Healthcare Leadership

Guiding the Organization through Transformational Change

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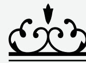

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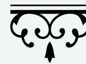

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Executive Summary

Economics, changing expectations, advancing technology, and the accelerating pace of change are transforming the healthcare industry. Insurance reform seeks to expand access to care. The progressively increasing cost of healthcare services threatens to bankrupt states and adds to the national debt. The Medicare program is approaching insolvency. While the U.S. spends more money per capita on healthcare than any other country, metrics that assess the overall health of its citizens question whether or not the benefits justify the cost. Concerns for patient safety, variability in the application of evidence-based medicine, public transparency related to the outcomes of medical care and the frequency of complications, and a growing emphasis on how patients perceive service satisfaction are all challenging the historical status quo.

ALL OF THE ABOVE FORCES ARE FUELING AN emphasis on payment reform. The current system—one that economically rewards volume of medical procedures—misaligns the provider community, places the payer and the provider of services in conflict, and progressively escalates healthcare costs. Fundamentally, under this fee-for-service system, the more you do, the more you make. Demonstration projects are seeking to bundle payments to reward value and not volume. The bundling of payments is an attempt to align the provider community, coordinate care, penalize inefficient and ineffective care, and place an emphasis on managing health and wellness, disease management, and case management. As a result, relationships within the healthcare community are significantly changing.

These new relationships require a new style of leadership to help move the provider community into an era of providing value rather than producing volume. There is a great need to effect leadership from three essential segments of the provider community: governance, administration, and physicians.

Barriers to Change

The primary barriers to the ability of healthcare organizations to adapt to the rapidly changing healthcare marketplace are organizational structure, generational differences in attitudes among the workforce, and language and ethical differences between those in governance/administration and clinicians.

The hospital/health system organizational chart remains traditionally top-down. Knowledge, power, and authority are concentrated at the top. Orders move down while information moves up. While this form of organizational structure serves well in stable times, it is an absolute hindrance in times requiring transformational change. When the future is unknowable, adaptability is the key to sustainability. Keys for success in an adaptability framework include an emphasis on horizontal rather than vertical structures, and real-time access to data and feedback. Investing in the adaptability of the organization's human capital is paramount.

The physician community is currently comprised of three generations. The oldest of these, the traditionalists, are individuals for whom being a physician is a vocational activity. Baby Boomer physicians, like the traditionalists, are working all the time. Generation X physicians possess a very different value hierarchy. Managing time and a balanced life are highly important. Gen X physicians tend to seek the economic security of employment and to have a preference for shift work. Older and younger physicians have great difficulty communicating with each other.

Generational differences are a significant challenge to physician leadership. It is important to stop viewing the differences as an either/or issue or a problem to be resolved, and begin seeing it as a polarity—a both/and issue to be managed by identifying common ground that can unify effort. Focusing on the patient has always been the unifying force.

Non-physician directors and administrators speak the language of business. Issues are framed through a business perspective, using business metrics to assess success. Clinicians, on the other hand, speak the language of clinical medicine. Issues are framed through the perspective of clinical outcomes, and success is defined in clinical terms. Often, board members and administrators understand business, but they do not understand *the* business. Clinicians understand *the* business, but not *business*. These perspectives are complementary; they are certainly additive and potentially synergistic. In the evolving world of pay-for-performance, each of these perspectives requires the other to achieve sustainable success.

In addition, there is an ethical divide that exists between physicians and non-physicians in governance and administration. Physicians have an ethical imperative to serve as the patient's

advocate (apostrophe-s). Directors and administrators, on the other hand, have an ethical responsibility to serve as the patients' advocate (s-apostrophe).[1] Each of these perspectives is attended by an equally valid but a totally separate set of ethics. It is important to appreciate that no one can simultaneously serve both.

Transformational Leadership

As the healthcare industry transforms and relationships enter a new phase, there is a great need for leadership among all the stakeholder groups to overcome barriers to change. Governance, administration, and physicians must move rapidly along the journey toward integration of purpose.

The Leadership of the Board

As healthcare moves from payment for volume to payment for value, what is the role of the board in leading this transition? *The* business is most often experienced by board members indirectly as the board acts in service of the community to promote and defend the organization's mission, vision, and values. The board must be able to articulate the vision down to all levels of the organization, while building relationships and inspiring movement toward this vision of the future. When the discussion shifts to people and relationships and becomes future directed, in consideration of intangible aspects, the board is getting into the important, generative discussions that will help steer the organization toward change. This requires transformational leadership from the board.

The board can begin by focusing on ways to develop stronger relationships with physicians—have more direct conversations about values and vision, and how those affect the patient experience and quality of care. Does the organizational culture reflect values and vision? Involve physicians in identifying and prioritizing those values to help shape the culture. Develop the board's relationship with the CEO by setting clear expectations up front that align with the organization's mission, vision, and values, and have the CEO help articulate and maintain the mission, vision, and values throughout the organization. Indeed, if the future is in fact unknowable, adaptability rests on the invisible guiding hand of the organization's culture.

The Leadership of Administration

Administration has the primary responsibility for promoting, supporting, and managing change. A world changing exponentially demands that leaders serve as agents of change. Failure to position the organization for future success causes the organization to suffer a slow death. Conversely, serving as a change agent and attempting to position the organization for where it needs to be to achieve sustainable excellence frequently results in the "death" of the leader. Individuals respond to those who seek to shift the dominant paradigm in a series of sequential steps. The initial response is one of criticism and ridicule. If that fails to stop the change, the next step is to marginalize the individual. If that fails, the final step is to shun or remove the individual from the group. Thus, creating change is extremely difficult and, above all else, takes courage.

A major responsibility of administrative leadership is to work with the board to prioritize organizational values. In this context, "values" refer to those initiatives to which the organization will preferentially devote its resources. It comes to life in the setting of organizational goals based on the strategic plan.

In order to change organizational structure and redesign care delivery, the management team must have the ability to communicate effectively and to influence the motivation of the workforce. Offering opportunities for dialogue and prioritizing organizational values are two essential administrative functions for creating an environment of creativity and adaptability.

The Leadership of Physicians

Physicians, who have traditionally focused solely on the effectiveness of the care provided, are now required to also be responsible for the cost of creating that outcome, including the quality of the patient experience and the appropriateness of the application of diagnostic and therapeutic interventions. Bundling payment across specialties, locations, and time further challenges the historic status quo. This creates a need for transformational leadership, with balanced authority and accountability from each leadership group: the board, management, and physician leaders.

The Journey from "I" to "We" to "Us": Transforming Culture with Physician Leadership

The need to integrate the provider community in order to achieve balanced accountability in an industry seeking to pay for value and not volume requires integrating physicians into the fabric of the healthcare organization. It is no less challenging for the culture of the healthcare organization to incorporate physicians into leadership and management roles. As the source of capital, the board and administration feel it is their right to control operations. For the physician, clinical work cannot be dictated by businesspersons ignorant of the processes of clinical decision making.

How do these cultures assimilate? Where are the divides and how are they bridged? The answers lie in acceptance of a responsibility for creating balanced accountability, and in a commitment to teamwork that spans domains, time, and location.

The challenge of physician leaders today is the need to move their colleagues from town hall democracy to representational democracy, to transform the primacy of individual autonomy into a collective identity, and ultimately to overcome physician distrust of the healthcare organization into a fusion of

1 This concept was created by David M. Eddy, M.D., Ph.D., founder and medical director of Archimedes, a healthcare modeling company located in San Francisco, CA.

interdependent skill sets. This represents a journey from "I" to "we" to "us." Metaphorically, physicians need to change the way they view the healthcare organization, moving from a hotel where they electively rent space, to a condominium where they acknowledge a set of shared covenants while remaining independent, to a collective where they live together in pursuit of a shared ideal.

It's All About the Intangibles

Today most healthcare leaders focus on the tangible aspects of the enterprise. Managing money dominates conversations, focuses attention, and determines priorities. Managing people is far less valued. The phrase, "no margin, no mission" presents justification for this distortion. However, people don't work for money. The essence of the human condition is the need to matter.[2] Daniel Pink has confirmed that the primary motivations for those who perform heuristic work are autonomy, mastery, and purpose.[3] He, and many other authors, document how extrinsic rewards (i.e., money) actually erode both the quality and the quantity of the work they are intended to influence. Individual rewards contingent on performance become entitlements and erode teamwork.

Transformational leaders will seek to refocus work and shift traditional paradigms. For the transformational leader, the pain of unfulfilled potential far outweighs the personal cost of seeking change.

Discussion Questions for Board Members

1. What are some of the barriers to change confronting healthcare organizations as they embark on the journey from volume to value?
2. How is our organization preparing for payment reform and the redesign of care delivery?
3. What will be required from the board to help the organization succeed through this transition?
4. What will be required from administration to help the organization succeed through this transition?
5. What will be required from physician leaders to help the organization succeed through this transition?
6. Do we have the physician leaders required to go from volume to value? If not, what steps should we take to identify physician leaders and integrate them into the framework of the organization?
7. Do we have the relationships with physicians and nurses necessary to go from volume to value? If not, what steps should we take to build these relationships?
8. What expectations should we set for our physicians and nurses during this transition? How can we hold them accountable to those expectations?
9. What expectations should the physicians and management have for the board? How can the board be held accountable?

2 Viktor Frankl, *Man's Search for Meaning* (Pocket Books, 1984).
3 Daniel Pink, *Drive: The Surprising Truth About What Motivates Us* (Penguin Group, 2011).

Introduction

Economics, changing expectations, advancing technology, and the accelerating pace of change are transforming the healthcare industry. Insurance reform seeks to expand access to care. The progressively increasing cost of healthcare services threatens to bankrupt states and adds to the national debt.

THE MEDICARE PROGRAM IS APPROACHING INSOLVENCY. While the U.S. spends more money per capita on healthcare than any other country, metrics that assess the overall health of its citizens question whether or not the benefits justify the cost. Employers who must compete globally can no longer underwrite the cost of healthcare benefits that undergo double-digit increases each year. Many are either no longer offering healthcare benefits or moving toward defined contribution plans. Individual co-pays and deductibles are increasing yearly in order to keep premiums affordable.

Concerns for patient safety, variability in the application of evidence-based medicine, public transparency related to the outcomes of medical care and the frequency of complications, and a growing emphasis on how patients perceive service satisfaction are all challenging the historical status quo.

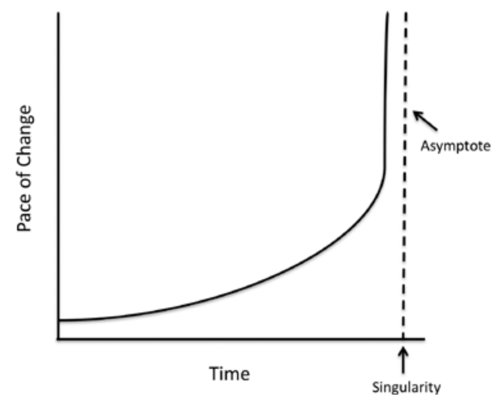
All of the above forces are fueling an emphasis on payment reform. The current system—one that economically rewards volume of medical procedures—misaligns the provider community, places the payer and the provider of services in conflict, and progressively escalates healthcare costs. Fundamentally, under this fee-for-service system, the more you do, the more you make. Demonstration projects are seeking to bundle payments to reward value and not volume. The bundling of payments is an attempt to align the provider community, coordinate care, penalize inefficient and ineffective care, and place an emphasis on managing health and wellness, disease management, and case management. As a result, relationships within the healthcare community are significantly changing.

The pace of change in our society is progressing exponentially.[4] If you plot the pace of change against the passage of time, the result is an asymptotic curve (see **Exhibit 1**). That curve resembles a hockey stick that is positioned with the blade pointing upwards. The point at which the curve points vertically is called the point of singularity. It is estimated that the point of singularity will be reached no later than the year 2050. At that point it will be impossible to recognize change because there will be no space of time in between change. Change will be pervasive. In a world changing exponentially, the future is not only unpredictable—it is in fact unknowable.

A world changing exponentially and rapidly approaching the point of singularity requires transformational leadership. In an often-told story about Wayne Gretzky, a reporter asked Gretzky how it was that he scored more goals than any other hockey player. He is said to have replied, "It is because I skate to where the puck is *going* to be (not to where the puck is, and certainly not to where the puck was)." Transformational leadership is the equivalent of positioning your organization where the puck is going to be. It demands that leaders serve as agents of change.

These new relationships require a new style of leadership to help move the provider community into an era of providing value rather than producing volume. This white paper seeks to define the context for change, describe the necessary leadership requisites to deal with this change successfully, and share insight into how best to navigate into a world of changed incentives, unending challenges, and accelerating change. It acknowledges the need to effect leadership from three essential segments of the provider community: governance, administration, and physicians.

Exhibit 1: The Pace of Change



Source: Peter Russell, *Waking Up in Time: Finding Inner Peace in Times of Accelerating Change* (Origin Press, 1998).

4 Peter Russell, *Waking Up in Time: Finding Inner Peace in Times of Accelerating Change* (Origin Press, 1998).

Barriers to Change

A number of factors serve as barriers to the ability of healthcare organizations to adapt to the rapidly changing healthcare marketplace. Among these are organizational structure, generational differences in attitudes among the workforce, and "language" and ethical differences between those in governance/administration and clinicians.

Organizational Structure

HEALTHCARE ORGANIZATIONS TODAY ARE STRUCTURED according to an industrial and/or military model of organizational design. The organizational chart remains traditionally top-down. Knowledge, power, and authority are concentrated at the top. Orders move down while information moves up. While this form of organizational structure serves well in stable times when replication of identified processes is the key to achieving success, it is an absolute hindrance in times requiring transformational change. When the future is unknowable, adaptability is the key to sustainability. Keys for success in an adaptability framework include an emphasis on horizontal rather than vertical structures, and real-time access to data and feedback, where decisions are made by those closest to the customer, where information is shared, and where cross-training is emphasized. Investing in the adaptability of the organization's human capital is paramount.

Complexity science provides a more appropriate metaphor for organizing work in today's rapidly changing environment.[5] Rather than organizing vertically in a top-down, departmentalized manner, work is better performed when horizontally organized. In the world of complexity, those in positions of authority think more as gardeners than as managers, and servant leadership is the rule. As Gareth Morgan has said, "Gardeners don't grow crops; they create conditions in which crops grow."[6]

Complexity science views healthcare as a complex, adaptive system. A complex adaptive system is a densely connected web of interacting agencies, each operating from its own schema in response to local knowledge. Those agencies coevolve within the system of which they are apart. The cause and effect is mutual rather than one-way. The entire system is emerging from a dense pattern of interaction. Healthcare is comprised of a large number of stakeholder groups. Each group or agency is responding to its immediate environment in ways that seek to maximize its own benefit. The relationship between stakeholder groups is non-linear and the outcome of the decisions made by each agency becomes variously the input to which other agencies are prompted to respond. In this way, the entire industry becomes self-organizing and the resulting consequences are emergent.

Creativity is essential to adaptability. According to complexity scientist Ralph Stacey, you maximize organizational creativity by controlling the amount of anxiety that exists within the organization.[7] This is achieved by modifying the following variables:

1. Control the amount of new information that is introduced into the organization. Too little awareness reinforces the status quo, while too much new and challenging information can introduce fear and destabilize the organization.
2. Nurture a diversity of opinion within the organizational structure. Freedom to express diverse opinion prevents groupthink and enhances the potential for identifying adaptive new behaviors.
3. Diversity is of no value unless those diverse elements are connected. Connecting those diverse opinions in dialogue provides an optimum environment for enhancing creativity.
4. Distribute power appropriately within the organization. If too much power is concentrated at the top, adaptability is compromised. Conversely, if power is distributed too thinly throughout the organization, the capacity for integrating, coordinating, and synchronizing action is impossible.

Margaret Wheatley, in her book, *Leadership and the New Science*,[8] summarized this dynamic as follows: when individuals who are interdependent for creating an outcome in which they are vested are given access to the necessary information and allowed to engage in "soulful dialogue," solutions emerge that creatively serve organizational adaptability. Healthcare leaders should provide opportunities for engaging in "soulful dialogue" about the creation of a new system of care that is adaptable, and centered on the patient experience.

The creation of self-organizing work groups that share information and have access to immediate measured feedback maximizes

5 Brenda Zimmerman, Curt Lindberg, and Paul Plsek, *Edgeware: Lessons from Complexity Science for Health Care Leaders* (VHA, Inc., 1998).
6 Gareth Morgan is the author of *Images of Organization* (Sage, 2006).
7 Zimmerman, Lindberg, and Plsek, 1998.
8 Margaret Wheatley, *Leadership and the New Science: Discovering Order in a Chaotic World* (Berrett-Koehler Publishers, 1994).

performance. In *The Human Equation*,[9] author Jeffrey Pfeffer documents the superior performance that results from horizontally integrating work groups. Within healthcare, organizing according to service line or around common procedures or common diagnoses, where groups of individuals frequently work together in pursuit of maximizing identified outcomes, would clearly enhance the efficiency and the effectiveness of healthcare delivery.

If horizontal integration around shared work creates superior outcomes, why isn't it found more frequently in healthcare? Several factors contribute to the perpetuation of the old, industrial, top-down model: departmentalized budgets, productivity indexing, and threatened managerial hierarchy.

Patients experience care across domains, and yet healthcare organizations exist in a departmentalized structure. In almost all healthcare organizations, the organizational budget is singular and organized according to operating departments. Each department manager is held most accountable to variance between budgeted and actual performance. When each department seeks to maximize its own performance, it invariably sub-maximizes the performance of the whole. One could argue that departmentalized budgeting is the single most important barrier to creativity. Budgeting for throughput would allow for the integration and synchronization of component parts and the creative redesign of patient care processes.

> Healthcare leaders should provide opportunities for engaging in "soulful dialogue" about the creation of a new system of care that is adaptable, and centered on the patient experience.

Most hospitals and health systems benchmark against some industry standard for productivity. Productivity indexing is a major inhibitor of work redesign. It invariably seeks to hold individual departments accountable to standards that exist within the industrial status quo and, thereby, inhibits creativity.

Finally, decentralizing authority and decision making erodes the power of those who occupy the status hierarchy. Withholding knowledge and concentrating authority within the C-suite secures power within the higher echelons of the organization, contributing to organizational inertia.

The implications of organizational structure for administrative leadership are clear. There is a need to let go, to share information, to decentralize decision making, and to reorganize work in such a way that throughput can be redesigned to maximize efficiency and effectiveness, and create a patient-centric experience. In every industry except for healthcare and education, the needs of the customer are paramount. In healthcare, however, work is designed to the convenience of the provider. Becoming patient-centric is the primary driver of teamwork and a force that breaks down historical-based determinants of relationships between the various members of the patient care team. Hospital and health system leaders need to define value from the patient's perspective and, based on that definition, refocus and integrate the various organizational components that need to come together to create a patient-centered care delivery organization.

Societal Forces

There are a number of societal forces that are disrupting the provider community. Three important forces that divide are: generational differences, "language" barriers, and ethical differences.[10]

Generational Differences

The physician community is currently comprised of three generations. The oldest of these, the traditionalists, are individuals for whom being a physician is a vocational activity. Their self-identity and their profession are one and the same. They are physicians 365 days a year and 24 hours a day. Being a physician is much like being a priest or minister. You respond when needed, no matter the circumstance or the time. Failure to do so evokes feelings of shame. Traditionalists would never have imagined asking to be paid for being on call.

Baby Boomer physicians, on the surface, appear to be much like the traditionalists. They are working all the time. There is, however, a distinct difference. Boomers tend to be status conscious and, in our society, status is related to the purchasing power of money. Like the traditionalists, Boomers are intrinsically driven to work. Not working hard evokes feelings of guilt.

Generation X physicians possess a very different value hierarchy. Managing time and a balanced life are highly important. In addition, the cost of medical training has skyrocketed over the last generation. At the conclusion of training, the average physician has accumulated somewhere between $150,000 and $200,000 in debt. Together these forces have had a significant impact on the way Gen X physicians choose to practice. Choice of specialty training correlates with the ability to manage time and projected earning power. There is no shortage of dermatologists, while there are progressively fewer individuals willing to practice general surgery.

Presently, women comprise slightly more than half of the medical school enrollment. For obvious reasons, women are even more sensitive to the ability to manage time, frequently pursue part-time work in flexible specialties, and may even stop practicing for periods of time to raise young children. Female physicians

9 Jeffrey Pfeffer, *The Human Equation: Building Profits by Putting People First* (Harvard Business School Press, 1998).

10 Joseph S. Bujak, *Inside the Physician Mind: Finding Common Ground with Doctors* (Health Administration Press, 2008).

generally are less productive than their male counterparts and this compounds the projected shortages in physician manpower.

Gen X physicians rarely attend medical meetings or social activities designed to promote collegial interaction amongst their peers. Most medical meetings occur either before or after a rather long workday. Because a balanced life is the primary value amongst Gen X physicians, time before and/or after work is personal time and not time to be governed by the work environment. The same is true of work-related social events.

There are significant upsides to the Gen X attitude. Gen X physicians are far more willing to delegate than their older colleagues. They are more comfortable with technology and the electronic care environment and they are more predisposed to working in teams. Gen X physicians do excellent work—when allowed to do so in their own time. Expecting them to prioritize work-related activities on what is perceived as their personal time meets with great resistance.

The above forces have prompted Gen X physicians to seek the economic security of employment and to have a preference for shift work. Over the same time period, the healthcare industry has become both commoditized and commercialized. As a result, humanism has given way to science—curing trumps healing, and professionalism as it was defined by earlier generations has eroded. There is a need for Gen X and successive generations to redefine professionalism in a way better suited to the society through which they have emerged.

Employing Physicians

Payment reform and shrinking margins are driving hospitals/health systems and physicians together. Physicians need a source of capital, if for no other reason than to afford the expensive IT systems required for remaining in compliance with the payer demands for process and outcome measures. Hospitals need physicians to prop up market share, coordinate care in preparation for bundled payments, and to commit to designing and adhering to process of care measures that seek to achieve balanced accountability and obviate "never events." Balanced accountability refers to accepting accountability for clinical outcomes (effectiveness), cost of care (efficiency), patient experience (satisfaction), and appropriateness of care. The latter is exceedingly important. Good business isn't always good medicine. Look at the growing concerns over unnecessary interventional cardiology, pacemaker/defibrillator insertions, elective inductions/C-sections, back surgery with fusion, and the value of testing for prostate cancer, just to name a few.

When physicians enter into an employment relationship, the contract usually ties reimbursement to productivity. For "essential specialties" there is often an income guarantee that protects the physician from inadequate volume. In today's world of payment for volume, this incentive makes sense. In the evolving world of payment for value, it is a formula for disaster.

What are the stakeholders to do? Build a physician organization that commits to "doing what is right." It requires a refocusing on the vocational aspects of being a healthcare provider, on being committed to best serving the needs of the patient, on committing to best practice and the pursuit of perfect care, and on the use of data to guide practice. Best practice is too complex not to approach care from a team-based perspective that is guided by an integrated and up-to-date EHR. Most importantly, it needs to restore balance between the science and the art of medicine, to revisit the professionalism embodied in the writings and life of Sir William Osler.

Older physicians and younger physicians have great difficulty communicating with each other. Their views of the world are so different that solutions designed to appeal to older physicians are often rejected by younger physicians and vice versa. Older physicians feel that younger doctors lack a work ethic, while younger physicians suggest that their older colleagues "get a life." Generational differences and economic realities have similarly impacted nursing.

Generational differences are a significant challenge to physician leadership. It is important to stop viewing the differences as an either/or issue or a problem to be resolved, and begin seeing it as a polarity—a both/and issue to be managed by identifying common ground that can unify effort. Focusing on the patient has always been the unifying force.

"Language" and Ethical Differences

Non-physician directors and administrators speak the language of business. Issues are framed through a business perspective, using business metrics to assess success. Clinicians, on the other hand, speak the language of clinical medicine. Issues are framed through the perspective of clinical outcomes, and success is defined in clinical terms. Often, board members and administrators understand business, but they do not understand *the* business. Clinicians understand *the* business, but not *business*. These perspectives are complementary; they are certainly additive and potentially synergistic. In the evolving world of pay-for-performance, each of these perspectives requires the other to achieve sustainable success.

In addition, there is an ethical divide that exists between physicians and non-physicians in governance and administration. Physicians have an ethical imperative to serve as the patient's advocate (apostrophe-s). That is, short of doing harm, it is the physician's ethical responsibility to do whatever he or she might to benefit their patient, ideally irrespective of the patient's ability to pay. It is the essence of the Hippocratic oath. Directors and administrators, on the other hand, have an ethical responsibility to serve as the patients' advocate (s-apostrophe).[11] They know that when they decide to allocate resources in one area, those resources are now no longer available for allocation elsewhere. They always seek to achieve the greatest good for the greatest number. They have a more systems-based or epidemiological perspective. Each of these perspectives is attended by an equally valid but a totally separate set of ethics. It is important to appreciate that no one can simultaneously serve both.

11 This concept was created by David M. Eddy, M.D., Ph.D., founder and medical director of Archimedes, a healthcare modeling company located in San Francisco, CA.

Transformational Leadership

As the healthcare industry transforms and relationships enter a new phase, there is a great need for leadership among all the stakeholder groups to overcome the barriers to change described in the previous section. Governance, administration, and physicians must move rapidly along the journey toward integration of purpose. There is a great interdependence at these levels and each must work diligently to overcome the forces of inertia that seek to defend the old paradigms. Governance has a particularly important role to play. This section describes leadership challenges and opportunities for the board, administration, and physician leaders; how these three groups are related; and how they can work together to help transform the organization.

The Leadership of the Board

THE WORK OF GOVERNANCE CAN BE CLASSIFIED INTO THREE separate areas: fiduciary, strategic, and generative.[12] Since leadership activities involve the future, people, and intangibles, these aspects shape the discussion concerning leadership and governance. Fiduciary activities focus attention on the present and past performance and thereby provide operational oversight. Similarly, when the conversation involves specific tactics or objectives, the activities are more process-focused and involve the board's responsibility to ensure management's accomplishment of goals related to the organization's strategic plan. Still, while an important part of the board's responsibilities, these discussions tend to focus on tangible aspects of structure or process change. When the discussion shifts to people and relationships and becomes future directed, in consideration of intangible aspects, the board is getting into the important, generative discussions that will help steer the organization toward change. This requires transformational leadership from the board.

Creative tension results from the ability to simultaneously hold in one's mind a vision of what could be, together with an honest assessment of current reality.[13] This disparity creates a tension that pulls the individual or organization toward the desired vision. As a result, an essential aspect of the change process is the capacity to articulate an inspiring and motivating vision. This is job number one of the hospital or health system governing board. Without a vision there can be no creative tension and thus, no movement toward change.

Most hospital and health system boards are dominantly comprised of non-clinical persons who are not remunerated for their efforts. *The* business is most often experienced indirectly as the board acts in service of the community to promote and defend the organization's mission, vision, and values. As the industry becomes ever more complex, the administrative team seeks to "protect" board members from excessive demands on their time, making it particularly difficult to grasp the details that can inform judgments going forward. How, then, can the board guide the organization? The board must be able to articulate the vision down to all levels of the organization, while building relationships and inspiring creative tension to move the organization toward this vision of the future. The paragraphs that follow describe some key governance challenges and relationships for the board to consider in this context.

> In a world changing exponentially, the future is not only unpredictable—it is in fact unknowable. A world changing exponentially and rapidly approaching the point of singularity requires transformational leadership.

Common Pitfalls in Essential Governance Roles and Relationships

The board's primary role is to represent ownership and to strengthen the organizational mission. Consistent with this mission, the board should develop and articulate a long-term vision to motivate and inspire all levels of the organization (again, producing that essential creative tension from the disparate questions, "Where do we want to be?" versus "Where are we now?" as described above). Asking the question, "Do these actions best serve the organizational mission?" should be the starting point in all deliberations. These conversations take time, are divergent and often exploratory, and too often are seen as "wasting" the board's valuable and donated time. Administration predigests the material, presents its executive summary, calls the question, and the board then votes "yes" or "no," after assessing the resources necessary to commit to the efforts that have been preselected. Too little time is allocated to tap into the collective wisdom of the

12 Richard Chait, William Ryan, and Barbara Taylor, *Governance as Leadership: Reframing the Work of Nonprofit Boards* (Wiley, 2005).

13 Robert Fritz, *The Path of Least Resistance: Learning to Become the Creative Force in Your Own Life* (Ballantine Books, 1989).

governing body, which is presumed to be unsophisticated in the details of the industry and seen primarily as the fiduciary allocators of financial resources. But the board is much more than this.

Setting strategic direction and prioritizing strategic initiatives are governance responsibilities that serve the purpose of furthering the mission and vision. Hopefully, generative conversations have preceded and informed the process of setting strategy. This is the activity usually given the least amount of time and paradoxically represents the most important aspect of board work. Generative conversations represent the dialogue that takes place as participants collectively seek to integrate the organization's purpose with the projected and anticipated future direction necessary to sustain financial viability.

The board's most important fiduciary responsibility is ensuring patient safety and guaranteeing optimum quality. Thus, setting a high bar for expected organizational performance is an essential leadership responsibility for the board. This is especially challenging because physicians—who are critical contributors to patient safety and clinical quality—tend to behave autonomously. In most organizations, assessing and controlling physician performance in support of patient safety and clinical quality is seeded to the medical staff. This is problematic because direct contact between board members and the medical staff committees responsible for credentialing and peer review is usually limited, deferential, and significantly influenced by cultural and political determinants. How can the board work with physician leaders? This requires either more direct conversations with those members (committees) of the medical staff who perform these functions, and/or changing the structures that define hospital–physician relationships. The board is a necessary ingredient to help create an environment in which physicians act as one with the organization to actualize best practice in pursuit of collective excellence.

Employing physicians is one opportunity to integrate these functions. Too often, however, while the physicians benefit from the economic security that attends employment, administration and governance still default to autonomous physician practice. There must be a balance. Employed physicians need to be seen not as employees, but as partners and authors of care processes. Standardization, where appropriate, is essential for creating safe and quality patient care outcomes, and the pursuit of best practice must trump individual physician prerogative. This is difficult when entering the domain of clinical decision making, since lay administrators and directors may be uncomfortable in this arena. On the other hand, focusing first on patient safety positions directors on the moral high ground and gives confidence to a lay board as it seeks to carry out its responsibilities in this domain. No individual can publicly object to initiatives that are designed to enhance patient safety, and quality does not exist in the absence of safety. Explicitly communicating performance expectations should be an integral part of every physician employment contract, for example.

Reinforcing organizational values is another essential governance responsibility, and these values relate directly to the organization's relationship with its physicians and staff. It is the actualization of values that determines the organizational culture. The board must assess organizational culture and determine that it in fact is an active and ongoing reflection of the organization's value hierarchy. Too little attention is paid to the importance of not only identifying core organizational values, but also to prioritizing them. In situations when you can't manifest them all, which takes precedence? If it is unclear, the choice is made at an individual level. It is critical for the board to not only identify values, but also to explicitly identify behaviors that are the living expression of those values. Absent explicit communication about what a specific value means, the default is left to subjective interpretation.

The board is a necessary ingredient to help create an environment in which physicians act as one with the organization to actualize best practice in pursuit of collective excellence.

Choosing the right individual for the role of CEO and holding him or her accountable in service of the organization's mission and values is a paramount board function. The CEO, the board's only employee, is the point person in the relationship between the board, the rest of the management team, and the physicians; a strong, transparent relationship between the CEO and board can help ensure that the board keeps on a level of oversight and does not micromanage. This is a tightrope on which all boards must walk—staying on course without entering the realm of day-to-day operations. This often relates to overseeing the "big dots." However, these big dots on the board's dashboard are most often lag indicators and, in a world transforming exponentially, present challenges to the timeliness of necessary course corrections. That is why it is essential to choose the right chief executive and to hold him or her explicitly accountable to making judgments that are consistent with the organization's mission, vision, and values.

Finally, board self-evaluation and the appointment and/or reappointment of its membership can significantly interface

with the board's leadership responsibilities and relationships. Is the board recruiting and selecting the best people available? Are board members meeting performance expectations? Do they understand their role in the relationship triangle of the board, management, and physicians? Are they operating in service of the organization's mission and values? Are they willing to hold the CEO and the medical staff accountable in service of those intangible elements?

Transforming the Board, Transforming the Organization

As healthcare moves from payment for volume to payment for value, what is the role of the board in leading this transition? Overcoming the governance challenges described here begins with asking questions that will engage the board in those dynamic, generative discussions that transform the board and, by doing so, the organization. With every board decision, directors must preserve and further the organizational mission. But beyond that, to truly transform the organization, there must be creative tension. Every physician and nurse can play a role in helping to reconcile the future vision with the current reality. The board can begin by focusing on ways to develop stronger relationships with physicians—have more direct conversations about values and vision, and how those affect the patient experience and quality of care. Does the organizational culture reflect values and vision? Involve physicians in identifying and prioritizing those values to help shape the culture. Develop the board's relationship with the CEO by setting clear expectations up front that align with the organization's mission, vision, and values, and have the CEO help articulate and maintain the mission, vision, and values throughout the organization. Indeed, if the future is in fact unknowable, adaptability rests on the invisible guiding hand of the organization's culture.

It is critical during this transformation to prevent the organization from having an imbalanced emphasis on profitability. Without question, access to capital is a big challenge that will fuel many future acquisitions and drive other new relationships. However, there can be such a focus on short-term cost management that the heart and soul of healthcare can be lost. Focusing on business can suffocate *the* business. Certainly, when you are out of money, you are out of options. But, in the balancing of margin and mission, mission must remain paramount. It is what stirs the soul of healthcare providers, most attaches their discretionary effort, and what fuels their potential. Remembering that success rests on the adaptability of the organization's human capital will help guide decision making in these turbulent times. Doing what is right will serve the community, patient, and caregiver, whether in a world of payment for volume or for value.

The Leadership of Administration

Administration has the primary responsibility for promoting, supporting, and managing change. A world changing exponentially demands that leaders serve as agents of change. Failure to position the organization for future success causes the organization to suffer a slow death. Conversely, serving as a change agent and attempting to position the organization for where it needs to be to achieve sustainable excellence frequently results in the "death" of the leader. Individuals respond to those who seek to shift the dominant paradigm in a series of sequential steps. The initial response is one of criticism and ridicule. If that fails to stop the change, the next step is to marginalize the individual. If that fails, the final step is to shun or remove the individual from the group. Thus, creating change is extremely difficult and, above all else, takes courage.

As mentioned previously, organizational sustainability rests on the adaptability of the organization's human capital. The administrative team is the brave group of individuals who take the vision from the board and make it reality through its relationships with the organization's human capital, by creating an environment of creativity and adaptability.

Remembering that success rests on the adaptability of the organization's human capital will help guide decision making in these turbulent times. Doing what is right will serve the community, patient, and caregiver, whether in a world of payment for volume or for value.

But when hospital margins are progressively shrinking, the attention of administration is increasingly focused on cost control, and so administration continues to manage by giving orders from the top. The most significant component of the hospital workforce is nursing and, in this regard, economic pressures have caused administrators to focus intently on nurse staffing ratios. However, today's hospital patients are sicker and their stays shorter. While a nurse on a medical–surgical floor may be assigned to six beds, the turnover in those six beds is significant. Admission, discharge, and transfer responsibilities are very time-consuming and demanding. In order to manage the growing number of tasks nurses have to perform, these most fundamental aspects of the nursing profession are delegated to nurses who, on admission, will never see these patients again, while those providing discharge instructions have never seen the patient before.

Historical staffing ratios are misapplied in today's world where patient care is more complex and responsibilities far greater. Documenting in the electronic health record has impacted productivity as well as patient contact time. In this context it is important to appreciate the distinction between labor rates and labor cost. The latter requires that productivity be factored into the equation. Discretionary effort has a significant impact on productivity and is strongly influenced by leadership.

The movement toward shift work, nursing's focus on task functions, and the emphasis on science have all come together to fundamentally change the nature of the caregiver–patient relationship.

Because healthcare organizations are still organized predominantly in a top-down manner, changes intended to improve operational efficiency in service of cost control are received in the form of dictates from above. Often, these are imposed without a clear understanding of the unintended consequences for patient

care. Demands of payers, regulators, legal authorities, and other forces external to healthcare delivery have significantly impacted and directed the reorganization of work. It seems as if the nurse has become the final common pathway for the application of every regulatory expectation that is imposed on the healthcare industry.

Rather than focusing on cost control in service of historic ways of delivering care, what is really needed are efforts at redesigning care at the bedside; this requires an environment of creativity and adaptability. This is where change management challenges truly lie. The historic ways of delivering care are not working in today's more complex world. Allowing those at the sharp edge of care delivery to pilot or prototype new ways of serving the patient would significantly tap into organizational creativity. That requires letting go, trusting in the workforce, sharing knowledge, and providing real-time measured feedback to those doing the work.

An examination of the elements that are critical to employee retention in the workplace reveals that on a list of the top 10 influencers, money ranks last. Far more important to retention are issues related to appreciation, self-actualization, relationship to immediate supervisor, and, most importantly, respect and finding meaning and purpose in their work. These elements are rooted in relationship and communication and are predominantly influenced through leadership qualities, because they lie in the domain of the intangibles.

If organizational success is primarily determined by leadership activities, if sustainability is directly consequent to investments in the adaptability of the organization's human capital, why do administrators spend most of their time on cost control, to the exclusion of focusing on the more intangible aspects of the work environment as listed above? Of course, managing finances is important. However, if you inquire as to the agenda at most hospital management meetings you will find that precious little time, if any, is devoted to a discussion of the intangible aspects of the enterprise. There is a total imbalance that exists between managing money and leading people. In the healthcare industry, it appears that individuals who manage money are more highly valued than those who are effective at influencing people. Healthcare is significantly over-managed and woefully under-led.

In order to change organizational structure and redesign care delivery, the management team must have the ability to communicate effectively and to influence the motivation of the workforce. Offering opportunities for dialogue and prioritizing organizational values are two essential administrative functions for creating an environment of creativity and adaptability.

The Importance of Effective Communication to Leadership

Nothing meaningful happens outside of conversation. Three elements that are critical to influencing organizational culture, managing relationships, and leading to intangibles are perception, communication, and motivation.

Perception is each individual's reality. We recognize only what we look for and we see only what we expect. People preferentially identify in their environment those elements that reinforce their beliefs about how the world works, and correspondingly ignore elements in the environment that challenge their existing belief system. In evaluating input, individuals have a preferred way of making sense. In effect, they connect the dots according to preexistent beliefs, attitudes, and prejudices. Administrators think in the language of business and frame and evaluate data in ways that make business sense. Clinicians looking at the very same data set apply a different set of beliefs and, in so doing, can arrive at a very different conclusion. To each, the conclusions and their implications are imminently clear. When the other party doesn't see it as they do, rather than inquiring as to why it is they think differently, they prefer to conclude that the other party either cannot see it or worse, chooses not to see it. The other party is either incompetent or self-serving, but in either instance the other party is not to be trusted. Administrators and physicians think and speak in a different language. Few people are bilingual. When the other party does not understand what you are trying to say, typically you speak louder.

To facilitate communication and thereby improve understanding and relationships, leaders need to practice simultaneous advocacy and inquiry. Advocate with transparency for your position: "This is what I think and this is why I think it." Then, acknowledge that the other person's conclusions must make equally good sense to them. Inquire as to how they arrived at their conclusion. It is the willingness to simultaneously advocate and inquire that builds an improved understanding of the perspectives of the other, and creates the potential for identifying points of common interest or for allowing the other to appreciate the logic behind your expressed position thereby avoiding fundamental attribution errors.

The next important requirement for effective communication is to speak in the language of the receiver. Individuals have a preferred way of relating. There are four dominant ways of "sense–making": 1) the rational self, 2) the organizer self, 3) the emotional self, and 4) the experimental self.[14] The rational self analyzes and focuses on data for the purpose of decision making in the present. It is for these individuals that the executive summary was developed. Their desire is to make a rational decision and to move on. The organizer self has the need to create order. Policies, procedures, sequencing, and project management are their strengths. They are organizational safe-keepers. The emotional self is sensitive to feelings and to relationships. They like to touch and to teach, and they are sensitive to the feelings and needs of those around them. Finally, the experimental self constantly explores

14 Ned Herrmann, *The Whole Brain Business Book* (McGraw-Hill, 1996).

the possible. For them, if it isn't broken, they break it. They are conceptual thinkers who possess a systems perspective and contribute significantly to strategic planning. To effectively communicate it is important to frame issues in ways that address the preferred style of sense–making, because those elements have a disproportionate influence on shaping judgments.

Another essential element of effective communication, as Stephen Covey would suggest, is to seek first to understand and then to be understood.[15] As has been appreciated in the work of *Crucial Conversations*,[16] we not only take in sensory input, but we also simultaneously tell "our story." That is, we interpret what we see or hear in light of what we already believe. It is our story that triggers our emotional response to the input. It is incredibly important to appreciate that, in telling our story, we co-create our current reality. It isn't just what is happening out there that matters. Equally important is how we choose to interpret the impact or the meaning. The interpretation creates our emotional response, and that, in turn, triggers our actions. Our emotions are not caused by the behaviors of those around us; rather they are self-generated. To appreciate that you co-create your reality is incredibly empowering because it means that you can be the architect of your own future rather than the victim of someone else's.

Knowing how to influence another's motivation is an essential component of effective leadership. Motivation ("wanting to") is the most powerful driver of change. Charles Dwyer[17] teaches how to make someone an offer they can't refuse. To do this, you change their perception so that adopting the behavior you seek will serve to enhance his or her personal values. Fundamentally, you are seeking to align self-interest with organizational interest.

In the context of motivation, it is important to appreciate the difference between compliance, engagement, and commitment. With compliance, the authority is external to the individual who manifests the behavior when oversight is present. Withdraw the oversight and the former behavior returns. Engaged individuals believe in the value of the new behavior. They willingly manifest that behavior but stay within the rules. Committed persons believe so strongly in the value of the new behavior that they would be willing to break rules to achieve the objectives. "Wanting to" can independently generate "how to." The ability to influence intrinsic motivation is an essential skill of transformational leadership.

Prioritizing Organizational Values

A major responsibility of administrative leadership is to work with the board to prioritize organizational values. In this context, "values" refer to those initiatives to which the organization will preferentially devote its resources. It comes to life in the setting of organizational goals based on the strategic plan.

There are few organizations that don't feel overwhelmed by the number of ongoing change initiatives imposed on the workforce. Many organizations have at least one strategic goal for every organizational pillar (i.e., finance, quality, people, service, and growth).

According to the Franklin Covey organization, the most important first step in goal setting is to appreciate that if an organization has five or more major strategic initiatives, it will most likely accomplish none. When the organization can focus on two or, at most, three major objectives at one time, there is a good chance that the organization can achieve the intended results. Leadership must prioritize the truly important. The board and administrative team must work together to determine what the major objectives need to be, and cull them down to only two or three at a time. Then, the administrative team takes those objectives and determines how to accomplish them.

In order to engage in new behaviors to accomplish these major objectives, the already overwhelmed workforce needs to find the time by identifying current work elements that can be eliminated. Work elements can be assigned to one of four areas: urgent and important, urgent but unimportant, important but not urgent, and neither important nor urgent. Positive evolution results from having the time to engage in behaviors that are non-urgent but truly important. In order to increase those elements, the non-urgent and unimportant and especially the urgent but unimportant elements need to be identified and eliminated. It is only by stopping the performance of unnecessary activities that workers can free up the necessary time to practice new behaviors.

The critical challenge of administrative leadership is to accept responsibility for prioritizing and limiting strategic initiatives, ceding to the workforce the freedom to design a change in work processes, and to assess its real-time impact. Real-time measurement provides focus and helps ensure that the workforce is indeed spending its time on the essentials to further the organization's values.

> In a world where the future is unknowable, adaptability is the key to sustainability. Creativity is essential to adaptability. Adaptability rests on the invisible guiding hand of the organization's culture.

The Leadership of Physicians

Physicians, who have traditionally focused solely on the effectiveness of the care provided, are now required to also be responsible for the cost of creating that outcome, including the quality of the patient experience and the appropriateness of the application of diagnostic and therapeutic interventions. Bundling payment across specialties, locations, and time further challenges the historic status quo. This creates a need for transformational leadership, with balanced authority and accountability from each leadership group: the board, management, and physician leaders.

Finding effective physician leadership is perhaps the most challenging need in the provider community. Several important barriers to effective physician leadership are culturally determined and include: 1) the perception that leadership is illegitimate;

15 Stephen Covey, et al., *First Things First: To Live, to Love, to Learn, to Leave a Legacy* (Simon and Schuster, 1994).

16 Kerry Patterson, et al., *Crucial Conversations: Tools for Talking when Stakes are High* (McGraw-Hill, 2002).

17 Charles E. Dwyer, *Shifting Sources of Power and Influence* (American College of Physician Executives, 1992).

2) collective decisions are made in a setting of town hall democracy—one person, one vote, majority wins; and 3) impatient physicians inappropriately vote on issues that require negotiated consensus.

Physicians comprise what, in sociological terms, has been labeled as an "expert" culture.[18] Physicians aren't the only expert culture in our society; other examples include tenured university professors, architects, engineers, and attorneys in multispecialty law firms. The critical characteristic of an expert culture is that its members make individual and often independent decisions from the personalized perspective of "how will this affect me?" Expert cultures fundamentally lack a *collective identity*. In physician culture this is consistent with autonomy being the transcendent value. Medical training emphasizes striving for personal excellence. The role models in medical training are renowned for their individual competency and their pursuit of personal perfection.

In an expert culture, the presumption is that leadership is illegitimate. In a room filled with equals, what is it that makes one person (i.e., the leader) more equal than another? The idealized physician is the captain of the ship—the person with the primary responsibility for guiding the diagnostic workup and the therapeutic plan.

If an individual physician were to stand before his or her colleagues and suggest that they follow his or her direction, the response would fundamentally be, "So who died and left you the boss?" Nowhere is this more evident than in the traditional position of the elected chief of the medical staff. The expected responsibility of the chief of the medical staff is not to provide leadership but rather to act in the role of a union steward whose responsibility is to protect his constituency from the unwelcome interference of either the board of directors or hospital administration.

When an individual comes before a group seeking to shift the shared paradigm, only a minority of individuals in the audience sees excitement and possibilities in true novelty. Everett Rogers' diffusion of innovation model[19] would suggest that no more than 15 percent of any group would be curious to explore the possibilities that might result from shifting the paradigm. When decisions are the result of majority rule, all truly new ideas are rejected. In effect, physicians in the collective are powerful in rejecting change and virtually impotent in acting proactively, much less creatively, as an influencing force in the rapidly changing healthcare industry.

While there are many ways to reach decisions, voting falls on one end of the spectrum and managing for consensus falls on the other. When is voting an appropriate avenue for decision making? Voting is appropriate when seeking to make a large list smaller. (For example, there are nine items on today's agenda but we only have time for three. Which three should we address?) Voting is also appropriate when there are multiple alternatives and no one is particularly vested in one or the other of those alternatives.

When must consensus management be applied in decision making? Consensus management is the need to allocate the necessary time and energy required to negotiate a solution that is acceptable to the parties involved. It is necessary in circumstances where there are multiple alternatives, individuals are strongly and emotionally vested in one or the other of those alternatives, and most importantly, when the decision is made, everyone will be expected to abide by that choice. However, when physicians encounter a circumstance that requires consensus management for appropriate decision making, the default position is to the primacy of individual physician autonomy and rather than making an attempt to build consensus, the matter is decided upon by vote.

18 Bujak, 2008.

19 Everett M. Rogers, *Diffusion of Innovations* (Free Press, 1995).

The Journey from "I" to "We" to "Us": Transforming Culture with Physician Leadership

The need to integrate the provider community in order to achieve balanced accountability in an industry seeking to pay for value and not volume requires integrating physicians into the fabric of the healthcare organization. As individuals aggregated in an expert culture, conditioned to respect autonomy and traditionally seeing the healthcare organization as his or her workshop, this represents a significant challenge. It is no less challenging for the culture of the healthcare organization to incorporate physicians into leadership and management roles. As the source of capital, the board and administration feel it is their right to control operations. For the physician, clinical work cannot be dictated by businesspersons ignorant of the processes of clinical decision making.

How do these cultures assimilate? Where are the divides and how are they bridged? The answers lie in acceptance of a responsibility for creating balanced accountability, and in a commitment to teamwork that spans domains, time, and location.

Traditionally, physicians have seen themselves as primarily responsible for clinical outcome (i.e., the *effectiveness* of the care provided). The world of payment for value now demands acceptance of responsibility for the cost of creating that outcome—the *efficiency* of care—as well as for how the patient *experienced* the care provided, traditionally measured as patient satisfaction. *Appropriateness* of care is the fourth domain of balanced accountability. An intervention can be done efficiently, effectively, and with great patient experience, but may not be appropriately indicated.

Domains of Care under a Balanced Accountability Approach

Effectiveness of care
Efficiency of care
Patient *experience*
Appropriateness of care

Physicians are increasingly being involved in developing processes of care that are applied in pursuit of achieving this more balanced accountability. Sometimes this is achieved by means of a management services contract. Other times it is achieved through direct employment. In either situation, key physicians are taking on more management responsibilities. To do this effectively requires access to real-time data.

One of the more commonly adopted structures for achieving balanced accountability has been the creation of a dyad form of service line management. This approach places the physician as the responsible head of the clinical elements involved and retains a non-clinician as the responsible party for managing the infrastructure that is required. Herein lie some cross-cultural landmines.

It is important to appreciate that physicians work according to the principle of distributive justice. That is, the end justifies the means. Physicians tend to be rule-breakers who frequently ignore existing policy and justify their deviancy as being in the immediate best interest of their patient. Employees in the affiliative or collective culture that dominates the healthcare organization work to the principle of procedural justice. That is, everyone who might possibly be impacted by a decision to be made must be consulted and have input. Any decision that bypasses this imperative, even if it is the best decision, will be rejected or at least met with resistance. Given this difference, one can appreciate why the inevitably slow pace of decision making within the healthcare organization frustrates physicians.

This reality frequently compromises the effectiveness of physician leaders. In *Primal Leadership,* Daniel Goleman describes six styles of leadership.[20] Four of these are well accepted within most organizations: visionary, coaching, democratic, and affiliative styles of leadership. Two styles of leadership create dissonance in organizations: the command style and the pacesetter style. On the basis of their training and acculturation, physicians naturally adopt a command or pacesetter style of leadership. Physicians initiate work within the healthcare environment by giving orders, and it is only natural to seek to assert influence within the organization in a similar manner. As noted above, failure to follow the expectations of procedural justice leads to rejection.

Identifying Physician Leaders

Healthcare organizations realize that physicians will play an ever-increasing role in achieving balanced accountability, so there has been a significant interest in investing in physician leadership development. There are many programs available that would suggest that leadership is a skill that can be taught. How are these potential leaders identified? Are leaders made or born?

Most likely the truth lies somewhere in the middle. A willingness to lead—a desire to lead—is an inborn propensity. Whether or not that leadership is accepted is contextually determined. There is no better example of this than Winston Churchill. Churchill was an outstanding leader in a time of war but was rejected twice by his electorate in times of peace. People inclined to lead can benefit from learning approaches likely to make them more effective leaders. However, didactically presenting and even practicing skills does not necessarily produce leadership. In other words, going to leadership school does not produce leaders, but can significantly enhance the effectiveness of those intrinsically motivated to lead.

Coaching and mentoring are important adjuncts to the maturation of leaders. These are especially valuable when they can be offered in an ongoing relationship. There is no better time to learn than in the context of a significant set of immediate short- and/or long-term challenges. Unfortunately, most physicians are not predisposed to accept coaching and mentoring activities. Because physicians are expected to know everything, most find it very difficult to publicly express vulnerability—that is, a willingness to acknowledge publicly that their current state of knowing is either incomplete or inaccurate. Unless one can do that, one cannot learn.

The Journey from "I" to "We" to "Us"

The challenge of physician leaders today is the need to move their colleagues from town hall democracy to representational democracy, to transform the primacy of individual autonomy into a collective identity, and ultimately to overcome physician distrust of the healthcare organization into a fusion of interdependent skill sets. This represents a journey from "I" to "we" to "us." Metaphorically, physicians need to change the way they view the healthcare organization, moving from a hotel where they electively rent space, to a condominium where they acknowledge a set of shared covenants while remaining independent, to a collective where they live together in pursuit of a shared ideal.

20 Daniel Goleman, et al., *Primal Leadership: Realizing the Power of Emotional Intelligence* (Harvard Business School Press, 2002).

Jumping to the Second Curve

Everyone believes that a transition from payment for volume to payment for value is underway. Some form of bundled payment, medical homes, ACOs, or other model seems to be in our future. As this transition occurs, it presents many points of tension:

1. When to jump from volume to value? We are still being paid for volume. Jump too soon and you are hurt economically. Jump too late and you are ill prepared to manage in a world that focuses on health maintenance, management of disease across time and across the care continuum, and orchestrating care to achieve maximum effectiveness, efficiency, patient satisfaction, and appropriateness of care.
2. Today's cash cows become tomorrow's cost centers, where good business in a pay-for-volume world becomes bad science and an unnecessary cost center in a pay-for-value world.
3. The source of capital in today's world, most often the hospital, becomes the biggest cost center as the locus of control shifts to physicians, especially ambulatory-based physicians who create value by eliminating waste.
4. There are not enough primary care physicians to provide a medical home or equivalent for a world of hopefully expanded access. There are not enough nurse practitioners or physician assistants to fill the void, and most primary care physicians resist a business model that distances them from the "sharp edge" of patient contact. Also, if mid-level practitioners displace primary care physicians as providers of primary care, it is likely that primary care physicians lack the training to move up-market to "disrupt" specialists.
5. Today's version of the EMR is woefully lacking in its ability to provide the glue that serves integration of care.
6. If capitation in some form underlies reimbursement, the provider community lacks the actuarial expertise to manage risk.
7. The models best prepared for the imagined future reality are physician-led, built on a salaried physician multispecialty group practice model, and include ownership of an insurance vehicle. Insurers appreciate these facts and are moving to employ physicians.
8. The provider community, which is progressively more sub-specialized, needs to transform its incentive structure from one that rewards solo musicians to one that rewards making music together. Efficient and effective handoffs become essential and the historical elements that define the desired endpoints of physician training need to be transformed.
9. Specialist income will decline and this alone will send shock waves through the physician community.

An incredible upheaval is in the making. Those who successfully adapt will organize around a shared sense of transcendent purpose, and adopt a shared set of behavioral values. It is all about managing relationships, managing intangibles, and rediscovering the vocational aspects of a calling to the healthcare professions. Manage relationships and the money will follow. Managing the transition means focusing on doing what is right. Doing it in today's world will serve the organization well in tomorrow's world. Create a world of safe and effective patient care, and beware of those services that represent good business but bad science.

Putting It All Together

Much of the preceding section highlights the need for transformational leadership in a world changing exponentially and the difficult challenges that confront leadership in the healthcare provider community at governance, administrative, and clinical levels. What follows is a distillation of approaches that can serve the need to make a difference.

Leading to Critical Mass

TRANSFORMATIONAL LEADERS SEEK to change the paradigm that currently governs group behavior. Groups are groups because of their shared beliefs. To shift the paradigm is to challenge one or more of those existing beliefs. To give up a historically shared belief challenges the very viability of the group. That is one of the primary reasons transformational leaders are rejected.[21]

An extension of this phenomenon occurs in associations. Groups like the American Hospital Association, American Medical Association, or state hospital associations are comprised primarily of dues-paying members. All associations are dominantly responsive to their most powerful coalition. Those coalitions, because of their size and influence, are the members currently best served by the existing paradigm. Paradoxically, it is those members least served by the dominant paradigm that are most open to considering new approaches. For this reason, associations are rarely, if ever, the leaders of transformational change.

The same is true within the physician community. Physicians primarily respect clinical competency. Because of their competency, physicians who are most respected are being well served by the dominant paradigm. It is the more marginal physician, practicing outside of traditional allopathic constraints, who is most willing to push the envelope. Paradoxically, their views are dismissed because they are outside the mainstream and they lack their colleagues' respect. Therefore, it is important to appreciate that, except in times of shared immediate and significant threat, all groups will act to preserve the status quo.

Transformational leaders cannot lead to consensus. To effectively lead transformational change, one has only to appeal to a critical mass. That critical mass has been empirically defined as the square root of N, where N is the total membership of the group in question. In a theoretical group comprised of 100 members, to lead by consensus would require at a minimum 51 percent agreement. Leading that same group via critical mass would require the active participation of only 10. There is a caveat, however—it has to be the *right* 10. The good news is that these people are usually easy to identify. They are those individuals in the group who have a disproportionate impact on influencing the total membership. This critical mass comprises the early adopter group.[22]

A visual metaphor to illustrate this concept is that of a slinky. A child moves a slinky by pulling on the front rings. The progressive tension that exists between the front rings and those that follow will cause the following rings to catch up when the tension overcomes their intrinsic inertia. Those front rings of the slinky represent the square root of N individuals—the early adopters.

Leading transformational change requires an appeal to both negative and positive vision. Negative vision is a reflection on how failing to transform threatens loss of something that the group intrinsically values. Negative vision is the equivalent of the burning platform. Its significance lies in its ability to impact the timing of change. It is in fact a "call to arms." It is important to appreciate that negative vision is never sustaining. People are motivated to act when the threat exceeds their threshold for tolerance. The response, which is directed against that threat, has the effect of lessening the stimulus and thereby reducing motivation. From a graphic perspective, what follows is a saw-tooth pattern that oscillates around the threshold.

Positive vision is required in order to sustain new behaviors. If negative vision wants to make a threat go away, positive vision is an attempt to bring something new into being. It is important to appreciate that the power of vision lies not in what it says, but rather in what it does. People commit to "big ideas." As Napoleon said, "There is no amount of money that can cause someone to lay down their life for you, something that they would gladly do for a piece of yellow ribbon." Understanding the impacts of positive and negative vision, while appealing to the critical mass, is key to leading transformational change.

21 James O'Toole, *Leading Change: Overcoming the Ideology of Comfort and the Tyranny of Custom* (Jossey-Bass Publishers, 1995).

22 Rogers, 1995.

Notes from the Author: How Doctors Work

I recently facilitated a one-and-a-half-day retreat with a hospital and its related providers, the majority of whom are employed. Several aspects of the meeting surfaced and reinforced my experience about how doctors think and work.

The first is the reaction to proposed initiatives. Most physicians can see in a heartbeat reasons why a proposal won't work. In the world of "yes…but," the "buts" prevail. I think it reflects a form of training that rests on the principle of first ruling out diagnoses that don't fit the symptoms (i.e., "it could be, but maybe it's something else…"). This response is opposite to that embraced by appreciative inquiry or positive deviancy, wherein you seek to identify positive elements with a desire to import them as a point of beginning. Fundamentally, there is a focus on why things won't work, rather than on why they could work. This reflects a physician's cultural need to predict and thereby control, and in some ways reflects a "first, do no harm" principle. This is why it is important to lead to critical mass, to appeal to the early adopters. The majority will always seek to defend the status quo. Prototyping or piloting is the avenue to change management. Provide evidence that the proposed change, once modified in response to local conditions, does work to the individual's advantage.

Second is the observation that physicians are quick to suggest what to do, and almost never willing to become the doer. Physicians are used to giving orders that others carry out. This is why I suggest never asking a physician for an opinion. They will be only too happy to tell you what they think and then will expect that, implicit in their answer to your question, it is now your responsibility to create the result they have suggested. Rather, always ask in this manner: "If you think the idea has merit, what can we do together to achieve the result?" The goal is to obtain a commitment from the physician to have specific involvement in the initiative.

—Joseph S. Bujak, M.D., FACP

Creating a High-Functioning and Committed Team

Another key component of success in leading transformational chance is the ability to create high-functioning and committed teams. Two important works that inform how to achieve this goal are described below.

Small Unit Leadership

Dandridge Malone, author of *Small Unit Leadership*, addresses principles of leadership from a military perspective.[23] Malone emphasizes a need to focus on three critical elements: skill, will, and teamwork. Training to achieve identified levels of skill creates trust. In the military, when you are engaged in battle it is imperative to know that the individuals next to you can perform at a high level. Your life can depend upon it. Basic training ensures that everyone can clear the bar of established expectations for performance. In addition, basic training instills a set of shared values that form the basis of group identity and transcend individual selfishness.

Will results from an appreciation that self-interest and group interest are aligned. That is, what the individual cares most about is shared in common by the group at large. Teamwork results when there is an acknowledgment that the individual can get more of what they care most about by acting together with others than they can acquire by continuing to work independently.

Building a Stage IV Tribe

In *Tribal Leadership,* David Logan, et al. offer a very useful model for achieving clinical integration.[24] They stratified people in organizations into five stages or tribes. According to this concept, one can accurately place individuals into their respective stage or tribe by simply listening to their conversation. Stage I individuals are characterized by the words, "life sucks." For these individuals, life is a bitch and then you die. Stage II individuals can be characterized as believing that not all life sucks, but rather that, "my life sucks." Somehow, the world is colluding to make their life miserable. Many in healthcare have descended to this level of function, believing that their current reality is not what they bargained for when they chose a career in healthcare.

Stage III reflects the desired endpoint of physician acculturation. Stage III individuals are characterized by the words, "I'm great, and you are not!" It is an accurate reflection of how physicians are trained to an endpoint of personal excellence in a culture where personal autonomy is the transcendent value, and where the physician is indeed the captain of the ship. Stage III individuals are highly successful, very competitive, and skilled performers. When needing surgery, you would want to be operated on by a Stage III physician.

The complexity of healthcare—the transition to pay-for-performance and the requirement to create teams that work together to optimize efficiency, effectiveness, service quality, and appropriateness of care, across time and across components—requires evolution to Stage IV. Stage IV is characterized by the words, "we're great, and they're not!" This represents the journey from "I" to "we" to "us" described in the previous section. The autonomous individual must first develop a collective identity and then appreciate that they are integral with the entirety of the organization into which they have been enfolded. Individual stakeholder groups have to acknowledge their interdependency and seamlessly share a commitment to creating outstanding outcomes.

(To complete the model, Stage V individuals would be characterized by the words, "life's great." These individuals are creating history and would be recognized in the work done by the Manhattan Project, or by those who came together to create the PC revolution.)

Logan emphasizes that what aligns members of the Stage IV tribe is a commitment to shared purpose. What unites them is a commitment to the behavioral expressions of a shared set of core values. They commit to behaving together in ways that are explicitly defined, and hold each other accountable to those behaviors.

23 Dandridge M. Malone, *Small Unit Leadership: A Commonsense Approach* (Presidio Press, 1983).

24 David Logan, et al., *Tribal Leadership: Leveraging Natural Groups to Build a Thriving Organization* (Harper Collins, 2008).

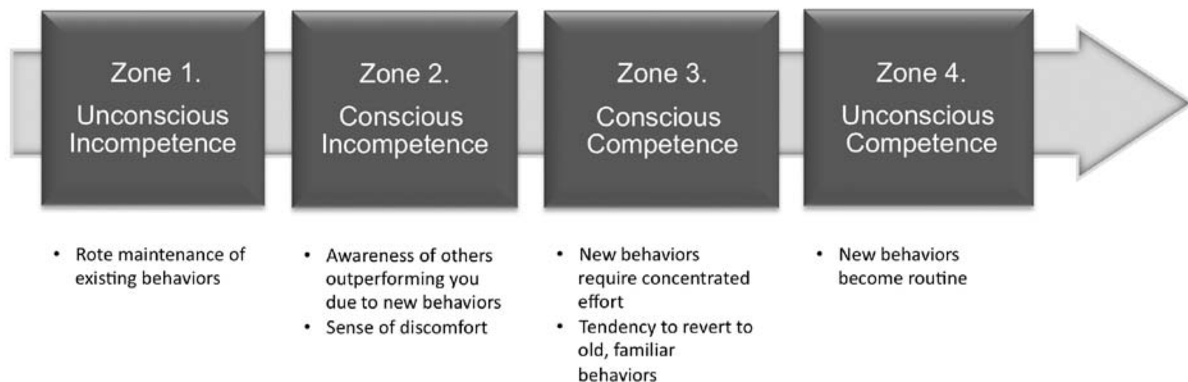
How do transformational leaders seek to form a Stage IV tribe? They start by explicitly communicating *what* it is they seek to create. Then they present the compelling rationale that justifies *why* it is imperative. They then identify the *who*. The who is defined by explicitly identifying a metric or metrics that will be used to determine success and the value hierarchy that will be applied in making decisions going forward into a future that is unknowable. That value hierarchy becomes the moral compass for decision making. When individuals explicitly understand the what, the why, the metrics that define success, and the value hierarchy that guides decision making they can judge for themselves whether there exists an alignment between self-interest and group aspirations. This guides recruitment and promotes retention in a group of like-minded and highly competent individuals. It is significant to note that Stage IV individuals do not want to associate with Stage II performers. Inviting all comers to join dilutes the quality of the group as it migrates toward the mean.

The Change Sequence

For the transformational leader, the challenges of leading change (many of which have been described in this white paper) are significant. In this context, it is important to appreciate the change sequence. The beginning point of this sequence represents unconscious incompetence; people are acting as they have always acted. The next zone is conscious incompetence—awareness that others are outperforming you by behaving differently. People in this zone develop a sense of discomfort. It is at this point that consultants often arrive and promote the benefits of adopting new behaviors. Individuals become excited at the possibility of achieving those results and are eager to begin the journey in pursuit of those deliverables. However, this moves the group into the zone of conscious competence. Old behaviors can be accomplished in a rote manner. New behaviors require concentrated effort. They are awkward, clumsy, and slow, and require energy. When stressed, the natural tendency is to revert to the historic and familiar. It is in this transition zone that most change initiatives fail. They always require more time, more effort, and they clearly are not as comfortable as the automatic behaviors that attended the old ways of acting. At this point the consultants are blamed, and the change initiative is abandoned and labeled as the "flavor of the month." If the group can be supported through this period of cognitive-emotional dissonance, they can then enter the zone of unconscious competence. Now the new behaviors become as easy as the historical behaviors and those involved cannot imagine ever returning to the past. This reflects a "burn the boats" commitment to not going back.

Lastly, for the transformational leader, it is important to appreciate that you are more likely to act yourself into new ways of thinking than to think yourself into new ways of acting. The best way to begin the journey is to begin the journey. The transformational leader must author promote and be the living expression of the change that he or she would bring about.

Exhibit 2: The Change Sequence



Conclusion: It's All About the Intangibles

Today most healthcare leaders focus on the tangible aspects of the enterprise. Managing money dominates conversations, focuses attention, and determines priorities. Managing people is far less valued. The phrase, "no margin, no mission" presents justification for this distortion.

HOWEVER, PEOPLE DON'T WORK FOR MONEY. THE ESSENCE OF the human condition is the need to matter.[25] Daniel Pink has confirmed that the primary motivations for those who perform heuristic work are autonomy, mastery, and purpose.[26] He, and many other authors, document how extrinsic rewards (i.e., money) actually erode both the quality and the quantity of the work they are intended to influence. Individual rewards contingent on performance become entitlements and erode teamwork.

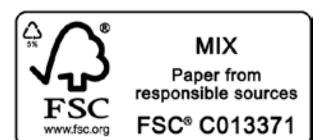
> "We do what we are called to do because we feel called to do it. We walked silently, willingly, down the well-trodden path still lit by the fire of millions. And the rest, I know now, is not our business."
>
> —*T.S. Eliot,* Four Quartets

In *Good to Great*, Jim Collins defined what distinguished companies that outperformed their competition by very strict economic criteria.[27] He chose to contrast "good" companies with those in the same business that achieved superior outcomes. While the book describes many distinguishing characteristics, the essential difference came down to the following metaphor: in the exceptional companies, the right people got on the bus, the wrong people got off the bus, they put the right people in the right seats on the bus, and then they decided where the bus was going to go. Sustainable excellence is indeed a result of managing to the intangibles. It's about individuals coming together to do something that matters.

Joy seems to be disappearing from the healthcare professions. Shift work, task orientation, and a focus on pay and benefits and individual needs, have combined to transform what was a vocation into a job. Science trumps relationships, curing displaces healing. The means has become an end in itself as healthcare services become commoditized. Fred Lee has defined "joy" in the following way: "Joy is working really hard, with people you like, doing something that matters, for somebody else."[28] Nothing better describes the essence of healthcare. Movements toward integration, coordination, and synchronization of healthcare in an industry redesigned to be patient-centric, focused on balanced accountability, and in search of perfect care holds the promise of redefining how we work, and redefining the elements of professional status that better adapt to a rapidly changing world of infinite possibilities. For this transition to occur, it will require strong and committed transformational leadership from governance, administration, and physicians.

Transformational leaders will seek to refocus work and shift traditional paradigms. For the transformational leader, the pain of unfulfilled potential far outweighs the personal cost of seeking change.

25 Viktor Frankl, *Man's Search for Meaning* (Pocket Books, 1984).
26 Daniel Pink, *Drive: The Surprising Truth About What Motivates Us* (Penguin Group, 2011).
27 Jim Collins, *Good to Great: Why Some Companies Make the Leap…and Others Don't* (Harper Collins, 2001).
28 Fred Lee, *If Disney Ran Your Hospital: 9 ½ Things You Would Do Differently* (Second River Healthcare Press, 2004).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