

INTRODUCTION TO THE FORUM ON HOSPITAL MANAGEMENT

Paul S. Adler

California Management Review published a Special issue on health care in Fall 2000. We now follow up with a Forum on hospitals. The 2000 Special issue addressed the business aspects of health care. These are surely critical, given that health care expenditures in the U.S. are over \$1 trillion annually and the share of GDP devoted to healthcare is 14% and rising. The articles in this Forum, by contrast, focus more internally, on the organizational and managerial challenges of health care organizations, notably hospitals. These issues are no less critical.

There are two reasons for a focus on hospital management. First, the stakes are huge. Hospital charges are the largest single component in the trillion-dollar price of health care, accounting for about half of all third-party health care payments by government agencies and private insurers. Moreover, somewhere between 44,000 to 98,000 people die each year as a result of medical errors in hospitals.¹

Second, hospitals hold lessons applicable to a much broader array of organizations. Three factors make hospitals particularly interesting.

Knowledge-intensive organizations

Hospitals are unusual organizations in many respects. However, they may hold lessons for many "knowledge-intensive" organizations.²

Patients are not typical service-industry "customers." Patients are simultaneously very demanding -- since their health is at stake, and often their very life -- and terribly ignorant -- often resentfully so -- in the face of medical science and technology. Many services, however, find themselves dealing with customers whose reactions increasingly resemble those of hospital patients. Many of us who have tried to install DSL service at home feel similarly passionate about our need for high service levels and similarly frustrated by our ignorance of their technological underpinnings.

The hospital's labor force is distinctive. In the U.S., physicians, whose decisions account for the bulk of a hospital's costs, are not typically employees of the institution -- they merely have "privileges" at the hospitals, and often at more than one. Nurses' turnover rates are notoriously high. High mobility, however, is rather typical of contemporary "knowledge-workers."

1 L. T. Kohn, J. M. Corrigan, M. S. Donaldson, "To Err Is Human: Building a Safer Health System," (Washington, D.C.: National Academy Press: Committee on Quality of Health Care in America, Institute of Medicine, 2000).

2 The "Six West" Problem: Professionals and the intraorganizational diffusion of innovations, with particular reference to the case of hospitals" by Paul S. Adler, Seok-Woo Kwon, Jordana M. K. Signer, 2003

With the growing proportion of professional and technical workers in the modern economy, a growing proportion of firms must contend with a shift in loyalties from organization to profession and with a commensurate increase in mobility.

Due to the importance of these professionals to its functioning, hospitals are unusually complex organizations. The medical staff typically has its own governance structures. Nurses are typically supervised by other nurses, as is the case for and other health professionals. However, here too other knowledge-intensive organizations face similar managerial challenges, and often implement differentiated career paths in response.

In sum: Hospitals increasingly look like precursors of the knowledge-intensive organizations of the future.

A new, more competitive and more complex landscape

Hospitals are also rich in lessons for a growing number of firms that face environments that are simultaneously more demanding and more complex. Following an era of "professional dominance" (roughly, 1900-1965) in which most hospitals' main challenge was attracting physicians, and a period in which government influence predominated (roughly 1965-1980), U.S. hospitals have entered an era of market competition.³ The more recent pressures have not replaced the older ones, but have added to them.

This multidimensional landscape resembles that facing a growing number of firms in a growing range of industries. For hospitals, it consists of:

- * greater cost pressures from payers (including employers and managed care organizations);
- * greater quality pressures from patients and regulators;
- * more aggressive competitive rivalry;
- * trends toward concentration and centralization of healthcare providers: fewer, larger competitors in each market.

Our forum gives readers several windows into how organizations can deal with such multidimensional challenges.

Accountability

Finally, hospitals are representative of a broader range of industries that have come under new and more intense accountability pressures.⁴ This is a challenge common to many professional service organizations, and indeed to broad swaths of industry that are under pressure to address the needs of a broader and more diverse set of stakeholders.

³ Scott, W. R., Ruef, M., Mendel, P.J., Caronna, C.A., (2000). Institutional change and healthcare organizations : from professional dominance to managed care. Chicago, University of Chicago Press.

⁴ Morrison, E. Moble, D. & Farley, B. (1996). Research and continuous improvement: The merging of two entities? Hospital and Health Services Administration, 43(3), 359-372.

Hospitals and doctors have always been accountable, but the nature of this accountability is evolving:

* *What hospitals are accountable for* is changing. Traditionally, hospitals were accountable for the individual patient's health and for maintaining minimum acceptable quality levels. Increasingly, hospitals are being held accountable for the health of whole patient populations, for cost as well as quality outcomes, and for improving as well as maintaining current levels of performance

* *To whom hospitals are accountable* is also evolving. Traditionally, doctors were accountable primarily to their professional colleagues and to their personal sense of professionalism, and hospitals were accountable to regulators for quality assurance. Increasingly, doctors are being held accountable to a broader set of stakeholders: hospital, regulators, employers, insurance companies, patients, courts; and hospitals are in turn being held more accountable for doctors' performance.

These changes in accountability encounter several tension points that result in considerable organizational turbulence.⁵ The new power of payers and regulators destabilizes the old balance of power within hospitals. The power of external accreditation bodies has grown — as has debate over its impact. JCAHO accreditation sometimes elicits "window-dressing," while process improvement proponents have sometimes managed to use this external pressure to build support for performance improvement.⁶

Hospitals provide valuable lessons in how organizations can respond to demands for greater accountability.

Learning from hospitals

The articles in this Forum aim to draw some generalizable lessons from the recent experiences of hospitals struggling to meet these challenges.

The first article, "Performance Improvement Capability" by Paul Adler and Patti Riley, sets the stage for much of what follows. Starting with the observation that some organizations sustain substantially higher rates of performance improvement than their competitors, the authors argue that the source of this difference lies not so much in the way individual improvement projects are managed as in the competencies on which the projects can draw. They call these competencies the organization's "performance improvement capability" (PIC). Based on their study of improvement efforts in several children's hospitals, and synthesizing the lessons of the literatures

5 Arndt, M. and B. Bigelow (1995). "The implementation of total quality management in hospitals: How good is the fit?" *Health Care Management Review* 20(3): 7-14; Lammers, J.C., Cretin, S., Gilman, S. & Calingo, E. (1996). Total quality management in hospitals: The contributions of commitment, quality councils, teams, budgets and training to perceived improvement at Veterans Health Administration Hospitals. *Medical Care*, 34(5), 463-478.

6 Westphal, J. D., Gulati, R., & Shortell, S. M. (1997). Customization or conformity? An institutional and network perspective on the content and consequences of TQM adoption. *Administrative Science Quarterly*, 42, 366-394.

on innovation, diffusion, organizational change, and organizational learning, the authors argue that PIC reflects the state of five key components: skills, systems, structure, strategy, and culture. They describe the efforts these hospitals were undertaking in each of these five components in order to strengthen their PIC. They argue further that these five components form a hierarchy running from skills at the lower end to culture at the high end, and that larger performance improvements require changes at the higher levels, but that changes at the higher levels take longer to accomplish.

The second article, "Framing for Learning" by Amy Edmondson, shifts the focus from the multiple forces shaping organization-level performance to the cognitive processes shaping the effectiveness of small groups. Edmondson starts with the common finding of numerous studies that some organizations fail in their efforts to adopt innovations that other organizations successfully implement. Edmondson studied 16 hospitals' efforts to adopt a new, minimally invasive technique for coronary artery bypass grafts, and identifies the factors that differentiated the successful from the less successful cardiac surgery units. She finds that the difference lies essentially in the tacit cognitive frames held by the unit leaders. Where team leaders used a "learning" frame -- where the challenge imposed by the change was explicitly recognized by the leader and the team and the goal of each surgery was to learn as much as possible as a team about the new technique -- teams were able rapidly to master it. Where they adopted a "performance" frame -- where the goal was to "get the job done" and everyone was assumed competent in their individual role -- implementation was frustrating, difficult, and eventually abandoned.

The third article, on "Why hospitals don't learn from mistakes: First-order problem solving in service organizations" by Anita Tucker and Amy Edmondson, zooms out a notch. It is anchored in a startling observation: Of the 228 problems they observed while shadowing nurses in their daily work, only 10% were resolved in a way that allowed the organization to learn from the incident and to change its processes such that the problem would not recur. In the other 90% of cases, the nurses implemented a short-term fix that enabled them to continue caring for their patient, but did nothing that would prevent recurrence of the problems. Based on their study of nine hospitals, specifically selected because of their reputation for nursing excellence, they argue that the reason for this failure lies not in the differences between individual nurses, but in the organizational contexts within which they work. Where organizations value individual vigilance, self-sufficiency, and efficient task performance, there is neither encouragement nor time to address root causes. They conclude with some actionable recommendations for creating a truly learning-oriented organization.

The fourth article in the Forum, "Hospitals as Cultures of Entrapment: A Re-Analysis of the Bristol Royal Infirmary" by Karl Weick and Kathleen Sutcliffe, maintains the focus on learning and zooms out further, back to the hospital as a whole, and specifically to its culture. Weick and Sutcliffe encourage us to consider the challenge of knowledge management in a setting where the stakes are life and death, and where the organization

structure is by nature complex. This complexity stems from the conjunction of (a) the considerable professional autonomy of physicians, and (b) the close cooperation required across several occupational categories and several hierarchically differentiated levels of status and authority. Their study of the Bristol Royal Infirmary reveals the immense power of self-justification in impeding learning. Most intriguingly, they show how autonomy often works against learning by encouraging rather than suppressing self-justification. They offer several provocatively counter-intuitive recommendations for creating a culture of learning and improvement.

The final article, Gil Preuss and Ann Frost on "The Rise and Decline of Labor-Management Cooperation: Lessons From Health Care in the Twin Cities," zooms out one last step, to the inter-organizational level. Notwithstanding a considerable body of research showing that labor-management cooperation can improve organizational performance and employee outcomes, a number of high-profile cases suggest that cooperation is often a short-lived phenomenon. Attempting to understand the sources of this instability, this article examines a major labor-management cooperation initiative undertaken in the health-care delivery system of Minneapolis/St. Paul, Minnesota. For 10 years, management of more than a dozen hospitals and several unions came together to negotiate and manage a process of wide-scale system integration, painful rationalization, and significant delivery improvement. The results were remarkable. Despite this record of success, however, the alliance fell apart. Preuss and Frost identify several handicaps that progressively undermined the alliance. The common core seems to have been the difficulty of ensuring the smooth, continuous adaptation of a multiparty alliance to the evolving needs of its parties. Balancing cooperation and conflict is difficult enough in a single round of negotiation, but renegotiating this balance as the parties' need evolve over time demands uncommon wisdom -- and a lot of luck. Preuss and Frost offer no easy solution; but readers confronting such challenges in their own contexts will find much to meditate on in their account.

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This Forum on hospital management thus addresses several challenges with which managers in many industries grapple: stimulating organization-wide improvement efforts, creating organizations that consistently learn, and mobilizing the various internal and external stakeholders to support those goals.

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