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Transforming Culture in Health Care

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Health care organizations that are struggling to reorient themselves toward delivery of higher-value care often identify culture as their greatest barrier. As with any diagnostic process, accuracy and precision are essential. Despite health care's widespread embrace and frequent use of the concept of "culture," its meaning is far from clear. The relationship between culture and desired outcomes is similarly murky. If culture change is essential to providing higher-value care, we will have to think clearly about what we mean by culture and how it can be transformed to achieve desired goals.

The term doesn't have a universally accepted definition in the social sciences. Lay understandings of culture usually focus on norms, values, interactions, and beliefs. Under such definitions, the culture of a group or organization may be seen as analogous to the unique style in which one sports team plays the same game with the same rules as competing teams, or the particular culinary experience created when a chef combines a recipe's set of ingredients in one way rather than another.

In the late 20th century, social scientists became interested in the resilience of existing cultures in countries that socialist governments were attempting to transform into economically efficient collectives — such as China during the Cultural Revolution. The countries changed, but the preexisting culture that these governments were seeking to transform was rarely erased, and it often shaped the nature of the desired change. The culture adapted to new circumstances but continued to exert itself, albeit in less prominent forms. For this reason, many social anthropologists conceptualize culture not as a fixed state but as an ever-changing and conflict-ridden process.[1]

These varying concepts are useful in elucidating how the culture of medical practice in some institutions (e.g., Kaiser Permanente or Geisinger Health System) supports care that is value-oriented (in the economic sense), whereas other organizations' cultures fend it off. We believe that the health care equivalents of a game's rules or a recipe's ingredients are two principles ("values" in the social sense) that are key to understanding the resilience of certain forms of medical culture. These principles seem to be embraced by virtually all health care organizations, but there may be tension between them, and organizations vary in the way they resolve that tension.

The first is the belief that patients are the focus of care and that safety and excellence in meeting their needs is the unchallengeable highest goal. The second is the tenet that physicians should continue to be guided by professional norms — that is, retain autonomy and self-regulation — because medical care is too complex to permit "rules" and "guidelines" to define optimal care for every patient.[2,3] Sometimes, to be sure, the importance of physician autonomy and self-regulation is invoked as a defense against change and pressure to improve, but effective cultural transformation requires contending with these deeply entrenched principles. Organizational cultures that globally support improving economic value tend to have environments that align these principles within a coherent framework that supports the organization's overarching goals.

NURTURING INSTITUTIONAL PURPOSE

Most U.S. health care leaders believe that the viability of their organization requires improving the economic value of the care it provides, but they feel overwhelmed by the task of transforming the organizational culture to support that goal. If we think of culture as a process in which tensions between social values are resolved,

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rather than as a fixed state, an approach to such transformation becomes easier to envision.

Leaders can begin transforming culture by developing a strategy that sustains their institutional mission.[4] The strategy will include a hierarchy of patient- and payer-oriented goals with simple metrics that allow all members of the organization to both recognize their contribution and assess their work toward sustaining the institutional mission.[5] It's important to make explicit both the organization's "shared purpose" reflected in the mission and the subsidiary goals that support its pursuit. The classic example is Mayo Clinic's continuous reinforcement of its "primary value" that "the needs of the patient come first." A well-designed goal hierarchy will give meaning and direction to everything that members of the organization do.[6] Any activity that has no discernible relationship to the goal hierarchy deserves to be questioned.

Since trying to change culture outright will lead to resistance, it's best to focus instead on establishing collective behaviors that create new norms in service delivery. Physicians reasonably expect leadership to develop expectations that clinicians and other personnel consistently adopt to support the organizational purpose. Defined habits (e.g., hand hygiene) and routines (e.g., scheduled forums for interdisciplinary decision making regarding patients with complex needs or regular family meetings for critically ill patients) help focus collective behavior on the organizational goals. The objective is to develop an environment that puts patients first and results in physicians feeling a deep sense of purpose and connection to their work — and thus strengthens their identification with their organization. Ideally, when performing expected behaviors such as using a preoperative checklist, physicians should recognize and convey to others that "this is the way we do things here." Eventually, such practices create the kind of consistency and group identity that characterize a championship sports team.

DRAWING PHYSICIANS INTO THE PROCESS

Physicians will continue desiring to preserve their autonomy and self-regulation, and challenging that aim may violate laws regarding the corporate practice of medicine and will almost certainly lead to animosity and resistance. Organizations that are effective in adapting their culture to improve value engage physicians in leadership and consensus building. They create forums where front-line clinicians can propose and develop solutions that target inefficiencies, non–value-added activities, and other problems they see in practice.[7] Decision making at organizations like Kaiser Permanente and Mayo Clinic can be difficult and slow, but eventually decisions are made. Physicians develop models of group autonomy and self-regulation rather than clinging to traditional models focusing solely on the individual.

As with any social creatures, physicians' sense of group identity is weakened by isolation and lack of interactions and feedback, so it's important to provide support for clinicians to socialize and to celebrate and scale up their cultural transformation efforts. Organizations can create opportunities for physicians to discuss their care, including telling stories about their patients, and to examine the metrics that have been identified for assessing their contribution to strategic goals. Beyond expressing appreciation to physicians, organizational leaders can make investments that allow physicians to focus on the elements of care in which their expertise has the greatest effect. For example, when a Cleveland Clinic physician was unhappy with the care his father received, the leadership appointed him chief experience officer; his efforts to improve patients' experience, some of which were captured in the celebrated "empathy video," reoriented the collective focus to change the way that patients were treated and improve their experience of care.[8]

If physicians are to participate in shifting the culture, they will need to be given time to focus on those transformation efforts — and not be penalized with extra, uncompensated work. Rather than holding physicians accountable only for simple clinical productivity measures (which in the short term may need to be reduced), organizations can shift toward more institutional and system-oriented metrics and give physicians adequate time to achieve them.[9]

OTHER INGREDIENTS

Though having physicians who are employees may make it easier to align behaviors with an organization's strategic goals, an employed-physi-

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cian model is not the only mechanism for achieving alignment. The transition of physicians from private practice to employed models is happening, but we believe that its pace should not be forced. Indeed, independent-physician–led accountable care organizations have performed admirably.[10] The presence of employed physicians who resent having to be part of an organization can be toxic to its culture; conversely, affiliated physicians who enjoy leading change efforts can have tremendous influence. The acid test is whether physicians are ready to work as members of teams — not whether all team members receive their paycheck from the same source. If we embrace clinicians who are motivated to make processes more efficient and to change counterproductive behaviors, we can harness this enthusiasm to create environments where physicians with strong team skills are nurtured, invested in, and promoted as leaders.

We do know that health care professionals feel a sense of purpose when they and their organizations help patients live better lives. It is therefore important to involve insightful patients in any large initiative related to the goal hierarchy and to use their stories along with data to highlight the need for culture change. Many organizations report that when patients are included on key operational committees, both physicians and nonphysicians develop new insights about how to improve care through exchanges about the issues that are important to all parties.

When, conversely, members of the organization behave in ways that defy the institutional purpose (for example, resorting to disruptive behavior), it's critical to manage the problem with urgency and sensitivity. Left unaddressed, such behaviors can provide an impetus for others to resist desired cultural transformation, though an overly harsh institutional response may generate similar resistance. Undesired behavior by groups of professionals (for instance, a hospital division's routine defiance of accepted norms of collaboration) necessitates the most sensitive response and requires a deep understanding of its motivation. Some individuals do not work well within "matrix organizations," in which traditional hierarchies (such as departments of anesthesiology, cardiac surgery, and cardiology) have been supplanted by administrative structures that support a collective focus on interdisciplinary process (a heart institute, for example). These may be highly regarded physicians, and at some point, leaders will need to decide whether eliminating their drag on cultural transformation is worth the reputational risk of losing them to another institution. Leaders of many high-performing organizations have faced such choices and are increasingly recognizing the cost of disruptive behavior not only on outcomes but also on the institution's financial health.[11] Once the culture begins to transform in the desired direction, it becomes more resilient and serves as an effective barrier to undesirable behaviors.

Culture is the process through which change is made and the vehicle on which the institutional purpose is delivered, not an entity that can be swapped out from one institution to another. Cultural transformation cannot be done piecemeal, and to be effective, it requires institutional commitment to changing the way that care is delivered. When done well, cultural transformation is self-sustaining and leads to a better experience for both patients and the people who care for them.

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