



Shari Welch, MD

## Understand Physician Culture to Facilitate Change

*Begin by engaging their scientific and competitive qualities.*

Talk to healthcare executives, quality improvement leaders or patient safety officers about improvement initiatives and you may hear one of the following laments: “New initiatives are guaranteed to fail if physicians are not on board and aligned with other members of the healthcare team”; “Physicians are frequently the most difficult stakeholders to get on board with improvement initiatives”; “Physicians want to lead, but they won’t take the reins of leadership”; and, paradoxically, “Physicians may make passive-aggressive attempts to derail an entire project.”

What is at the heart of physician push-back against change? Is there a secret to moving physicians and getting them onboard with new initiatives?

One strategy lies in understanding physician culture, in particular the culture in which physicians are trained. Most medical training encourages rugged individualism. The traditional medical education establishment may in fact select candidates for their traits of autonomy, authority and rigidity. Medical students and residents are not taught how to function as members of a team. Joseph Bujak, MD, explores physician culture and its effect on work in the areas of quality improvement and patient safety in his book *Inside the Physician Mind: Finding Common*

*Ground With Doctors* (Health Administration Press, 2008).

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Another factor influencing the ability of leadership to effect change among physicians is the so-called physician compact. Jack Silversin and M.J. Kornacki first defined the physician compact in a May/June 2000 *Medical Group Management Journal* article titled “Creating a Physician Compact That Drives Group Success,” in which they described the expectations of practitioners and healthcare organizations.

In 2007 the authors built upon these ideas and, with other leaders, compiled a book about change management strategies applied to physicians titled *Leading Physicians Through Change: How to Achieve and Sustain Results* (American College of Physician Executives). In that framework the physician has traditionally expected to have complete and total

autonomy in his or her practice, that the healthcare organization with which he or she has contracted will provide protection from market forces and generate referrals, and that he or she will not have to deal with regulation. Physicians believe these are reasonable expectations for the sacrifices they made in achieving a medical degree. As Silversin and Kornacki indicate, however, these expectations are no longer valid in the current practice environment.

In today’s environment, the practice of medicine has become increasingly complex and costly, and the old *craft* of medicine and its compact have broken down, evolving into the *profession* of medicine.

The medical education system in the United States continues to foster unrealistic expectations in its new physicians. It teaches autonomy, authority and rigidity when the healthcare world today finds little use for these traits. Autonomy is not feasible in a profession where physicians are increasingly mandated to perform according to practice metrics, guidelines and standards and to provide care as part of a team. Unyielding authority is not adaptive in an environment where the benefits of teamwork are being realized. Rigidity does not allow the physician the dexterity to change practice habits and patterns with the breakneck pace that applied medical research now often suggests. Thus, medical education, training

and culture leave the physician in many ways unsuited to the new practice environment and the new compact.

One element of physician culture that works in favor of a culture of improvement is that physicians are, first and foremost, students of medical science. They think and parse data like research scientists, but data must be made available to them. The physician's innate curiosity and willingness to engage facts and adapt behaviors in response to data can be tapped and leveraged by the quality-improvement movement.

Physician culture is steeped in tradition and built upon a strong ethic of independent endeavor. Standardization is viewed as antithetical to this independent culture, and high variation is

acceptable. Physician culture also builds a reservoir of resistance to future change. In an earlier era, physicians' culture protected patients from unscientific and untested treatments. The conservative physician culture required thoughtful vetting and debate of new therapies, and without doubt, patients were spared much experimentation with unproven therapies. In the current practice environment, cultural legacy can stymie process-improvement efforts when physicians are the last to get on board with a new initiative.

### **Behavior Change Strategies**

Two common characteristics of physicians can be used to develop strategies for facilitating change in physicians' behavior:

- Physicians are scientists—they are moved by data.
- Physicians are competitive—they are performance driven.

First, appeal to the physician as a scientist by using data to make the case for change. Though physicians initially may take issue with the data—in particular quality-improvement data—they will eventually heed it. It is helpful to show physicians the data over time and to stress the focus on trending. A much less difficult sell to physicians involves presenting evidence-based clinical data; often exposing them to sound research data will make the clinical case for change.

Second, physicians typically are characterized as competitive and often

easily moved by data presented as part of a performance feedback structure. Performance data are effective in facilitating change when distributed in a blind fashion. Physicians will recognize their position as performance outliers and will adjust their practice patterns to pull themselves within the bell curve. The result is improvement across the medical staff. With awareness, and the physician's intrinsic desire to perform well, improvement in clinical and practice metrics will follow the dissemination of performance data.

Brent James, MD, chief quality officer and executive director, Institute for Health Care Delivery Research at Intermountain Healthcare, Salt Lake City, has spent decades changing

physician behavior through the dissemination of data. His Advanced Training Program teaches healthcare executives to understand the evolution of healthcare from a craft to a profession and how to change individual physician behavior using data for the diffusion of innovation.

Other factors can contribute to successfully changing physician behavior. Physicians loathe time stealers and inefficiencies. A change that is introduced should be easy to try and easier than the status quo to execute.

For example, physicians at one hospital emergency department within Intermountain Healthcare pushed back against the requirement that they complete a computer mouse

click upon entering the patient's room. The mouse click was designed to cue the registration and nursing staff to the physician's attendance to the patient, allowing them to time their own work processes without interrupting the physician's time with the patient. These physicians railed at yet another required computer interaction, but once they realized they were performing better operationally than under the old method, compliance quickly reached 90 percent.

Another important approach in moving physician behavior involves getting physicians involved early in any improvement initiative. These "captains of the ship" like to be in on the ground floor of an initiative and need to know they have some influence in

the project. This early involvement is critical to gain their buy-in and commitment to the project. Often, they have ideas that other staff might have missed. Bringing in physicians early also acknowledges the centrality of their role in the hospital, as delineated by J.L. Reinertsen, A.G. Gosfield, W. Rupp and J.W. Whittington in a 2007 white paper for the Institute for Healthcare Improvement titled *Engaging Physicians in a Shared Quality Agenda*.

Although healthcare executives may be enthusiastic about an idea that saves the organization money, the financial incentive may not motivate physician behavior. Physicians will, however, pay attention when healthcare executives talk about better patient care and efficiency. Aligning initiatives with patient-centered goals demonstrates sensitivity to physician perspectives.

Increasingly, physicians are concerned about lifestyle issues. Rewarding physicians in ways that address these concerns can be effective. As reimbursements continue to fall, physicians find they are performing more clinical procedures and look for ways to make that work easier. Healthcare executives are beginning to think in these terms and are also considering ways to facilitate physician participation in hospital activities. Offering reserved parking spaces; technology that supports working from home such as smart phones, home computers and other information technology; scribes; and physician extenders are all ways being tried at the system and organizational level to assist and reward physicians.

Leading physicians through change can be one of the biggest challenges for healthcare executives. By understanding physicians' education, culture and characteristics, healthcare executives can develop strategies that encourage the desired behavior among physicians and bring about positive, effective organizational change. ▲

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