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The role of the physician in transforming the culture of healthcare

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Abstract

Purpose – The healthcare system in the USA is undergoing unprecedented change and its share of unintended consequences. This paper explores the leadership role of the physician in transforming the present culture of healthcare to restore, refine and preserve its traditional care components.

Design/methodology/approach – The literature on change, organizational culture and leadership is leveraged to describe the structural interdependencies and dynamic complexity of the present healthcare system and to suggest how physicians can strengthen the care components of the healthcare culture.

Findings – When an organization's culture does not support internal integration and external adaptation, it is the responsibility of leadership to transform it. Leaders can influence culture to strengthen the care components of the healthcare system. The centrality of professionalism in the delivery of patient services places a moral, societal and ethical responsibility on physicians to lead a revitalization of the care culture.

Practical implications – This paper focuses on cultural issues in healthcare and provides options and guidance for physicians as they attempt to lead and manage the context in which services are delivered.

Originality/value – The Competing Values Framework, the major interdependent domains and five principal mechanisms for leaders to embed and fine tune culture serve as the main tenets for describing the ongoing changes in healthcare and defining the role of the physician as leaders and advocates for the Patient Care Culture.

Keywords Culture, Leadership, Change management, Management, Health care

Paper type Conceptual paper

Introduction

The healthcare system in the USA is experiencing structural changes intended to improve access, safeguard quality and contain costs (Bowden and Smits, 2015). But in a complex and dynamic system, well-intended change often has unintended consequences. When change becomes chaotic, stabilizing forces are sought to mitigate the chaos and preserve a semblance of order. One stabilizing force is culture, widely seen

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as a socially constructed attribute that "serves as the social glue binding an organization together" (Cameron and Quinn, 2011, p. 18). Here, we explore the leadership role of the physician in transforming the present culture of healthcare to restore, refine and preserve its traditional care components while still driving the necessary improvements and change in care delivery.

In our opinion, the physician-patient relationship is the central tenet from which the culture of healthcare evolved. This socially constructed glue has held the system together since its early days when the practice of medicine was more of an art form than science. The physician making house calls carried a small black case and provided "low tech, high touch" care, to use more modern terms. The "high touch" care was meaningful at an emotional level and over time came to symbolize medicine as a profession focused first and foremost on care. As the profession evolved with educational requirements, standards of practice and a code of ethics, each change was careful not to diminish the physician-patient relationship. That relationship is challenged today, as healthcare shows signs of moving from a professional service to a market commodity, as patients experience services from interdisciplinary teams of specialists, as science and technology move medicine from an art form to a science-based, high-tech service and as regulatory bodies and the insurance industry influence regimens of care.

Schein (1985, 2010) relies on a cultural fit to help organizations operate smoothly (internal integration) and cope effectively with changes in their environment (external adaptation), and he relies on leadership to build such organizational cultures: […] *the unique and essential function of leadership is the manipulation of culture.* (1985, p. 317)

The purpose of this paper is threefold: First, to describe the structural interdependencies and dynamic complexity of the present healthcare system; secondly, to use the Competing Values Framework (CVF) (Cameron and Quinn, 2011) to describe the current culture of healthcare and the ongoing tensions within it; and finally, to suggest how physicians acting in the role Schein (1985, 2010) labels as "culture leaders" can strengthen the caring components of the healthcare culture and help block competing values from the other components of the system.

Framing the culture issues in healthcare

The "culture construct" has been called upon to help us understand the subtleties of decision-making and behavior in multiple contexts: national, organizational and occupational. Because culture exists at three levels (visible, discernible and hidden), historically it proved difficult to define and measure. However, over time, value systems emerged as a measurable component of culture that produced useful applications, serving as the interface between visible artifacts and hidden beliefs. Cameron and Quinn (2011) made the values-culture application more useful by demonstrating how values compete for dominance in organizations. They argued that a greater consensus about values results in one of four defined cultures, each with a reasonably consistent pattern of behavior. Here, we use Cameron and Quinn's CVF to describe the cultural components of the healthcare system in the USA, the changes in process and what we see as the consequences of those changes.

Why does culture matter? Schein (1985, 2010) argued that strong cultures have a demand quality; they tell members how to perceive, think, feel and behave in response to the challenges and opportunities they face. Culture has a strong influence on how we assess reality, even when reality is based on facts. With the healthcare system in the

USA undergoing unprecedented change and with cultural beliefs and values having a strong influence on our perception of reality, culture matters.

Structural interdependencies in healthcare

We see that the healthcare system comprises major domains, each with a large number of individual organizations united in a complex web of structural interdependencies as they interact to produce system outcomes (Bowden and Smits, 2011). For example, care-giving professionals provide direct patient services using knowledge, skills and abilities (KSAs) acquired in the educational settings that prepared them for practice; with these institutions developing those KSAs from information provided by knowledge workers who produced the basic science, converted it into clinical applications and transmitted it through curricula approved by professional associations and licensing bodies. The settings for patient services are constructed, maintained, equipped and supplied by for-profit businesses; and reimbursement for patient services may involve a variety of third-party payers combining both public and private resources. Our summary listing of major domains is presented in Figure 1.

Given this network of interdependencies, the healthcare system is prone to what Senge (1990) labeled *dynamic complexity* – a series of events wherein well-intentioned

Figure 1.
Major interdependent domains within the healthcare system

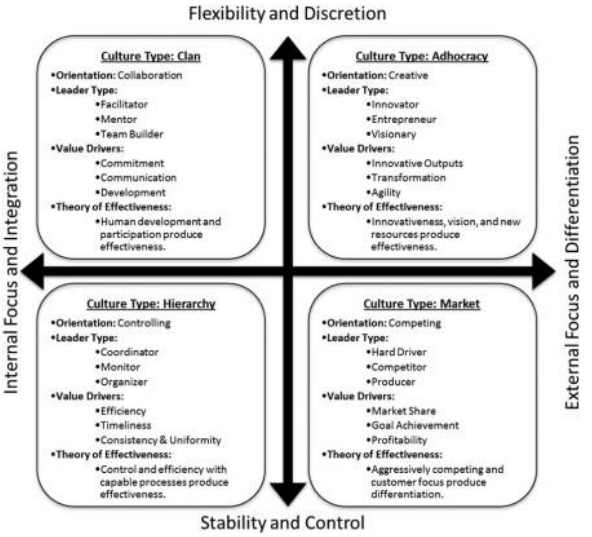
changes in parts of a system, over time, result in unintended consequences in other parts of the system:

> When the same action has dramatically different effects in the short run and the long, there is dynamic complexity. When an action has one set of consequences locally and a very different set of consequences in another part of the system, there is dynamic complexity. When obvious interventions produce non-obvious consequences, there is dynamic complexity. (p. 71)

The competing values framework

Our aim here is to describe the possible long-term system issues stemming from the unintended consequences of recent changes to the healthcare system and to suggest ways to prevent or ameliorate the potential problems. To do so, we rely on the CVF developed by Cameron and Quinn (2011), which is used extensively to diagnose and change organizational cultures. In brief, we are concerned that the parts of the healthcare system that provide scientific and technological advances, regulatory oversight and control and marketplace competition will have long-term and unintended consequences for the system components that provide professionalism and standards of care.

The competing-values approach to describing organizational culture has been in place for decades (Scott *et al.*, 2003) and responded to by 100,000 managers in assessments of approximately 10,000 organizations (Cameron and Quinn, 2011). The Organizational Culture Assessment Instrument (OCAI) assesses the mix of four organizational culture profiles. Figure 2 presents a synopsis of key aspects of the framework and its culture profiles. Given the nature of the enterprise and its strategic approach, organizations and systems typically find the dominance of one of these four cultures as best suited to their performance.



Source: Cameron and Quinn (2011, p. 53)

Figure 2.
Selected characteristics descriptive of the competing values framework

Here we summarize what transpires in each culture by paraphrasing Cameron and Quinn's (2011) descriptions:

- *Quadrant 1: The Clan Culture* is a people-centered, friendly place to work with leaders often serving as mentors, parent figures. The organization is held together by loyalty and tradition and commitment is high. It develops its people for the long term and attaches great importance to cohesion and morale. Success is defined in terms of sensitivity to customers and concern for people. Teamwork, participation and consensus are the preferred *modus operandi*.
- *Quadrant 2: The Adhocracy Culture* is a dynamic and creative place to work, characterized by risk-taking and entrepreneurship. There is a strong commitment to experimentation, innovation and being on the leading edge. The long-term emphasis is to lead in the development of unique and new products and services. The organization encourages individual initiative and freedom.
- *Quadrant 3: The Hierarchy Culture* is a very formalized and structured place to work. People are governed by procedures. The organization is held together by formal rules and policies. The long-term goal is to be a smooth-running, stable, efficient deliverer of dependable, low cost products and services and to provide its members secure and predictable employment.
- *Quadrant 4: The Market Culture* is a results-oriented workplace. Leaders are tough, demanding, hard driving and competitive; members too are competitive and goal-oriented. Winning in the marketplace holds the organization together. The organizational style is hard-driving competitiveness.

Organizations often evolve new cultures as their situations change. Cameron and Quinn (2011) warn us that changes in their model from flexibility and discretion to stability and control may be difficult to reverse:

> Over time, organizations tend to gravitate toward emphasis on the hierarchy and market culture types. Once their culture profiles become dominated by those lower two quadrants, it seems to be difficult for them to develop cultures characterized by the upper two quadrants. […] It takes a great deal of effort and leadership to make the change to a clan or adhocracy culture. (p. 92).

The CVF has been used to study hospital cultures as the context for clinical services often reporting the adverse impact of bureaucracy (for example: Shortell *et al.*, 1995; Strasser *et al.*, 2002). Healthcare-system studies are less common but beginning to emerge. Mannion *et al.* (2009) adapted the CVF to study the British National Health Service and found a decline in the clan culture. Similarly, a recent national survey of the healthcare system conducted in The Netherlands (OCAI Online, 2010) found that respondents preferred a healthcare system with more clan culture and adhocracy culture involvement and less hierarchy and market involvement. "The preferred culture shows that healthcare practitioners want more flexibility, a more people-oriented environment, more innovation and professional freedom" (OCAI Online, 2010, p. 10).

Threats to the "care" dimensions of healthcare

The beliefs, values and behaviors used to successfully resolve crises tend to become strongly embedded in the culture (Schein, 1985). No crisis is more important and personal than a life-threatening health situation for oneself or a loved one. The early

delivery of healthcare featured the family physician versus the threatening injury or disease without benefit of today's elaborate diagnostic and treatment technologies or specializations. Generations have passed since the days when family physicians made house calls ministering to the sick and injured by applying their clinical knowledge and experience using the modest technology they carried with them but the *modus operandi* underlying their hands-on, highly personalized service had a strong culture-embedding effect and established a lasting cultural benchmark for healthcare: The caregiver-patient relationship. This relationship involves a high level of emotion and is not always objective or sympathetic toward impersonal influences such as regulations.

We see the "care" elements of the healthcare system occurring primarily in Quadrant 1, the clan culture in the CVF. This people-centered culture is sensitive to the needs of the people it serves, values the development of the people providing the services and seeks to engage them through teamwork, participation and consensus-building, and incorporates approaches to care consistent with the professionalism that defines healthcare. Caring and people-centered values and behaviors are possible in the other three culture quadrants; however, they are the defining characteristics of Quadrant 1 (Q-1), the clan culture. Historically, healthcare was predominantly in Q-1, the clan culture with the physician-patient relationship the *sine qua non* of the service delivery system.

Changes in Quadrants 2, 3 and 4 have resulted in Q1 losing its centrality in the healthcare system. We see the combined effects of these often well-intentioned changes leading to three unintended consequences that threaten the "care" portions of healthcare: depersonalization, bureaucratization and commoditization:

Q1. The personal bond between physician and patient and other professionals on the care-giving team and patients is diminished by increased reliance on technology (Q-2), government and third-party payer regulations and requirements, economic necessity and sustainability (Q-3) and an assortment of pressures converting healthcare from a science-based art form to a commodity subject to market forces (Q-4). As the professionalism in Q-1 loses the competing-values contest to forces in the other quadrants, bureaucracy expands and healthcare moves in the direction of being a commodity subject to market forces.

Q2. In an earlier paper, we discussed culture issues associated with the rapid advancement of science and technology in healthcare vs the slowly evolving culture changes in the traditional physician-patient relationship. We applauded the benefits of technological breakthroughs and cautioned about effective management during a period of culture change (Bowden and Smits, 2012). The many benefits of science and technology sometimes have the unintended consequence of lessening caregiver-patient interactions and bonding.

Q3. The traditional physician-patient relationship has an authoritative component to it based upon the physician's expert power. Patients expect this to continue and are disillusioned when they see the influence of their physician diminished. The rapid increase in regulations and controls imposed by governmental bodies and insurance providers lessens that authority with a degree of unintended depersonalization. Accompanying the control process is a mass of paperwork

that conveys "bureaucracy" in care settings once viewed through more professional expectations.

Q4. With the greater emphasis on healthcare as a business, professionalism is diminished, in reality or perception, and a degree of depersonalization results. Units of care become another commodity subject to market forces. Independent physician practices morph into group practices, or are subsumed by hospitals and hospital systems, enabling the individual practitioner to benefit from shared overhead, increased volume and assistance with information technology, but also reduced control over care delivery. There is a need to process large numbers of patients rapidly, thereby diminishing the caregiver-patient relationship. Caseloads are assigned by the service unit with physicians deployed via rotating schedules and service delivery is influenced by payment policies defined by commercial and government payers.

Unintended consequences

The changes to the interdependent, complex array of organizations and subsystems that make up the healthcare system are real and result from an equally complex multiplicity of causes. Given the nature of dynamic complexity (Senge, 1990), under such circumstances, unintended consequences are a normal part of the ongoing process. Here, we conclude this section by summarizing two potential unintended consequences of concern to us:

(1) *Quality of Care*: What are the combined unintended consequences of the changes in Q-3 and Q-4? Unfortunately, it seems that healthcare is emerging as a poorly differentiated commodity destined to be delivered by mid-level providers and some physicians who are restricted by economic and regulatory factors.

(2) *Supply and Demand*: What potential unintended consequences exist long term for the provision of professional care? If our analysis of competing values threats to professional-based care in the form of depersonalization, bureaucratization and commoditization are accurate, the overall unintended consequence to the healthcare system, long term, may be insufficient numbers of professionally educated caregivers to meet the needs of future patient populations or changes in the characteristics of a new generation of caregivers.

Physician leadership in the new culture of healthcare

> With a centuries-old precedent, physicians have a moral, societal and ethical responsibility as leaders in all types of healthcare environments to foster positive change – particularly, change that creates nurturing organizational cultures. Cultures that embrace a team focus on optimal patient-centered care and create a supportive environment that is transparent in processes. (Angood and Shannon, 2015; p. 274).

Strong cultures are a stabilizing force producing shared behavioral norms and approaches to problem solving that help members work together efficiently and effectively. However, cultures are weakened by leadership and member turnover, frequent changes in technology and *modus operandi* ("how we do things around here") and a lack of congruence with the organization's external environment. When an organizational culture no longer contributes to internal integration and external adaptation, Schein (1985, 2010) looks to leaders to transform it.

Schein (1985) presented five principal mechanisms for leaders to embed and fine-tune culture. We describe them briefly here as starting points for physician leaders who accept the challenge of strengthening the care components of the culture of healthcare (Q-1 presented earlier). Leaders influence culture through the following:

- *What they pay attention to, measure and control*: Physicians must behave consistently in support of the values of the Patient Care Culture. Members are quick to spot leaders that preach expected values but do not behave in accordance with them.
- *Reactions to critical incidents and organizational crises*: When physicians find ways to cope effectively with depersonalization, bureaucratization and commoditization, they will have potent strategies for embedding and reinforcing the revitalized care culture.
- *Deliberate role modeling, teaching and coaching*: The physician-patient relationship has evolved over time into caregiver-patient relationship with services increasingly delivered by teams of professionals from multiple disciplines and medical specialties. Team leadership places new demands on, and presents culture-embedding opportunities to, the physician in her/his role as teacher/coach (Smits *et al.*, 2014).
- *Criteria for the allocation of rewards and status*: Physicians in group practices have less control over tangible rewards (Terry, 2013), but praise is still potent and when it comes from a leader with high status, its potency is increased. When team members provide an outstanding service to patients, praise will reinforce the culture of care.
- *Criteria for recruitment, selection, promotion, retirement and excommunication*: Here too, group practices curtail physician input on personnel decisions (Terry, 2013), but to the extent they do influence human resource management decisions, it will impact culture.

Strengthening the care culture

In the CVF (Cameron and Quinn, 2011), the strategy for preserving and strengthening one's preferred organizational culture is two-fold. First, to find ways to express one's values in behavioral terms and when such actions are successful to leverage the success to strengthen belief in and commitment to the preferred culture and second, to block or buffer interfering values from other quadrants in the model. Here we focus on the first strategy: strengthening one's preferred culture.

Example 1: Leading and managing "Care pathways". Deneckere *et al.* (2012a, 2012b, 2013) studied care pathways as an intervention to promote and improve inter-professional teamwork in healthcare. They see care pathways as "most effective for standardizing low complexity and low uncertainty care processes" (Deneckere *et al.*, 2012a). Their validation study was conducted in an acute hospital setting using the European quality of care-pathways protocol via a cluster randomized controlled trial. The European Pathway Association defines a care pathway as "a *complex intervention* for the mutual decision making and organization of care for a well-defined group of patients for a well-defined period" (Deneckere *et al.*, 2012a, p. 2). Their Care Pathway study involving 30 teams and a total of 581 team members found that:

> […] the intervention teams scored significantly better in conflict management, team climate for innovation and level of organized care. They also showed lower risk of burnout as they scored significantly lower in emotional exhaustion and higher in the level of competence.

Applying the research of Deneckere *et al.* (2012a, 2012b, 2013) to the challenge of strengthening the Patient Care Culture of the healthcare system using the Competing Values Model, we find:

- The intervention is consistent with the values of the care culture and therefore, strengthens the culture.
- The strategic decision to implement Care Pathways is a leadership function whereas the research and training involved in doing so involves much effort that would be labeled as managerial in nature.
- If the improvements to patient care, teamwork and burnout prevention help resolve a crisis in the care units, the impact on culture would be substantial because success in crisis resolution is a potent means of embedding culture.

Example 2: Burnout prevention via facilitated physician discussion groups. The clan culture of the competing values model (Cameron and Quinn, 2011) described in Figure 1, which we labeled Patient Care in Figure 3, is "people-centered" and has as a core value the development of its human resources. Unfortunately, physicians are stressed and unhappy in many of today's work settings, with more than half experiencing burnout (Shanafelt *et al.*, 2015; Swift, 2015). Our focus here is on a recent intervention that decreased burnout substantially and is consistent with the cultural values we labeled in Q-1 Patient Care Culture in Figure 3.

Siedsman and Emlet (2015) reported on an intervention to reduce physician burnout involving 74 physicians who participated in 19 bi-weekly facilitated discussion groups one hour in duration with the institution providing compensation. They were compared with 350 non-trial physicians who responded to an annual survey. The validated instrumentation assessed meaning in work, empowerment and engagement in work, burnout, symptoms of depression, quality of life and job satisfaction. The results are summarized in the study's conclusion: "An intervention for physicians based on a facilitated small-group curriculum improved meaning and engagement in work and reduced depersonalization, with sustained results 12 months after the study" (Siedsman and Emlet, 2015; p. 1).

While strengthening the care culture is preferable to more defensive measures, we turn next to the physicians' leadership role in protecting the care culture from competing values in other parts of the healthcare system.

Protecting the care culture

Here, we return to the threats to the care culture from competing values in other parts of the healthcare system (Figure 3) to explore ways the physician acting as a culture leader might block or at least buffer the major threats: depersonalization, bureaucratization and commoditization.

Depersonalization. While depersonalization can come from Q-3 and Q4, here we focus on Q-2 as its source. Science and technology have been hugely beneficial to the care portions of the healthcare system. But these advancements have two major depersonalizing effects: First, they may act as substitutes for more hands-on diagnostic

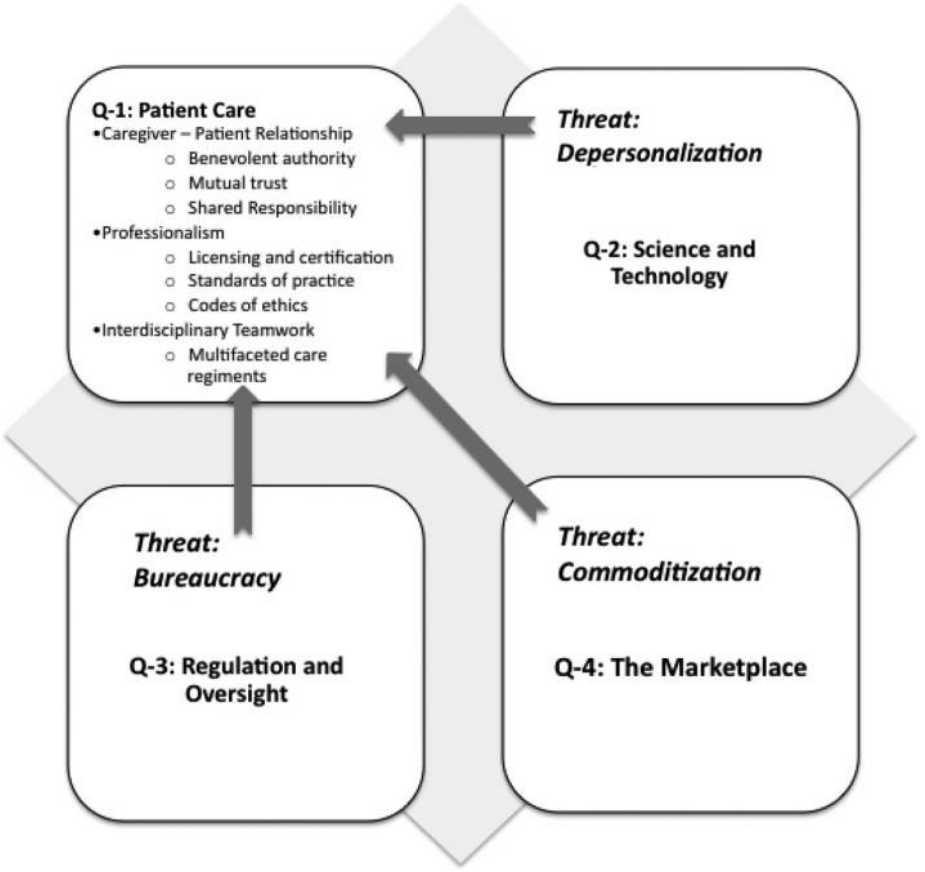


Figure 3.
Threats to the patient-care culture from competing values in the healthcare system

and treatment regimens previously provided by the physician and other caregivers. Second the use of technology often introduces a technician, perhaps located at a remote site, into the interpersonal mix through which services are provided.

The physician may help buffer the depersonalization impacts of high-tech care by providing personal communication regarding its need and benefits. This could be done in person or via a short video presentation. Alternatively, a skilled liaison could be added to the care team to explain such referrals and treatments and serve as the interpersonal expert to help personalize and leverage the benefits of technological advances. Receptivity for high-tech care should increase dramatically as today's tech-savvy children, adolescents and young adults advance in age (Bowden and Smits, 2012).

Bureaucratization. Bureaucratization in the form of hierarchical/impersonal decision-making, excessive rules and controls and redundant paperwork can come from Q-3 and Q-4, even from Q-1 where care units in large hospitals often complain about its presence. But here we focus on Q-3, the primary source of escalating oversight and rule making/enforcement, required record keeping and excessive paperwork and efficiency

mandates that often limit care in the name of cost containment. Southon and Braithwaite (1998) warned us about the assault on professionalism almost two decades ago — "Health services around the world are being restructured in ways that fundamentally affect the nature of professionalism" (p. 23). And they concluded that "If health reforms are to promote effective service delivery, they need to recognize the nature of the task and the central role of professionalism" (p. 27). Promoting that recognition remains a formidable task for leaders.

Commoditization. Healthcare is big business and has accounted for 17.4 per cent of GDP in the USA in 2013. It is also multifaceted, incurring investments, costs, revenues and profits in all of the domains, as presented earlier in Figure 1. Not surprisingly, the free market system with its focus on competition and winning (Q-4 in Figure 2) has impacted the delivery of care as well as the construction of facilities, the marketing of technology, promulgation of insurance, the proliferation of mergers and the countless other commercial aspects of the healthcare system. But the concept of "buying units of care" is quite different from the professional contract between physician and patient at the center of the care culture. Good business is good business but when it diminishes the professionalism sustaining the system, blocking/buffering interventions are needed.

If one starts with the premise that the value underlying the business of healthcare emanates from its professionalism, preservation of the business is dependent on the long-term existence of professionalism and the quality that goes with it. The volatile nature of the market-driven Q-4 culture might help support the Q-1 Patient Care Culture if marketers follow a differentiation strategy and communicate the benefits of personalized care.

Moving forward

The healthcare system in the USA is undergoing unprecedented change (Bowden and Smits, 2015) and its share of unintended consequences. Culture traditionally acts as a stabilizing force allowing incremental, cumulative change. But as Gersick (1991) pointed out, when the slowly evolving equilibrium is punctured, revolutionary upheaval takes place, deep structures lose their holding power and the old rules no longer apply. We contend that the healthcare system's deep structure is the physician-patient relationship and the care culture evolving from those early days of the practice of medicine, in fact historically all the way back to Hippocrates teaching medicine under the Banyan Tree on the Ile of Kos.

Conclusion

Changes in the healthcare system over the past decade or two in the USA and elsewhere have been revolutionary, leaving healthcare's deep structure in disarray. The choices around which a new deep structure is being formed call for strong leadership, some of it being cultural in nature. The Competing Values Model of culture used in this paper highlights the choices under consideration. Moving forward, we have advocated for strong leadership from the Care Culture and the physicians positioned as its leaders.

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