

A Practicing Surgeon Dissects Issues in Physician–Hospital Relations

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I presume that I do not need to write about the rationale for improving physician relations. Although, publicly, healthcare leaders tell me that they serve at the pleasure of the board, privately, they tell me that they serve at the pleasure of the medical staff as well. At an ACHE seminar I led in 2005, “Practical Strategies for Engaging Physicians,” one hospital CEO confided: “If I have a problem with my board, I can resolve it. But if I have a problem with doctors and they tell other influential doctors, I better dust off my resume.”

Physicians resemble university professors in that their allegiance goes first to their subject matter, second to their colleagues, and lastly (and distantly) to their workplace (Cohn 2008a). Physicians are trained differently from healthcare administrators. However, if physicians are treated as adults, they behave as adults, a prerequisite for improving physician relations. As Dr. Bujak (2008) argues, when physicians see that supporting the goals of a healthcare organization serves their self-interest, then synergy occurs and magic can happen.

My passion for physician–hospital relations stems from what I have witnessed: Clinical and financial outcomes can improve when healthcare administrators, physicians, nurses, and board members learn to work more interdependently (Cohn 2008b). Care coordination is also enhanced, and the practice environment becomes one in which people reconnect with the values that attracted them to healthcare in the first place. In this column, I introduce myself, my observations, and some issues between physicians and administrators that cause conflicts.

ABOUT ME

I am a practicing general surgeon who takes his work seriously and himself lightly. A sign in my office reads, “It’s never too late to change what you want to be when you grow up.”

I was an associate professor at Dartmouth College and chief of surgical oncology at a VA hospital. I fully expected to stay in academia my entire life, but on February 14, 1996, the VA hospital underwent a budget cut and eliminated five part-time physician and surgeon positions. My wife wanted to stay in the area, so I applied and was accepted into the MBA program at Dartmouth’s Tuck School of Business. Overnight, I went from being an 80-hour per week surgeon to a 110-hour per week graduate student. During school breaks, I worked as a locum tenens surgeon.

After earning my MBA, I intended to teach finance, accounting, and spreadsheet analysis to physicians. However, I learned that physicians needed guidance in

process skills, such as communication, negotiation, and conflict resolution (Cohn and Peetz 2003). The topic of physician–hospital relations attracted me. I viewed it as a concern with which I could help my fellow physicians cope with disruptive changes in the healthcare marketplace, using the lessons I learned in business school.

With this background, I founded HealthcareCollaboration.com, which offers strategies for helping physicians, nurses, administrators, board members, and other stakeholders to work together.

My Observations

In the last five years, I have traveled approximately 400,000 miles across 40 states, speaking, consulting, and teaching about physician–hospital relations and healthcare communication and collaboration. I also provide locum tenens general surgical coverage in New Hampshire and Vermont, a clinical aspect that enables me to establish rapport with fellow physicians. As one West Coast physician counseled me, “Continue doing your locum tenens coverage no matter what, because there are plenty of retired docs out there, and we don’t listen to them!”

Fewer than 1 percent of the physicians I have worked with are cynics, who know the price of everything and the value of nothing. Most are skeptics, who speak of their dealings with healthcare administrators as though physicians are Charlie Brown and administrators are Lucy, who promises, “Honest, Charlie Brown, I won’t pull the football away this time,” as Charlie runs to kick it downfield. Another physician quoted The Who’s “Won’t Get Fooled Again.”

Based on what I have witnessed in working with physicians and healthcare administrators, here are some common differences in their thinking and vocabularies:

- *Time frame.* Physicians are trained to immediately process data to close in on one diagnosis, while administrators take time to generate options and solutions. This approach makes some (impatient) physicians feel that the administrators are indecisive or stalling. This physician reaction comes as no surprise because physicians work within the clinical time frame of the next hour, unlike administrators who, except in crises, deal with a time frame of several days to months or even years. As Dr. Bujak (2008, 6) noted, “now” to a physician means without delay, whereas to an administrator, it may mean the next budget cycle or a more distant time.
- *Team orientation.* According to Dr. Bujak, physicians and administrators define “team” differently. Physicians view themselves as members of an expert culture, so they think of teams in terms of individual contributions, much like members of a golf team compete in their own matches. Administrators, on the other hand, see themselves as part of an affiliative culture that is interdependent, much like members of a volleyball team who dig, set, and spike to win a match together. In business school, 30 percent to 50 percent of my grade derived from team projects. In contrast, in medical school, team orientation was rarely cited as a basis for performance.

- *Control.* To physicians, control involves the management of people and processes related to physicians' productivity. To administrators, control applies to assets, such as property, plant, and equipment, but generally not to people and processes.

I have learned that physicians, myself included, lack formal training in communication, negotiation, and conflict resolution. I have yet to work in a healthcare organization where physician–physician communication problems did not coexist with physician–administration communication issues.

COMMUNICATION

Medical school teaches students how to take a medical history and perform a physical exam, not how to interact with others. I acquired interpersonal “skills” by emulating the style of my clinical mentors, who themselves had no formal training in communication. Hence, the sins of the previous generation of physicians are visited on the next. When people ask why this is the case, I reply that the advocates (department chairs) for teaching physiology, pathology, pharmacology, and other clinical areas are more powerful than the advocates for teaching communication skills.

I agree with Christensen, Marx, and Stevenson (2006) that physicians' practice arrangements affect the way they use and respond to common communication tools:

- Solo practitioners tend to wield and respond to *power tools*, such as command and control, threats and coercion, and setting an example.
- Physicians in a small group tend to respond to *management tools*, such as using measurement systems and conducting productivity analyses.
- Physicians who have a service contract with a hospital tend to prefer *inspirational tools*, such as charisma, clear vision, and salesmanship.
- Physicians in a multispecialty group tend to rely on *cultural tools*, such as mentoring new recruits, storytelling, and shared belief.

NEGOTIATION

In my presentations to physicians, when I talk about win-win negotiation, I initially receive blank stares. One physician challenged me, “If I have to give something up, the hospital has to give something up. That's lose-lose negotiation.” Another confessed, “As the portions get smaller, the table manners deteriorate!” (Cohn 2005, 24–29). At many hospitals I have visited, a siege mentality exists, wherein

- on any given day, both physicians and administrators have more to do than there are hours in the day;
- interruptions, delays, and crises occur commonly, rendering printed schedules irrelevant; and
- people have influence but no control over events; they can only control their

own responses to those events. A hospital COO lamented, "It took me half my life to learn that by giving up control, I gained influence."

Malhotra and Bazerman (2007) suggest the following approaches for dealing with irrational negotiators:

- Question the assumption.
- Ask if the other party has different data.
- Use an independent third party, such as a respected physician champion, to present data.
- Look for hidden constraints, such as rising office expenses, in the face of declining reimbursement.
- Explore hidden agendas, such as in instances of perceived disrespect, loss of status, or lack of control.

CONFLICT RESOLUTION

A cardiac surgeon once told me, "I would rather be up all night for seven days in a row than to be trapped in a room with my peers talking about how we can do a better job communicating. I know it's true that we need to communicate better, but I would rather be in the OR!" Patterson and colleagues (2005) wrote that, in the face of conflict, people have a choice to either talk it out or act it out. Unfortunately, for many physicians, talking it out is neither a comfortable option nor associated with much prior success.

Interpersonal conflict is inevitable in times of rapid, disruptive change, which is often present in healthcare. Rosenberg (2003) recommends the following framework for resolving conflict:

- Set a mutually agreeable time to discuss the issues.
- Prepare for the discussion by writing down the concrete actions, feelings, consequences, and proposed solution. Here is an example (Cohn, Algeo, and Stackpoole 2005, 63–70):
 - Yesterday, a problem in the operating room caused me to lose sleep last night.
 - I was concerned that you felt I let you down.
 - I need to feel like a respected team member to function optimally.
 - In the future, would you be willing to let me know ahead of time the possible consequences of what you are doing so that I can feel more prepared in the event of a complication?

ABOUT THIS COLUMN

The next columns will discuss in greater detail the issues presented here. Also, I will explore how physicians can move from an us-versus-them mentality, how to help

independent as well as employed physicians, why physician engagement is a prerequisite for alignment, and why complete alignment is a fantasy.

Lessons Learned

Each installment will conclude with a section called “Lessons Learned,” a list of the primary messages conveyed within the column. The main points in this first installment are as follows:

- Physicians and administrators are trained differently; hence, they think and communicate differently.
- Physicians’ practice arrangements affect the way they use and respond to common communication tools.
- Most physicians lack formal training in communication, negotiation, and conflict resolution.
- Most physicians are skeptics, not cynics.
- When physicians are treated as adults, they behave as adults.
- Healthcare leaders serve at the pleasure of both their board and their medical staff.
- Improving physician relations can yield great community benefit and ameliorate financial and clinical outcomes.

CONCLUSION

It is truly an honor and a privilege to discuss physician relations in this forum. I hope this column moves you to reflect, learn, and initiate a discussion about physician-relations topics that matter to your organization. I welcome a dialogue with you; please let me know your concerns and any additional subjects that would be of interest to you. You may contact me at ken.cohn@healthcarecollaboration.com.

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