	45%	19%	9%	8%	4%	3%	12%
Job #4 before CEO	41%	19%	7%	8%	5%	10%	11%
Job #5 before CEO	37%	24%	8%	9%	0	13%	10%

Formal Education

Bachelor	Master	Doctorate
BS=58% BA=42%	MPH=30% MBA=25% MA/MS=21% Other=3%	MD=4.6% PhD/JD=4.9%

Results are displayed from a survey of 670 U.S. hospital CEOs. College and postgraduate education are the foundation, followed by ladders representing work experience leading to the CEO position. Nine percent started as doctors or nurses. Increasing concentration is noted toward administration. The length of time the 670 CEOs had been CEO is shown in the bar graph.

One-third of the CEO respondents protested the lack of national health policies and inherent contradictions in the present system and similar large percentages criticized the ubiquitous unfunded government mandates, the plight of the uninsured or underinsured, and issues surrounding patient safety.[23,24] Other concerns voiced by the CEOs included loss of public confidence, insufficient capital to provide mandated services, keeping up with technological imperatives such as electronic records, the impact of malpractice insurance, and the need for tort reform. Eleven percent directly expressed concern over internecine competition between their hospital and its own attending doctors.

A striking feature of the CEO responses was that their concerns mirror the concerns of vocal clinicians.[10]

CEO Values

As part of our research, we asked CEOs of U.S. hospitals why they chose to become CEO. From the 670 responses, some very lengthy and passionate, we

could deduce a number of primary values. In Table 2.1, we offer a number of representative quotations made by the CEOs.

Thirty-one percent of the CEOs reported a primary focus on their own careers. Most then emphasized their desires to combine what they were good at with what would benefit society: in essence, a combination of a personal skill set and altruism. A separate group (26 percent) directly indicated altruism as their purpose in choosing a healthcare career. Thirteen percent stressed their desire to be in the healthcare field in contrast to the for-profit business world. Combining these three groups, one sees that altruism in various forms was a driving force in seventy percent of U.S. hospital CEOs.

Nineteen percent of the respondent CEOs indicated that the love of a challenge was the primary reason for their career choice; they liked the difficulty of combining good business with good medicine. As several wrote, their work was never boring. These people might be likened to the adrenalin junkies of medicine, such as heart or trauma surgeons and interventional cardiologists.

An interesting subgroup (6 percent) reported that hospital administration was a family tradition, crossing several generations, similar to the oft-touted, multigenerational physician families.

Table 2.1
Reasons for Becoming a Hospital CEO

Legend*: Gender; State; Number of hospital beds.* Quote follows beneath.

Male; Pennsylvania; 95
"It was a way to combine meeting the healthcare needs of people and my interest in business. On any given day, my busiest physicians might care for 10 inpatients—I care for all of them. I've been able to make a difference in the community by bringing technology, manpower, and a philosophy of care together to enhance a community resource."

Male; Indiana; 70
"There is simply no other job that gives you the challenge to run things fiscally sound, while doing our best to provide quality healthcare to our patients with a diverse and wonderful workforce dedicated to caring for patients."

Male; Indiana; 108
"I'm driven to succeed. I wanted to make greater contributions to society than being a clinician allowed."

Female, Washington, D.C.; 130
"Wanted to use financial and managerial skills in an environment that was socially responsible."

Female; Georgia; 78
"Because I wanted to influence decision making for patient care and maintain a patient advocacy role in the board room and at the bedside."

Male; Illinois; 163
"Father and older brother were physicians. Sister, a nurse. Thus had an interest in the medical field but did not desire to be a physician. Older brother recommended that I look into hospital administration. His words to me 41 years ago, 'Why don't you check out hospital administration, I think it's a good racquet.'"

Table 2.1

Reasons for Becoming a Hospital CEO *(continued)*

Male; Virginia; 153

"My mother was an RN working at the Medical College of Virginia and my father was a practic-
ing attorney. I intended to be an attorney like my dad, but my mom helped me get a part-time
job at the hospital after high school in medical records. The administrator overseeing medical
records who also taught in the graduate program took an interest in me and encouraged me
to pursue a masters in hospital administration and forget law school. It was good advice and I
have never regretted that decision."

Male; South Dakota; 86

"I had worked in a hospital as an orderly during early college, liked the field—helping people,
and so forth—but was not suited to be a physician as I was more skilled in numbers, statistics,
and working with groups rather than being autocratic, and not being a team member. Now
some of that has changed for physicians coming out of school as they hopefully see the need to
be team players, but in the 50s and 60s that was not the case."

Male; Ohio; 453

"This is one of the greatest jobs in this century. The opportunity to make a difference in the lives
of individuals and the greater community occurs every day! Ninety-nine days out of 100, I
can't wait to get to work. Many of my colleagues share this view."

Male; Tennessee; 219

"Didn't so much 'choose' what I'm doing as much as my passions led me here. I am a clinician
at heart, and I approach administration the same way I would treat a client/patient through
systems theory. This health system is like a great big (potentially) dysfunctional client/
patient/family system. Strategic planning is nothing more than creating, with the patient/
family involved, a detailed treatment plan with short-term, measurable objectives and long
term goals. Then you work with your client/patient within the context of all the overlap-
ping systems, including financial to achieve these goals. Concerns about money and the
cost of care, as well as reimbursement (or benefits), is as relevant for an individual who is
seeking treatment as it is for a large health system. I balance quality care/outcomes and fiscal
responsibility every day."

Female; Ohio; 651

"I love healthcare. It is a sacred trust to care for others. I also enjoy people and serving their ef-
forts to provide care. Finally, I feel that I am able to make a difference in the lives of those we
serve in the community."

Female, South Carolina; 106

"My background is in Nursing and operations of clinical areas. I progressed in my positions
above the staff nurse level to increase the voice of the caregiver. I accepted the CEO position
for the same reason—to see if a hospital could be successful with the priorities and point of
view of the physicians, nurses, and patients. Creating an environment to support the profes-
sionals caring for the patients instead of catering to the ego of an executive."

Male, North Carolina; 50

"I felt there were far too many MBAs running hospitals who have no understanding or appreciation
what occurs at the patient's bedside. Financial decisions often have serious clinical consequences,
and these folks either do not care or do not know how to adequately or successfully manage the
consequences to minimize negative patient care impact. I feel more clinician need to take the reigns
of the healthcare facilities to ensure that patients are truly getting the care they seek and deserve."

Male; West Virginia; 168

"Healthcare is a ministry; simply look at the work of Jesus! I take pride at using my busi-
ness skills to keep a hospital going strong as opposed to lining my own pockets. I am not
a clinician—I am a businessman—and a hospital requires many different types of people to

Table 2.1
Reasons for Becoming a Hospital CEO *(continued)*

be strong. Some CEOs want to think they are clinicians, and some clinicians thinks they are CEOs. The real truth is you can't be both, but both have equal merit and deserving of respect."

Male. Minnesota; 215

"Having begun life as a practicing pediatrician, then moving into academic medicine, I gradually became more interested in participating at a broader level in decisions and policy making. Never intended to go into hospital management, and was persuaded to take a VP position by a previous CEO/mentor who had never had physician on his executive team. Over the next decade, I handled most of the different portfolios, always learning on the job. Ended up COO, and one day was recruited as CEO at a different hospital. I never left any previous position because of dissatisfaction, only because of a new and exciting opportunity. Each phase of my life has been valuable and rewarding, and each new phase has built on skills acquired in the previous one. Being CEO of a large children's hospital system is, in my view, entirely consistent with the initial direction of my career as a pediatrician. However, now my decisions have the potential to have a much broader impact than when I was dealing with one patient at a time. (Probably more than you wanted to hear!)"

COMPARISON OF ATTRIBUTES

For physicians, educational background and licensure/accreditation require-ments are highly structured and provide common rites of passage for all doctors, nurses, and therapists. This creates bonds of cohesion among clinicians. Socialization during postgraduate training, particularly the role models of teachers, emphasizes personal responsibility, individual goal setting, and autonomous decision making. Physicians have little knowledge and less interest in rule-following bureaucracy, organizational structure, accounting, personnel management, or strategic planning (Table 2.2).[16,17,25]

Those in management have a very wide diversity of educational backgrounds and no set job accreditation or licensure process. Not only is this markedly different from doctors, but during socialization, managers learn to make group decisions and to delegate responsibility. In strategic planning, managers generally try to forecast and anticipate, while physicians are typically in reactive mode, responding to the acutely ill patient.

In theory, the two sides of the gap have different time horizons: short- or moderate-term for doctors and long-term for healthcare executives. However, most healthcare managers are now judged on the variance from their monthly or annual budget. Because of the incentive structures and the constantly changing mandates, as well as regulations, healthcare executives are forced to focus on im-mediate concerns and ad hoc crisis management.

Changes in healthcare over the past 50 years have had profound effects on the power relationships within medicine. The power and influence of healthcare executives has increased with corresponding fall in power and prestige of physicians. Nevertheless, each side sees itself as on the top of the power pyramid, that is, most important in the system. Doctors reason that, as the patient comes first and the phy-sician or nurse are the only people legally allowed to touch the patient, they must be

Table 2.2
Contrasting Medical and Management Attributes

	Attribute	Providers of direct care (Medicine)		Organizational decision-makers (Management)
1	Responsibility	Personally held		Oganizational; often delegated
2	Education	Structured. Uniform.	T	Unspecified. Highly varied.
3	How handle expertise?	Individually possess & use		Orchestrate. Facilitate.
			H	
4	Place in hierarchy?	On top [clinical]		On top [CEO]
5	Focus	Individual patient survival	E	Organizational survival
6	Focus of work	Individual patient		Patients in aggregate (market)
7	Time horizon	Short term		Long term
8	Gratification	Immediate and specific		Delayed or absent; diffuse.
9	Decision-making	Independent. Rapid	G	Group process. Deliberate
10	Strategic approach	Reactive		Anticipatory
11	Mgmt approach	Authoritative; act alone.	A	Collaborative, communal
12	Professionally accountable to:	Professional standards & peers, external to hospital	P	Hospital Board
13	Decisions impact:	Medical quality & resource use		Resource use & medical quality
14	Job defined by:	Accreditation, licensure		Job description
15	Healthcare changes caused a	Loss of power		Gain in power
16	Core Values	Altruism; Service; The Challenge		Altruism; Service; The Challenge

Mgmt=management.

on the top of the power hierarchy. In any situation involving strategic decisions and money issues, the healthcare executive is responsible. Since the ultimate decision maker is the hospital CEO, he or she must be at the top of the power hierarchy.

A real important, but subliminal, cognitive difference is the value of business. Academic physicians are socialized to disdain or at best ignore money, as everything should be done for the patient without regard to expense. Physicians in private practice have a similar problem to hospital executives: trying to balance escalating expenses with fixed revenues, while they have control over neither. The physicians' ethos places patient survival first, while for those in healthcare administration, the institution must survive by having the budget balance.

Despite the host of divergences between doctors and healthcare executives, we find that common core values—altruism, service, and the challenge—motivate both.[18]

RELATIONS BETWEEN PHYSICIANS AND HEALTHCARE EXECUTIVES DIRECTLY IMPACT OUTCOMES

Today's medical center is a complex, matrix-structured organization. The results of modern medicine are summation effects of the activities of large numbers of people in multiple teams. The "'one-ill, one-pill, one-bill doctor' is a thing of the past," wrote Wittkower and Stauble over 30 years ago. [26]

When my (JDW) 93-year-old mother goes for her semiannual checkup, her care involves a general physician, several office staffs, at least five computer programs,

central supply, patient transport, three separate laboratories, cardiology, radiology, and pulmonology, and she speaks perfect English. These diverse elements encompass function and expertise of both white coats and blue suits.

To the extent that medicine and management relate well, the patient gets what he or she needs. If physicians and hospital executives function independently (silo systems; minimal interaction), the care will be disjointed, less effective, and inefficient. If the providers and managers think and behave as adversaries, it is a wonder that anyone gets care at all.

Forces external to the medical center further complicate relations between doctors and healthcare executives. These elements include accreditation and licensure entities, insurers, advocacy groups, for-profit medical companies such as the pharmaceuticals, and of course, governments at state and federal levels, sometimes even other national governments. The rules, regulations, and laws must be interpreted and to variable extents implemented by both physicians and healthcare executives. If they are adversaries, each side will seek to game the system to individual advantage. The patient in many U.S. hospitals finds himself or herself in the middle of an internecine war.

STRUCTURAL ASPECTS OF PHYSICIAN-HOSPITAL CONFLICT

The Real Enemy Is the (Non) System

Reasons for physician-manager conflict can be viewed as structural, cultural, and perceptual. The cultural and perceptual reasons—how the two sides view and relate to each other—have been covered already. There are at least six structural reasons.

First, each stakeholder group—patients, providers, and payers—has expectations that are often unattainable or in conflict. Patients want all the care they want or need, when they want it and believe they are entitled. Providers behave as though there is no issue with resources, and payers want not to spend the country into bankruptcy. In a fixed reimbursement structure—, for-profit entities, whether hospitals or insurance companies, generate profits by avoiding or delaying payment for healthcare. Furthermore, the outcomes we track are the opposite of what we want. We measure death, complications and costs when we desire longevity, good health, and resource responsibility.

Second, the whole system of medical payments is bizarre. It pits the physician (the cost driver) against the hospital manager, and the consumer (patient) against the payer(s). In a previous article, we called this "Billing Schadenfreude,"[27] where medical payment structures subvert the *fiduciary relationship* (position of trust) that is supposed to exist between doctor and patient.

Third, as all behavior is strongly influenced by incentives, what is the incentive system under which the physician and the healthcare executive must operate? Based on the confused, ill-defined, and contradictory expectations, both doctors and managers work in a world of conflicting carrots and sticks that has made them "accidental adversaries," as described in systems thinking.[28,29] George Bernard

Shaw, directly addressing the issue of financial incentives and profit-generating self-referral, wrote in his own inimitable way: "As to the honor and conscience of doctors, they have as much as any other class of men, no more and no less. But what other men dare pretend to be impartial where they have a strong pecuniary interest on one side?" and "That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity."[30]

Fourth, healthcare organizational structures and management philosophies are holdovers from the nineteenth century—but healthcare workers care for patients in the twenty-first century. The power shifts that have occurred are in conflict with the desired outcomes as decision makers are given multiple, dichotomous mandates and are expected to achieve the impossible.

Fifth, while the external environment expects definitive answers to medical problems, it provides punishment for bad outcomes without corresponding positive incentives for improvement. Therefore, healthcare has become highly risk averse, which translates to defensive and dedicated to the status quo. If every incentive punishes risk taking and rewards stability, learning will be suppressed.[31] The environment—in theory, the marketplace—seeks to reward efficiency, but places a huge regulatory and bureaucratic, uncompensated burden on the healthcare industry.

Sixth and final, there is the unique nature of healthcare. It is a people-processing activity performed by people. A lug nut doesn't complain if you overtighten it. An overstuffed chair does not expect you to reduce its puffiness with a pill.

The primary cause of physician-healthcare executive conflict—the real enemy— is the healthcare system, which is not systematic and offers ~~contradictory~~ stakeholder contradictions, perverse incentives, microeconomic disconnection, punitive medico-legal environment, and overregulation.[32,33]

Collaboration Is the Beginning

Russell Ackoff[34] makes an important distinction when he contrasts *resolving* a problem (making the best possible result) with *dissolving* a problem (changing the system so that the problem can never recur). We believe that collaboration between medical schools and management schools can begin to dissolve healthcare woes.

Management knowledge and expertise, and business experience and tools have much to offer healthcare. We and others have demonstrated the potential utility of proven management principles in the healthcare arena.[35–37] In collaboration, a medical school and a management school can begin to achieve high-quality, reduced-error, resource-sensitive healthcare. However, we also have noted with concern that most universities lack any bridge—physical, philosophical, cognitive—across what we call the chasm (Figure 2.2) separating medical schools from their university-affiliated management schools.

We believe that an analogous and equally unhealthy separation exists *within* most medical centers between the providers and the managers. We call this schism the Gap (Figure 2.3).

Figure 2.2 The Chasm

What Is the Gap?

The gap represents a gulf, both substantive and perceived, between managers and care providers. The gap includes differences in thinking and approach, priorities and incentives, and responsibilities as well as roles. Most of the substantive distinctions are due to divergent educational backgrounds, temperament and self-selection, radically different professional socialization, alternate worldviews, and specific expertise.

Figure 2.3 The Gap
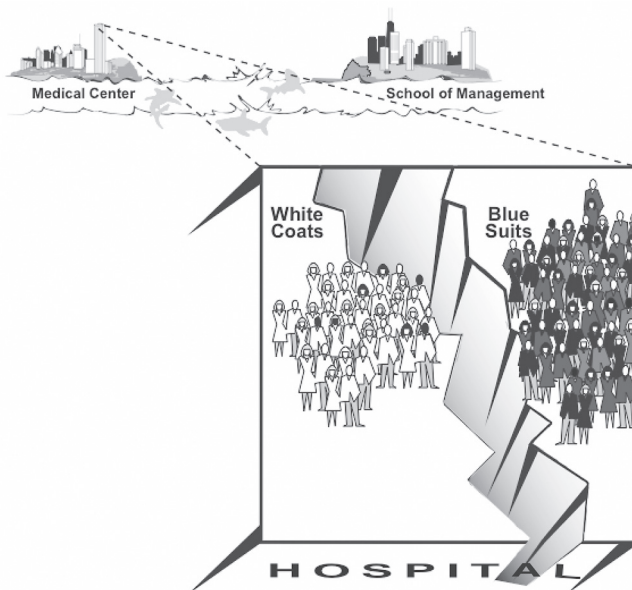
Most hospitals have a cultural and functional separation between direct care providers (white coats) and hospital administrators or executives (blue suits). The Gap prevents effective interactions.

The two sides also tend to have stereotypical and negative perceptions of each other. The manager sees a doctor who has no understanding of or interest in resource constraints or proper organizational behavior, even if the doctor has an MBA and manages a successful multimillion dollar division. The doctor sees a heartless bean counter who cares nothing for patients, despite the CEO spending seven hours before a state oversight committee aggressively seeking support for the doctors' medical programs. For example, scotoma is common in healthcare. It is the Italian word meaning that we see what we expect, and not necessarily what is there. This is true for both doctor and manager, and clouds what could become a fruitful collaboration.

Table 2.2 offers both the reasons for the gap and, based on recent data, what can be used to mend it. Physicians and CEOs (representing healthcare executives) share common core values. We suspect this similarity may surprise both sides of the gap. Such basic, gut-level commonality can provide the structural supports to bridge the gap.

MENDING (ACTUALLY, BRIDGING) THE GAP

In trying to understand physician hospital relations, we begin by explicating who they are, what their attributes are, and end suggesting that we mend or actually bridge the gap (Figure 2.4). The differences between physicians and healthcare executives can be used to great advantage. We need to embrace this diversity rather than eliminate it. Combining the diverse talents of physicians and healthcare executives could dissolve (per Ackoff[32]) many of the problems healthcare faces every day.

Conflict is inevitable in times of rapid change.[4] Physicians and hospital leaders can no longer pass on cost increases at will to patients and third-party payers. Effective dialogue and collaboration are in all parties' interests to optimize patient

Figure 2.4 Mending (Bridging) the Gap

care and to develop innovative services. To improve the practice environment for physicians and patients and to keep hospitals financially solvent so that they can continue to serve the public good, physicians and hospital management must learn to work more interdependently.

At the local level, improved physician-management interaction may not immediately improve pricing power, but it could enhance efficiency and thus improve competitive position. Perhaps the greatest long-term value of improving physician-management communication lies in developing shared perspectives that enhance mutual respect and build trust. Because physicians collectively influence hospital revenue, clinical costs, quality, and safety issues, having practicing physicians involved in a meaningful way in a hospital priority setting may provide competitive advantage and improve quality.[38]

Systems Thinking and Thinking Systems

General systems theory, complexity science, systems thinking, systems analysis or dynamics are names given to a school of thought initiated by Ludwig Bertanalanffy in the mid twentieth century, subsequently expanded and modified by others.[39–46] Its essence is the concept that all systems—biologic, mechanical, chemical, social—produce outcomes by the interactions of the parts, not by the parts in isolation, and that all systems are functionally subsystems of larger systems. Thus, the heart is part of the body; the body is a person that is part of a social group such as a hospital staff; the hospital functions within and for a community; healthcare is merely one of the systems within the community in addition to education, commerce, emergency services, and so on; the community is part of a nation state; the nations share a planet; the planet is part of the solar system. Thus, the heart is a tiny sub-sub-subsystem of the solar system.

Practical consequences flow from the general concept of interaction and causal loop relationships.[28] For example, study of and optimization of the function of a part of a system in isolation often does not improve overall system results and may actually degrade the system's output.[34,43] Consider a healthcare example. Improving the efficiency of the OR and balancing its budget may reduce patient throughput and cost more for the hospital than the savings in the OR.[46]

Systems dynamics describes what are called complex adaptive systems, which have three distinct characteristics. They *self-organize*, meaning that whatever organization may be imposed from the outside (or not), complex adaptive systems develop their own internal organizational structures and means of interaction. Such systems *coevolve*, so that they are changed by their own interactions. The results from systems that self-organize and coevolve *emerge*; they cannot be precisely predicted in advance.[42]

Thinking systems exhibit the three characteristics of complex adaptive systems—self-organization, coevolution, and emergence—but have two additional unique features: the ability to structure their own learning and goals different from and sometimes inconsistent with personal survival.[46] Healthcare is a paradigm of a thinking system.

Several authors have recommended the use of systems thinking and complexity science to healthcare.[10,45,47] The Pittsburgh Regional Healthcare Initiative is actively applying systems thinking to various medical centers.[48] We concur strongly, but add that the unique nature of thinking systems must be incorporated into any application to healthcare. With physicians and healthcare executives working together rather than at cross-purposes, healthcare institutions can improve their outcomes based on their own initiatives by applying systems thinking. The exact results cannot be predicted in advance, nor should they be. In order to achieve such a to-be-desired collegial relationship, doctors and executives need to communicate more effectively.

Skills in Communication and Confrontation

Clinical training alone is insufficient to ensure quality patient care. Communication is a critical element in providing care, and physicians are not trained to communicate well. Their authoritarian style and limited listening skills hamper clear exchange of information. Healthcare professionals can improve their communication by utilizing the skills summarized below.[49]

Communication[10]

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Active Listening. Like so many everyday, every minute activities, listening is considered a skill that everyone has. After all, we listen all the time—to the radio, to our children, to the people in the next office, and to the passing air stream as we drive the car. Listening is not something we all automatically do well, but is particularly important because it makes people feel that their concerns matter. A mnemonic for improving listening skills is CLOSE:

- *C*oncentrate on the speaker, maintaining comfortable eye contact for 6 to 10 seconds at a time without staring, giving the person the feeling that nothing else matters but what the speaker is saying.
- *L*isten with multiple senses, paying attention to the speaker's body language, facial expression, and tone of voice, in addition to the content of the message.
- *O*pen one's stance to convey receptivity to the speaker's message; avoid crossing one's arms over one's chest, which imposes a barrier between the speaker and listener.
- *S*uspend judgment to maintain objectivity.
- *E*mpathize, trying to put oneself in the speaker's frame of reference with summary comments such as, "Do I understand you to say . . ." to build trust and credibility.

Checklists. A formal written checklist is highly useful to surface assumptions and discuss expectations proactively. At the beginning of a group

project, a checklist helps people to adopt a common wavelength, to learn to welcome diversity of opinion, and to minimize feelings of disappointment, betrayal, and anger. Checklists will vary based on the nature of the project and the backgrounds of the participants, but common features include:

- punctual attendance and starting on time;
- active participation;
- building on others' ideas;
- avoiding personal attacks;
- developing win-win solutions;
- respecting members' confidentiality;
- monitoring progress at regular intervals; and
- sharing ownership of results.

Sensitivity and Empathy. As discussed in the previous case report and the physician-administrator exchanges, highly charged words can contribute to an us versus them, adversarial atmosphere and thereby interfere with successful communication. Listening with sensitivity and avoiding hot button words or phrases improves our listening and others' hearing. Saying, "Maybe there is another way to view this," is better than, "I disagree," because the latter creates a you versus me construct. Focusing on costs rather than benefits immediately after someone makes a suggestion often narrows the discussion focus and impedes collaboration.

Confrontation Skills

Differences in strategy and responses to the environment are inevitable in times of rapid change.[49] Therefore, to communicate well and collaborate, professionals need confrontational and conflict resolution skills. As Grenny wrote, "We can either talk out or act out our differences; the choice is ours."[50] Having the same frustrating conversation repeatedly may reflect the lack of confrontation skills, in which the focus is on content the first time, on the pattern of events the second time, and on issues of competence, respect, trust, and loss of confidence in a relationship the third time. Patterson et al.[51] wrote that to avoid the fundamental attribution error, people need to ask questions and obtain information rather than assuming hidden and evil motives. Other causes for failure to meet expectations involve ability, training, and social and structural incentives. To influence others' behavior, we must start from a position of safety and security, maintaining respect, establishing mutual purpose, and ending with a question rather than a threat. In the process of discovery, skeptics can become believers and act more like long-term partners and owners rather than short-term renters, as illustrated in the following.

Structured Dialogue. Structured dialogue is a process that helps a group of practicing physicians articulate their collective, patient-centered

self-interest. For example, structured dialogue can help physicians improve physician-physician communication, understand more fully the complexity of hospital operations, and articulate clinical priorities for their communities.[52] Structured dialogue can improve both physician-physician communication and physician-administrator communication.[38]

Unlike hospital-centric change efforts, the structured dialogue process is led by a medical advisory panel of high-performing, well-respected clinicians, who review and recommend clinical priorities based on presentations by the major clinical sections and departments. Contrary to the apprehensions of some hospital executives, the recommendations generally include performance improvements and minor expenditures that support these improvements, rather than a list of capital-intensive budget items. In return for giving physicians a say in clinical priority setting, the hospital is able to enlist physicians to attend meetings and outline their priorities.

Over 30 hospitals of varying sizes and locations in the United States have successfully undertaken a structured dialogue process, which has improved the practice environment, reenergized physician-physician and physician-hospital communication and collaboration, and has served as an effective training environment for new physician leaders. What has surprised one author (KHC) is the extent to which a process that improves hospital executives' standing with their physicians and board engenders suspicion and mistrust on the part of administrators. A Western CEO, considering using the structured dialogue approach at his hospital, when asked by his board chair if losing control to physicians upset him, replied, "Heck no. I never had control in the first place!" (A surprising commonality found in our 2006 study[18] was the sense of powerlessness felt by many U.S. hospital CEOs.) The Western CEO decided to use the structured dialogue approach and has since been a speaker at national seminars about the value of physician engagement. Healthcare professionals need to understand that control is illusory[53] and the only control we have is over our own response to our helplessness in the face of rapid change.

We can also build on what is going well. Rather than complaining and blaming, we can focus on what is going right and build on success, as described below.

Appreciative Inquiry. Appreciative inquiry (AI) is a technique that focuses on building on success. Practical applications of AI in healthcare settings include[54]:

- Making rounds with front-line workers, asking:

  - "What is going particularly well for you?"
  - "Do you have the tools and resources that you need?"
  - "What can I do to help you?"

- Asking affirming questions during performance appraisals and following up with thank-you notes in response to the question:

  - "Do you have colleagues or coworkers who have been particularly helpful?"

AI is based on the premises that people respond favorably to positive reinforcement and that sharing stories of past successes generates more energy and less defensiveness than analyzing problems and attributing blame. Storytelling, which is an integral part of AI, decreases the inhibiting effects of hierarchy on sharing knowledge, uses metaphors to summarize important points and make them vivid, and provides vignettes that are remembered more readily than facts.[55] Healthcare professionals may not feel comfortable using AI, incorrectly perceiving it to condone poor performance rather than as an alternative to consider when problem solving hits a wall because of defensiveness. Work at the Baptist Hospital has made AI easier to operationalize, such as rounding on wards, rewarding positive behavior, and being more proactive and receptive to improvement opportunities.[56,57] Another important development involves bottom-up efforts that change the culture, as described below.

Positive Deviance. Positive deviance (PD) is an approach to organizational change based on the premise that solutions to problems already exist within the community. It encompasses intentional behaviors that depart from the norms of a group in honorable ways.[58] PD seeks to identify and optimize existing resources to solve problems rather than using the more conventional identification of needs and obtaining of external resources to meet those needs.

For example, healthcare workers at Waterbury Hospital used the PD method to analyze and resolve problems in communication at discharge. Miscommunications over discharge medications were responsible for an average of two readmissions per month. By observing the steps physicians and nurses used in discharging patients, a process was created that prevented the miscues. To follow up, a nurse called the patient within 48 hours of discharge to review discharge medications.[49]

Keys to the PD method include[59]:

- Self-identification as a community by members of the community; people see themselves as alike rather than conflicting
- Mutual designation of a problem by the community members, that is, a bottom-up rather than a top-down approach
- A search for community members on the leading edge who have managed to surmount a problem
- Analysis of meritorious behaviors that enable outliers (positive deviants) to achieve success
- Introduction and adoption of new behaviors into group practice

PD appears to work by unfreezing commonly held perceptions without threatening people. It hastens the transition from early adopter to early majority by creating a safe environment for learning that does not make anyone feel stupid. It is based on adult-learning principles of learning by doing and mentoring. Finally, it avoids the transplant rejection approach to best practices adopted from other institutions because it celebrates the accomplishments of local heroes with whom insiders can relate.[60]

Financial Confrontation or Collaboration

Berenson et al.[61] recently wrote that economic pressures have greatly exacerbated the potential for physician-hospital conflict in many areas of the country. According to their survey of 1,008 healthcare leaders, relations were under greater strain in 2005 compared with 2000 to 2001. They cited selective employment and financial collaboration as two strategies that have been used in response to an ever-changing economic environment.

Several U.S. states prohibit physician employment by hospitals based on the fear of conflicts of interest or, worse, collusion. Other states allow such employment. All jurisdictions accept a variety of medical school–hospital financial arrangements. Berenson and colleagues report on the increasing fears of private practice physicians that *their* hospitals are competing with them by selective employment or, worse, exclusionary methods such as economic credentialing to prevent physicians who compete with the hospital-employed physicians from practicing within the hospital. We will focus below on opportunities for collaboration.

The goal of physician-hospital financial collaboration should be to create value for patients, physicians, and hospital. Collaboration implies win-win-win scenarios that enlarge the economic pie rather than divide a predetermined, insufficient, and contracting pot of money. Both parties gain if physicians act as owners rather than clients, increasing revenue and collaborating on ways to improve processes and outcomes.

Regardless of how deals are structured,[62] successful financial collaboration between physicians and hospitals requires[63]:

- mutual understanding of each party's interests and needs;
- sharing information widely;
- distinguishing negotiating from thinking aloud;
- stepwise building of transparency and trust; and
- both sides acting as a team of active owners rather than as individual, passive investors, jointly improving care processes in an ongoing fashion.

Dealing with Physician-Hospital Competition[64]

We doubt that physicians and hospital leaders were ever in alignment. A difference now, however, is that neither party can pass on increases in costs independently of the other as was the case in the era of cost-based reimbursement.

Like it or not, they are bound together in a complex web of interdependence. We offer a three-part strategy of proactivity, collaborative conflict (not an oxymoron), and containment as a guide for dealing with physician-hospital competition. With the difficulty of predicting how events will unfold, we empathize that both sides must begin to respect and trust the other or healthcare will never break out of the current cycle of conflict. Both parties can actually become stronger by loosening individual control.

> *Proactivity*. It may seem counterintuitive for hospital leaders to take the lead in partnering with their highest revenue generating physicians, but a proactive approach minimizes the opportunity for turnkey operators to create unrealistic expectations among physicians looking for greater efficiency and reimbursement. In turn, a more content medical staff can help the hospital and the community by increasing revenues, decreasing the costs of clinical care, and improving outcomes.
>
> *Collaborative Conflict*. In collaborative conflict, people attack problems rather than one another. They solve problems in a way that satisfies both parties and builds long-term relationships. Success depends on each party's preparation and their understanding of what each wants and needs to accomplish, what each is willing to concede, and what hot buttons might cause an angry response.
>
> *Containment*. When negotiations break down, the prior effort that went into them was not wasted. Both parties have learned more about each other and about areas of mutual interest. It is important to depersonalize potential conflicts by agreeing to revisit the issues in the next two to three months rather than assigning blame and walking away. Discussions may be more favorable after each side learns more about the costs and possible consequences of continuing physician-hospital competition.

RECOMMENDATIONS

In computer terms, both physicians and healthcare executives should delete their files containing stereotypical images of each other. They need to learn who the other really is and accept the fact that they have similar core values: altruism, service, and love of a challenge. As suggested before, this can provide the foundation for a bridge across the Gap.

Malcolm and colleagues[65] use the same term—gap—to describe the separation between clinical culture and governance or managerial culture. They believe that New Zealand is seeking a convergence of cultures, meaning two fundamental changes are in store: (1) "A shift from preoccupation with resource management to health outcomes as the 'bottom line' of the organization"; and (2) "Acceptance by clinicians of a key role in managing resources and in achieving the organization's goals." Malcolm et al. then foreshadow what we advocate here by writing that the converging cultures need a "more trusting relationship based on . . . shared values." As our data show, physicians and healthcare executives *have* shared values

and core ideals in common. They act, however, as though they have irreconcilable differences.

We would prefer avoiding military analogies in healthcare. However, we must recognize that there is a mindless, unintended but real and *very* powerful enemy of what we all want: high quality, compassionate, and efficient healthcare. It is a system that does not work. Hospital management and doctors must become allies, brothers-in-arms. The patients are noncombatants and insurance companies are the accidental adversaries of both patients and hospitals.[28] If goals were clearly defined and outcomes tracked by appropriate measures, incentives could be aligned with desired results. The relationships between patients and providers or hospitals and payers would not be win-lose scenarios and the so-called enemy would cease to exist. One phrase mentioned in Malcolm's opinion piece[65] was crossing over to the "other side." When the cultures converge and a trusting relationship of colleagues develops, there will not be two sides, just one team with members having different talents and responsibilities. Continuing the military analogy, an effective army does not have the infantry and artillery think of each other as being on opposite sides.

Physicians and managers need to learn about and learn from each other. If they do so, their differences can become strengths. Physicians need to educate executives about research and rigorous science so that managerial decisions can be based on proof rather than just logic. Healthcare executives need to educate doctors about proper management, from financial planning to proven error-reduction techniques and application of queuing theory, namely, in the ER. There are dozens of powerful and applicable business-proven management tools and approaches that can be adapted to healthcare. While we mention (above) some useful techniques such as structured dialogue and positive deviance, others with great potential include continuous quality improvement,[66] learning curve theory,[31,37] total quality management,[67] the theory of constraints,[68] failure mode and effect analysis,[69] the internal customer concept,[70,71] generative relationships,[72] lean systems,[73] and possibly most important, systems thinking.[28,34,39–47,74]

Together, physicians and healthcare executives can accomplish most of their goals-in-common. If they continue the present adversarial relationship, nothing will improve. What Benjamin Franklin said about revolutionary politics is equally true for the revolution needed in healthcare: "We must hang together, gentlemen … else we shall most assuredly hang separately."[75]

Key Concepts

- Over the past 50 years, the functions of healthcare institutions and the people within them have changed dramatically. The system for healthcare delivery has not experienced corresponding changes or adjustments.
- Both physicians and healthcare executives are frustrated by the confusion, systemic contradictions, perverse incentives, and opposing priorities of the stakeholders in healthcare. They tend to behave like adversaries, competitors, and even combatants.

- An adversarial relationship between physicians and healthcare executives negatively impacts both clinical as well as financial outcomes.
- Numerous differences exist between physicians and hospital executives in education, background, socialization, and work experiences. However, they share striking similarities in core values and future concerns. Neither side behaves as though it is aware of the commonalities.
- Physicians and hospitals executives have a common enemy: the system, or really, the absence of a functional system.
- The core values that physicians and hospital executives share could provide a foundation for developing a collegial relationship. Each has important skills and knowledge that the other needs. Working in collaboration, together they could solve many of the challenging problems in modern healthcare.

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