

Changing Physician Behavior Through Involvement and Collaboration

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During a seminar several years ago, a participant asked if I could offer a tool that would help him manage physician relations at his hospital. Seeing this question as an opportunity for a class dialogue, I asked participants, "What is the first image that comes to mind when you hear the word 'tool'?" The majority replied "hammer." A few shouted, "gun" or "machine gun." One even bellowed "chain saw!" These responses confirm that physician-relations issues provoke not only practical but also desperate ideas from healthcare executives. Many of the criteria on which their performance is judged (e.g., revenue, expense, and clinical outcomes) depend on the involvement of physicians over whom they have influence but lack control.

What can leaders do to better exercise their influence and, in that process, change physicians' behavior? In this column, I present strategies for involving and collaborating with physicians—the most important first step in changing behavior. Specifically, I discuss a bottom-up approach, finding the "win" with small projects, healthy competition, physician champions, positive deviance, and helping independent and employed physicians.

BOTTOM-UP APPROACH

Physicians with whom I have worked prefer bottom-up processes to top-down edicts. As an internist from New Jersey explained to me, "We strongly prefer inspiration to supervision." Autonomy is important to most physician cultures; they do not like being told how to care for their patients.

Culture is made up of the beliefs, habits, attitudes, and assumptions shared by people in the group. It is the framework for the way the group deals with its members and copes with problems. Healthcare executives make time to shape their respective organizational culture because it allows them to delegate tasks and be more productive (Cohn 2006, xiv). I know of no other way to change physician behavior than to use a bottom-up approach that engages physicians.

FINDING THE "WIN" WITH SMALL PROJECTS

During the report-writing phase of a clinical priority-setting project at a community teaching hospital, one of the project cochairs expressed his frustration over his colleagues' reluctance to discuss clinical protocols. A former Navy surgeon, the cochair sputtered, "Every time we have a complication because nurses cannot keep track of 30 different ways physicians like to treat patients with the same diagnosis, physicians

dismiss protocols as ‘cookie-cutter medicine’ or ‘my patients are different.’ There has to be a better way!”

He and I gazed out the office window and saw physicians running across the street to their offices. An idea came to us: Rather than appeal to the doctors’ clinical sensibility, why not appeal to their time pressures? After all, time-wasting efforts frustrate physicians and make them feel disrespected.

This insight led to the initiation of an anticoagulation clinic, which reduced the daily calls clinicians had to answer. Next, a weaning protocol for postoperative patients was developed, which cut the number of patients staying overnight in the postanesthesia care unit (PACU) by more than 30 percent. For surgeons, this new protocol meant that they did not have to discharge patients from the PACU at 6:30 am, allowing them more control of their schedules.

Several years ago, the physicians and the community hospital followed their “wins” with the successful implementation of a computerized physician order-entry system, which eliminated pages to doctors related to handwriting recognition. Following are the lessons that healthcare executives and physicians learned from their collaboration to improve the practice environment:

- Start small.
- Focus on the benefits to those involved. To gain participation from physicians, executives must offer an overt benefit—the answer to “what’s in it for me?”
- Build on and celebrate successes at least quarterly. Use word-of-mouth to promote new ideas and activities.

HEALTHY COMPETITION¹

The medical director of a cardiac catheterization laboratory faced a challenge: An increase in supplies created a storage problem. He knew that converting a procedure room into storage space would limit the lab’s opportunities to expand its programs and services. At the same time, hospital leaders were questioning him about procedure times and outcomes of the six invasive cardiologists on his staff.

The medical director contacted his cardiologists to ask for their input. At a staff meeting, he showed simple bar graphs of outcomes data and supply use. Each graph represented the work of each of the six cardiologists, who were identified by number rather than by name. Only the medical director knew which name corresponded to which number on the graphs. The cardiologists agreed that they could see widespread differences among the graphs. The medical director encouraged the cardiologists to share their thoughts on how they might minimize variation, improve outcomes, and cut supply costs. He said, “We’ll re-examine these data in six months. If we don’t see improvements by that time, I will add the cardiologist’s name to his or her own graph and post the graph on the bulletin board so that the entire lab staff can help.”

Within four months, the six cardiologists had decreased procedure times, improved outcomes, and reduced costs substantially. As one of the cardiologists explained, "None of us wanted to be an outlier, except on the positive side." Another cardiologist affirmed, "Cardiologists are a lot like alpha dogs who, when a bone is tossed their way, are eager to fetch."

Another example of healthy competition is the success achieved by physicians and administrators of a physician hospital organization (PHO). The PHO's ability to compete for managed care contracts depended on its providers' compliance with CMS's (Centers for Medicare and Medicaid Services) core measures. The PHO held a friendly contest among its clinicians, with the goal of improving compliance with the core measures for diabetes. Posted on the bulletin board located in the facility's waiting room were paper boats, each of which bore the name of a different provider. Start and finish lines were clearly marked. A provider's boat moved forward (or stayed put), depending on his or her compliance with measuring blood pressure, hemoglobin A1c, low-density lipoprotein, and urine microalbumin and performing a physical exam for retinal deterioration and foot ulcers in his or her patient population. Within three months, all physicians were at the finish line—in full compliance with core measures.

PHYSICIAN CHAMPIONS

Physician champions are those who have earned the respect of their peers by delivering exceptional clinical outcomes (Cohn 2008). Physician champions leverage their knowledge and experience beyond individual doctor–patient encounters to improve healthcare for the community as a whole. Physician champions can help healthcare executives in the following activities:

- Presenting and discussing clinical data with physicians
- Minimizing physician–hospital battles
- Creating a safe, learning environment
- Building transparency and trust between administrators and the medical staff

Healthcare executives can turn to physician champions to achieve desired goals through healthy competition, as mentioned earlier. Healthy competition is valuable when hospital leaders and physician executives become frustrated with "herding cats" and trying to obtain consensus among physicians who have different backgrounds and strong opinions.

POSITIVE DEVIANCE

Positive deviance (PD) is based on the premise that solutions to problems already exist within the community or group (Cohn, Thieme, and Feldman 2006, 117). It seeks to identify and optimize existing resources and strategies to solve problems, avoiding the conventional method of determining needs and then obtaining external resources to meet those needs. The PD approach rewards intentional behaviors

that depart from the norms in honorable ways. As such, it makes heroes out of people who do things differently but more effectively, given existing resources and conditions.

Key points in positive deviance include the following (Weber 2005):

- People see themselves as working toward the same goal rather than having conflicting agendas
- A bottom-up rather than top-down approach—problems and solutions are mutually designated by the group members rather than imposed by senior leaders
- A search for group members on the leading edge who have managed to surmount a vexing problem
- Analysis of meritorious behaviors that enable the outliers (positive deviants) to achieve success
- Adoption of the new behaviors into group practice

The following examples illustrate ways that positive deviance can improve healthcare outcomes:

- Dr. Cusano at Waterbury Hospital used positive deviance to cut the number of patient readmissions caused by medication noncompliance from two per month to virtually zero. He arranged for physicians or nurses to contact patients within 24 hours of discharge. The physician/nurse calls were intended to determine patients' compliance with their medication orders. Dr. Cusano learned of this solution by studying patients who took their medications correctly and hence avoided readmission. He said, "If communication is the issue, positive deviance showed us that it is also the answer. To me, this was a beautiful thing" (Cohn, Thieme, and Feldman 2006, 119).
- Along with hundreds of healthcare professionals at the Pittsburgh VA Hospital, Dr. Lloyd and Dr. Jain implemented positive deviance practices, including patient testing, isolation, decontamination, environmental cleansing, and hand hygiene. This effort resulted in a 50 percent decrease in MRSA (methicillin-resistant *Staphylococcus aureus*) surgical-site infections in 15 months. "A true cultural transformation has occurred from within, with support from leadership that demonstrated faith in its people, which manifests in a growing sense of ownership among staff and patients of the implementation of hundreds of small solutions" (Singhal and Greiner 2007).

Positive deviance bridges the gap between what healthcare workers know and what they do (Lloyd, Bruscell, and Lindberg 2008). It also encourages participation, as a surgical ICU director commented, "What we're seeing is just a whole culture change. People really want to be part of a team. People who used to be very quiet are coming forward. This has let them bloom." The Billings Clinic, one of six beta-site healthcare systems in the Positive Deviance MRSA Prevention Partnership,

achieved a 69 percent reduction in MRSA incidence (Lloyd, Bruscell, and Lindberg 2008).

HELPING INDEPENDENT AND EMPLOYED PHYSICIANS

One of the most frequently asked questions posed at the seminars, board retreats, and medical staff conferences I lead is: "How can we support our employed physicians without our independent physicians accusing us of favoritism?" As outlined below, the answer involves streamlining processes and procedures that optimize the practice environment for both groups:

- Form a physician task force that suggests ways for streamlining processes, optimizing care, and increasing productivity. This task force should be composed of the hospital's top clinicians (regardless of irascibility) and physician champions, as discussed earlier (Cohn 2005).
- Use wikis as a web-based repository of contacts and information and blogs (and social networking sites) as a virtual meeting place to implement the recommendations of the physician task force in a timely fashion (Cohn, Mohr, and Ives 2006, 127–42).
- Develop multidisciplinary institutes and medical staff models that permit a variety of practice infrastructures. This way, independent physicians can work together with employed physicians to improve care for the community. For example, in a cancer center, independent oncologists, radiotherapists, and surgeons could collaborate with hospital-employed internists, nurses, radiologists, and pathologists to provide comprehensive cancer care (Cohn and Brennan 2006, 99–106).
- Use a multidisciplinary physician-retention task force to proactively identify physician-practice issues.
- Recruit new primary care physicians and specialists into communities that have a documented need.
- Apply for federal and state grants to be part of a regional health information network. This funding can subsidize the cost of implementing an electronic health record system, which allows healthcare professionals (executives and providers alike) to share information across inpatient and outpatient settings.

I welcome your suggestions on additional methods that work in your community.

LESSONS LEARNED

The main points in this column are as follows:

- Most physicians prefer inspiration and bottom-up processes to supervision and top-down commands.

- Starting with small projects and building on quick wins can deliver overt benefits to physicians: time savings and improvement of the practice environment.
- The healthy competition method entices physicians to work toward goals and avoids the frustration of asking physicians to reach consensus.
- Physician champions can help healthcare executives present and discuss clinical data with physicians, minimize physician–hospital battles, and build transparency and trust.
- The positive deviance strategy operates according to a basic concept: Solutions to problems already exist within the group.
- To improve care by hospital-employed physicians without engendering charges of favoritism from independent physicians, healthcare executives can form a task force that consists of high-performing clinicians from both employed and independent groups. This task force can suggest ways to streamline processes, optimize care, and increase productivity.

CONCLUSION

Continuing the goal of furthering dialogue regarding physician issues, the next column will focus on cutting-edge recruitment strategies, including a checklist for physician employment contracts. Please send me your comments, questions, and ideas.

NOTE

1. This case originally appeared in Cohn and Lambert (2005, 47–48).

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