

MENTAT SYSTEMS INC.

Physician Relationship Engineering



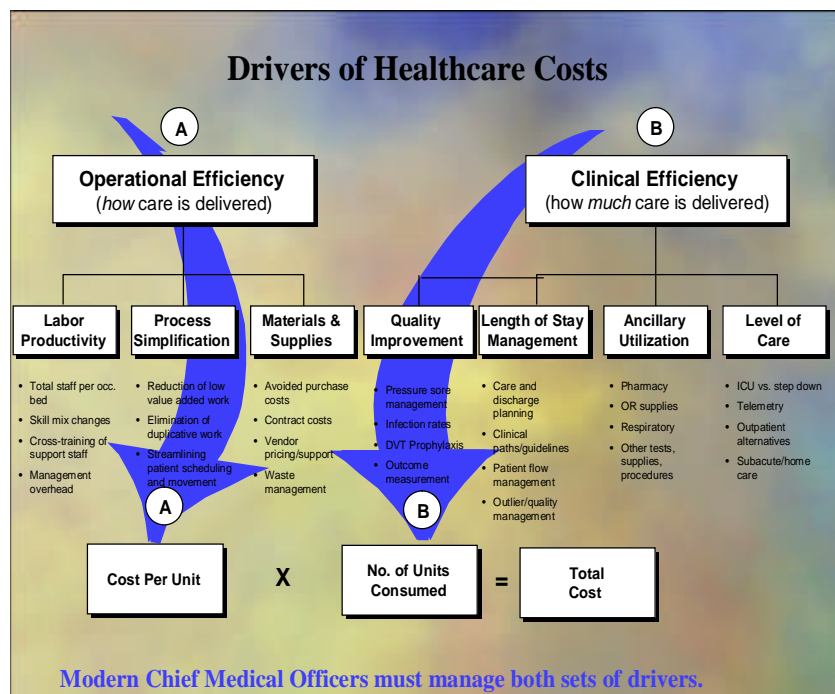
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Physician Relationship Engineering

by Donald C Thomas III MD

Introduction

Health systems have been trying to operate in a manner that increases the amount of income that reaches the bottom line. One of the reasons that reengineering efforts have been so popular is that they promised to increase operational efficiency to the point of profitability. In some cases that was done, but the



problem with that approach is illustrated in the diagram above. The operational efficiency side of the “Drivers of Cost” diagrams (A) demonstrates the traditional areas available for reduction during the classic reengineering effort. The problem is that approximately 70% of the expenses are controlled by actions of the physician staff and those activities reside on the clinical efficiency (B) side of the equation. It is quite possible to reduce the left side of the equation to a point of non-viability without reaching an appropriate level of expense reduction. It is clear that management of the physicians is key to changing the efficiency of operations within the system, but there are significant obstacles to the success of that approach. With enumeration of a few basic concepts, we hope that the approach to medical staff management might start to emerge from the “hit or miss” arena...

Trilingual Hospital

There are three dialects of English spoken in the health care world: Physician, Nursing and Administrator. They share almost all of the same words, but the words often have different meanings.

Consider a conversation between a CEO, CMO and a CNO where they both agree that they want to deliver the best “Quality Care” to their patients. This satisfies them all and they are fine until the words are put to a practical test.

When the CEO refuses to buy an extraordinarily expensive piece of equipment for a newly articulated procedure, the CMO felt betrayed, but for the CEO, quality care meant delivering the best care for the most people within responsible budget constraints.

When the CMO arranged for a presale loan and use of the equipment and the CNO blocked its use for lack of credentialing and operating procedures, she was focused on the Nursing belief that minimization of errors is the major quality issue.

Physicians generally believe that quality care means the best care available regardless of cost.

Alphas Are Forever

Physician Groupings exhibit pack behavior, as do other groupings of people, with the intensity turned up by several degrees.

The aggressive style of most medical training regimens tends to develop intensely dominant gender independent behavior patterns normally designated as • (Alphas). The few • (betas) that survive intact through the training process are themselves very intense and require their own form of special handling.

Alpha behavior has the same bell curve distribution as many other behavior attributes; It stands to reason that the dominant members of an "alpha pack" would need to be at the dominant end of the • spectrum. We refer to these individuals as 2• (double alphas), 3• (triple •) In larger aggregations of physicians or where there is more selective pressure, there are more of these high end alphas. One has only to attend a medical staff meeting to observe this.

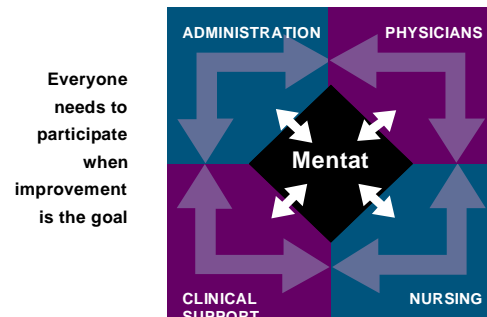
These thought leaders are not always officers of the organized medical staff, but they must be managed. Consider this when selecting the CMO...

Diagnosis Requires Understanding

Cultural Conflicts

There are some basic dynamics that govern physicians' behavior generically. We call these **cultural conflicts** because either they arise as a result of the cultural biases built into our healthcare training models (type I) or they stem from issues rooted in the culture of medical practice (type II). If physician group problems are approached with some of these generalized issues in mind, it becomes much easier to move toward resolutions that have permanence and do not increase social trauma within the system.

One of the most common arenas of physician conflict within the healthcare system is with the nursing staff. Admittedly there are as many reasons for those conflicts as there are individuals squared, but there are some common themes that can be used to defuse these situations considerably.



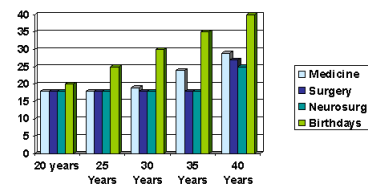
Seniority is the most commonly used work environment determinant of authority, when education and or merit do not intervene. In the military, the disparity between authority and experience is well understood. Senior enlisted personnel are well aware of the practical experience gap that may exist within the junior officer corps although it is clear where the authority to make decisions is placed. Judicious application of this model can diffuse much of the daily conflict that type I and type II problems cause in the clinical areas. In a basic model, using an **Age Adjustment Factor (AAF)**, where one subtracts the years spent in premedical study, medical school and residency training from the chronological age of a specific physician, it is possible to "adjust" to a social age which corresponds well with issues related to management maturity and interpersonal relations. It is much easier to detoxify a conflict between a 35 year old nurse manager and a 35 year old neurosurgeon when the **AAF** reveals the social interaction for what it is. It is important to understand that this dynamic is present in almost every physician interaction, and yet, is almost never considered.

Type I Examples

After hours and weekend conflicts between physicians and nurses are the things that legends are made of within particular

Age Adjustment Factor

The Age versus Respect Paradox



Physician Social Ages generally follow the formula
 (Chronological Age in Years) - (Premed Years + Med School Years + Residency Years)

health organizations. What is not well known is that the conflicts are entirely predictable given the difference in the way that nurses and physicians are trained and the way that they are organized. Nursing education is much more structured toward procedure than that of physicians. Physicians are exhorted to collect their own information, question what they receive from others and not accept conclusions, without questioning their validity. Nurses are not berated for questioning authority. There is a much more traditional approach to experience and procedure; Check, cross-check and protocol are emphasized both in procedure and documentation. This diametric is painted in extreme specifically to illuminate two separate type I problems.

In the **after hours conflict**, the conflict between a given nurse and physician has its roots in the way that the system is constructed and is amplified by differences in the way that the two disciplines are trained. In most health systems, the guardian of policy and procedure outside of standard business hours is the staff nurse. If a physician attempts to act in a way that is considered outside of "policy", the nurse will attempt to intercede. The disagreement may be handed up the nursing chain of command, but the original physician is usually at the center of the conflict for the duration. When the intensity of the conflict gets to an extreme level, an administrator, and/or much more rarely, a physician manager will get involved. But, by that time, a considerable amount of damage has been done. The way to avoid this situation is to construct the flow of events so that strong medical managers are included in conflict management at the earliest signs of its onset. Unfortunately, most systems do not have an appropriate administrative physician management system in place, and among those that do, there is often either a lack of appropriate policy and procedures, or a lack of the specific management training that would make the physician manager effective.

The **Patient Advocacy Argument (PAA)** is another Type I conflict that frequently surfaces. Both nurses and physicians are taught that they are patient advocates, but the difference is in the emphasis of the advocacy. Nurses have learned from numerous practical examples that the healthcare system is at best confusing and at its worst dangerous for patients. In this environment, nurses have taken responsibility for patient guidance and often go to extraordinary lengths to insure the best outcomes for them.

On the other hand, physicians have the attitude that the patient is best served by the best care. The Physician – Patient relationship is time tested and nearly inviolate. This perspective is further complicated by recognition that the physician is responsible for the quality of delivered patient care and related clinical outcomes, in almost every instance. This has often led to situations of extreme delicacy.

There are situations when the "best care" is not what the patient or patient proxy might choose, if given free choice. These situations are made even more complicated by intense debate, within the physician community, related to the dynamics of informed consent. Informed consent is often done in an insufficient manner. There are several reasons for this, ranging from the physician's inability to translate, into level appropriate language, the concepts needed for the patient / proxy to make a decision to the extreme cases where the physician feels it appropriate to make the decision alone.

Quality Initiatives

The medical profession is trained much like the trades. Think of any procedure and it has been taught in the "see one, do one, teach one" method that includes rote measures for materials, preparations and methods. In any given training program this does not represent a problem because the "masters" or professors are the ones that specify the materials and the methods. Therefore, in that program there is homogeneity. However, when the residents finish the program as "journeymen" and set up their practices in non-academic settings, they naturally continue to practice in the manner that they were trained. This results in a chaotic multitude of local inventories and proliferating methods ad infinitum.

The need to control spiraling costs and reduce medical errors requires modification of this self-perpetuating behavior and it turns out that the solution is simple in concept: When the "journeymen" convert themselves mentally into the local "masters" they are then able to set local standards for materials and methods.

In almost every case, this simple change in perspective is all that is needed to initiate major quality activities within the local environment.

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Governance 101

Medical staffs require two different sets of leaders that I like to describe as the "Beauty" and the "Beast." The Chief of Staff or the "Beauty" is a practicing physician, popularly elected, usually for a short term of office, who represents the Id of the physicians to the administration and the governing board. In addition, the COS is responsible for JCAHO mandated activities within the system and is not usually an employee of the system.

The "Beast" is the physician head of medical affairs, and employee who reports to the CEO and is usually not in practice. In the best situations, this medical administrator is responsible for the budgets, personnel and operations that are essential to the activities of the medical staff and its relationship to the rest of the system. This includes direct supervision of employed MDs and supervision of physician contracts.

The synergy between these two positions is essential for efficient medical staff function

When nursing personnel, acting as "the patient advocate" attempts to intervene in a situation that they feel is not in the patient's interest, the state of affairs can quickly combust, and, if handled without extreme delicacy can spread to involve large numbers of nurses and physicians in open conflict.

Type II Examples

Type II conflicts are related to the inner culture of medical practice and usually operate within the confines of medical staff, although they can and often do, spill over to affect other functions within the health system. In some cases, the problem which is originally identified is actually an indication of the underlying dysfunction. Two very common examples of this are the **Hatfield-McCoy problem** and the **Rose Myth**.

For the administrator, there are few things as potentially threatening as the medical staff relationships and their maintenance and long-time medical staff feuds present a particularly difficult set of unpleasant problems. **Hatfield-McCoy Problems** are labeled because they bear many of the stigmata of that legendary feud. Like their namesake they have numerous far flung but related participants and often the origins of the conflicts have been obscured by time. In the medical staff version, practice and referral partners substitute for sibs and cousins, but without a guide or an index, identifying the various lines can approach the impossible. In the worst cases, disruption of hospital operations can drastically affect efficiency and the bottom line. The unwary administrator can inadvertently become associated with rival factions, through innocent actions, hampering his or her effectiveness without any clear indication of the actual aegis of the underlying problem. Attempts to untangle oneself may not only be unsuccessful, but may make the situation worse. Impartial outside mediation may be required to unravel and solve the problem at its root.

The other Type II problem, the **Rose Myth** is a self inflicted problem that stems from the inability to distinguish between significant ways that medical staff members differentiate themselves. "A rose by any other name..." does not apply to physicians, especially when referring to hospital based, employed, contracted and independent individuals or practices. In general, independent physicians feel that employed physicians, of any variation, are not the same species as they are: They feel that the market forces are not the same, that there are unnatural entitlements and that those physicians are obliged to follow the health system party line, regardless of how it affects the independent practitioners. In addition, there are often differences in the way that the various employed groups view each other, leading to a mish-mash of socio-political background noise that can affect everything from peer review activities to recruitment and marketing activities. Fixing the problem may require ingenuity and extraordinary negotiating skills.

Mentat Particulars

Mentat Systems Inc was founded in 1991 to address medical management problems that were rampant in the health care industry at the time: Increased governmental regulations, increased liability, more complex procedures and the

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public's increasing disenchantment with its perceived decreased quality of care combined into an unpleasantly unstable mess that administration had to handle daily. Physician reaction to this increasingly difficult environment was multivariate but generally negative. Although it was clear that the issues surrounding the delivery of quality care to patients depended heavily on management of the medical staff, there was little expertise available to accomplish the task.

The situation has not gotten appreciably better with the passage of time. Steadily increasing requirements for documentation, quality of care and privacy, coupled with increasing complexity of business models have magnified the negative effects of new forms of competition and shrinking profit margins..

Mentat Systems Inc. develops, renegotiates and rearranges structures and the relationships that underlie the conflict and stress that characterizes most modern healthcare environments and practices through the three step process of **diagnosis, prescription and implementation (DPI)**.

Each Step Builds Upon the Last

There are no standard solutions to be applied to medical staff problems because there are no standard problems. Variations in environments, structures, practice patterns, histories and participant personalities all have a direct bearing on the nature and severity of complex issues contributing to the reduced efficiencies that ultimately challenge the survival of the strongest institutions.

The most unique aspect of the ways that Mentat approaches problems is based upon understanding and modification of the interaction undercurrent layers that dominate the relationships within healthcare organizations. Without a thorough reworking of aberrations rooted in these layers only cosmetic changes are initiated, making permanent solutions improbable.

In our **Diagnostic Process** we delve beneath the superficial manifestation of problems or clusters of problems to find the underlying sources of friction. Often these frictions are based on readily recognizable and /or predictable clusters of behavioral baggage that have developed as part of training, professional philosophy, or cultural influences complicated by personal growth patterns. Identification of these "syndromes" helps to pinpoint the most probable prescriptive solutions, given the details of the targeted healthcare institution. At the end of the **Diagnostic Process**, a catalogue of problems is produced, and each significant finding is discussed during a set of interactive presentations. It is important that each identified significant issue gets thorough consideration by all of the stakeholders, although this stage in the engagement is usually a temporary way point in the transition to the **Prescription Phase**.

In the **Prescription Phase**, specific and detailed steps are developed for each problem or problem cluster. This information is synthesized into an **Implementation Plan** consisting of an effective action blue print and an estimated timeline. The purpose of detailed written information at this stage of the engagement is to provide the opportunity for the engagement to decide how to proceed. If a client feels that the first two phases have provided sufficient data for the project to be completed internally and there are sufficient resources to implement the plan, then the engagement is finished. If there are inadequate

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He practiced Emergency
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Officer in a variety of
setting including private,
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year tenure as the
Associate Director and
CMO for the Los Angeles
County Department of
Health, he returned to
the consulting practice
full time in 2001.

resources for the client to proceed with internal implementation, the **Implementation Phase** is initiated.

During the **Implementation Phase** the Implementation Plan is finalized, particularly with respect to timelines. Champions or executive sponsors are assigned and the plan is executed, on multiple fronts simultaneously. The client is constantly updated in interactive sessions designed to follow the progress of the implementation and to make corrections as they are needed. We often use an implementation committee for this interaction.