CONFLICT RESOLUTION MANAGEMENT BETWEEN HEALTHCARE MANAGERS AND PHYSICIANS

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ABSTRACT

Healthcare delivery in the United States has undergone a complete transformation in the past 75 years. Dramatic changes have occurred in critical functional areas such as medical technology, reimbursement methodologies, employment arrangements, and other important administrative and clinical areas. Despite the influx of changes, one particular structural aspect has not changed. The adversarial relationship between the medical provider community and healthcare managers has continued to be a normal part of the daily functioning in healthcare environments. Healthcare industry participants would suggest that the dysfunctional relationships between doctors and mangers have intensified with each passing decade. With the United States' recent recognition that the current system of health care is trending towards an unsustainable financial future, along with the recent passage of the Patient Protection and Affordable Care Act (ACA), the primary goal of all new healthcare public policy has been to increase access and improve quality. By achieving ACA's primary goals, cost reductions become a secondary positive outcome. These objectives can be accomplished only by means of a systems thinking approach in which healthcare providers and healthcare managers work in tandem.

This essay explores the origins of the adversarial relationships between medical providers and healthcare managers. Conclusions are drawn that place current emphasis on the inability of providers and mangers to engage in effective communication due to structural roadblocks. Systemic structural barriers enmeshed in long-standing institutional systems of education, in addition to a healthcare system that is inherently structurally flawed, create multiple opportunities for conflict between providers and managers. Strategies including alternative dispute resolution and the use of communication tools will be explored as methods to reduce conflict. Understanding the conflicts between healthcare managers and physicians

highlights the importance of resolving these conflicts within the new framework of healthcare delivery in the United States. A continuation of the current adversarial relationship between doctors and managers has direct impact on public health. This issue has public health relevance due to the fact that if left unsolved it will work in opposition to the basic tenets of the Affordable Care Act leading directly to more costly health care and contributing to poor health outcomes for all healthcare consumers.

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1.0   INTRODUCTION

The existence of conflict between doctors and healthcare managers is not a new social phenomenon in the healthcare culture of the United States. A professional culture gap has existed for many years. Doctors are perceived to have a level of confidence that borders on arrogance. Their sole focus is the health of their patients no matter what the costs. In the same circles, healthcare managers have been labeled by doctors as "bean counters" who simply have one motivating factor–achieving a solid financial bottom line (Waldman & Cohn, 2007). The axiom, "No money, no mission!" has been used by many healthcare managers as a logical retort when responding to criticism. This inherent perceived dichotomy of motivating factors has cultivated adversarial feelings between these two professions for many years. Lines have been drawn and labels bestowed. The doctors are the "white coats" while the managers are the "blue coats" (Waldman & Cohn, 2007).

As if the feelings of tension were not substantial enough already, the healthcare industry has seen an escalation in the divisions both overtly and covertly over the past decades (Harrison & Davies, 2003). While both the medical profession and healthcare managers report rapid advances in areas such as technology, pharmaceuticals, and software development, the gap in areas of expertise have substantially widened. Each party feels as though the other has no legitimacy to intervene in its profession on any matter whether large or small (Rundall, Davies, & Hodges, 2004). Thus, the communication gap has continued to prevail without any substantial negative consequences felt by stakeholders including hospitals, patients, and state and federal regulatory agencies. Disparity exists in ideals relating to the most efficient and effective deliver methods, but the impact of poor communication has not, until recently, been substantial enough to alter the perception of the quality of care being received by patients. It is a phenomenon that is self-contained within the hospital walls. However, in recent years, the perspective of consumers has shifted as costs within the healthcare system have increased (Preskitt, 2008). With that

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shift, all participants in the healthcare industry are expected at the behest of consumers and by the mandate of public policy to make changes that would benefit consumers and stakeholders alike. With the passage of the Patient Protection and Affordable Care Act in 2010, the framework for how services are provided by doctors and hospitals has changed and managers must work within a new framework to maximize reimbursements (DuBois, 2013). Efficiency and cost effectiveness have come into primary focus and direct drivers for reimbursement methods. In order to achieve greater levels of efficiency and lower costs of delivery, it is apparent to all participants in the healthcare market that the prevailing adversarial relationship between doctors and managers must be resolved. If the United States healthcare system is going to succeed in shifting the paradigm of healthcare delivery in a dramatic way, it must include buy-in from all stakeholders including government agencies, physicians, managers, and patients.

Conflict between physicians and managers has a direct negative impact on public health. First and foremost, the most severe direct influence is seen on the physical health of patients. Conflict fosters a lack of communication between coworkers which in turn can be the impetus for medical errors and adverse health outcomes. In conjunction with physical harm, conflict can also cause emotional harm in the form of increased stress on patients, physicians, and managers. Indirect effects of conflict include financial concerns and potential litigation. Finally, from a systems thinking perspective, conflict can negatively impact the morale of an entire organizational ecosystem leading to issues of employee retention and consumer satisfaction.

2.0   CAUSES OF CONFLICT

A majority of doctors and other healthcare providers practice medicine with the intent of helping those in need with health problems. They acquire the skills necessary to perform their jobs through long and arduous education and training. Once they are able to practice medicine on their own, doctors' preferences suggest that they would rather be left to pursue their profession with as few distractions and interference as possible (Unruh, 2013). However, this is not the reality in today's healthcare environment. Healthcare providers are under constant pressure due to factors such as patient expectations, dynamic administrative policies, and changes in regulations.

In the same environment, healthcare managers are tasked with managing a work environment that promotes efficiency, patient safety, patient satisfaction, and financial sustainability. Healthcare managers face daily pressures from internal and external forces in the same fashion as the medical providers. High-level managers' jobs include mitigating employee turnover, reducing hospital errors, keeping board members satisfied, and most importantly, managing a hospital's operations with a finite amount of resources. As part of the pursuit to maintain efficient and effective clinical staff, the job dictates that doctors must be scrutinized on the basis of utilization rates, costs per case, case volume, as well as other metrics.

This situation in which doctors prefer to function autonomously in conjunction with hospital managers, whose jobs are to create systems of accountability for the practice of medicine in organizations, is where the conflict arises. The core of this conflict is that each party believes that neither is performing their jobs with the purest intentions in mind. The doctor believes that the manager is simply a "bean counter" at his core and makes daily, weekly, or monthly managerial decisions based solely on financial rationale (Waldman & Cohn, 2007). Healthcare managers foster contention based on

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their perception that doctors believe manager's job functions are insignificant and not grounded in evidence based practices.

The conflict between doctors and managers can be better understood by examining the significant contributing factors. The dynamics that create the stimulus for conflict are linked to several elements. The following section will address the issues of educational differences, differences in career paths, reimbursement structure, and regulatory oversight.

2.1   Educational Differences

At first glance the educational differences between the path towards becoming a medical doctor and that of becoming a healthcare manager might seem fairly obvious. Most respondents, if asked, would note two obvious differences: the focus of studies and length of educational requirements (Freudenheim, 2011). After dissecting these differences a little more thoroughly, the underlying issue of respect and acknowledgment presents itself. Physicians are not often eager to discuss the matter publicly, but there is a certain unspoken sense of justifiable entitlement that physicians feel based on their educational background (Morse, 2010). With this sense of elitism comes a formidable atmosphere of comradery with fellow physicians. A professional working environment based on understanding and familiarity is achieved when surrounded by like-minded colleagues. When physicians take on management roles within a healthcare system, the chance of conflict is diminished due to the underlying level of reciprocated professional respect for a physician who serves in both a provider and managerial capacity.

In contrast, the sense of elitism that is perpetuated from physicians does not go unnoticed by healthcare managers and is therefore a source of conflict. Healthcare managers feel inferior and disrespected. These differences create conflict. Physicians oppose the way that many managers and CEOs conduct their operations in healthcare practice.

2.2   Different Career Paths

Waldman and Cohn (2007) conducted a study in which 670 CEOs from United States hospitals were surveyed to determine the types of work experience they held prior to their executive position. Table 1.0 displays the percentage breakdown of the various positions held prior to becoming a CEO. In addition, the table showcases a percentage breakdown of formal education that was attained by the 670 respondents surveyed.
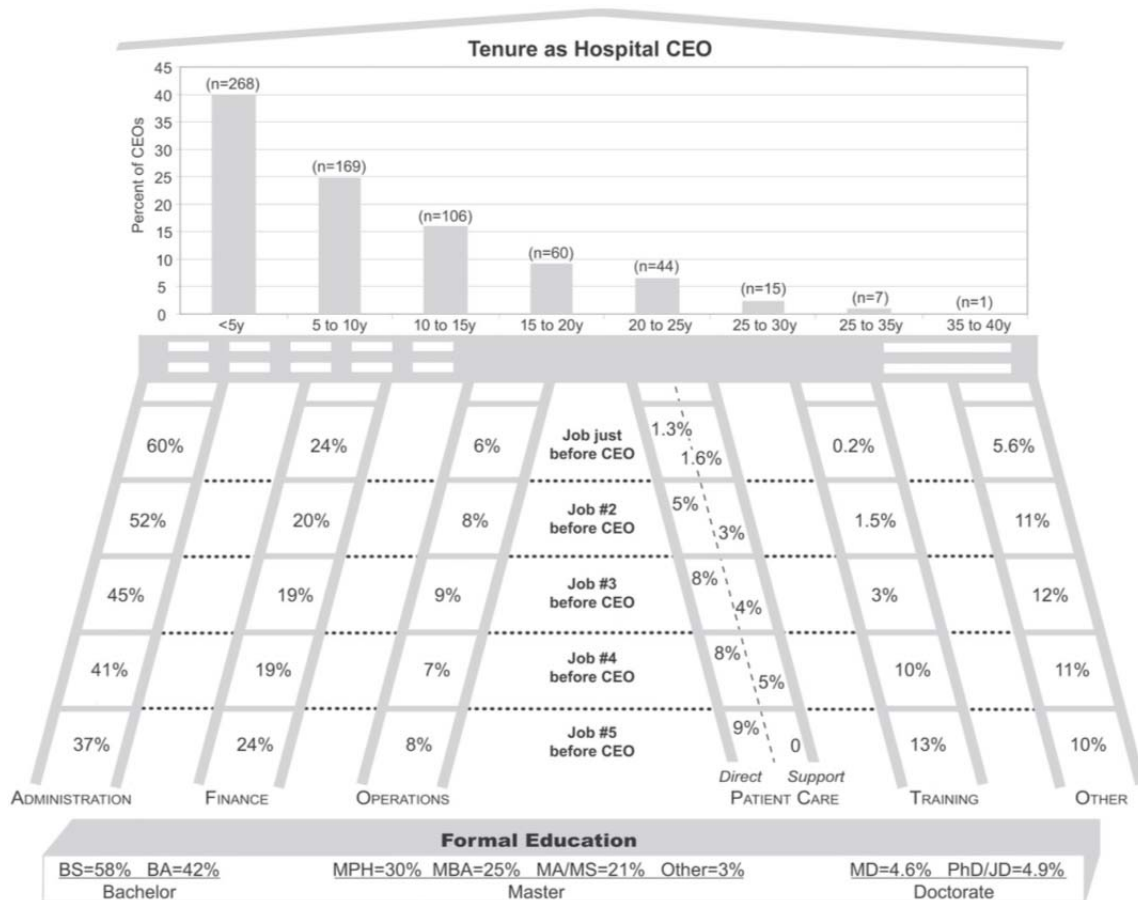
Figure 1. Ascending the Hospital Ladder to CEO

(Waldman & Cohn, 2007; Re-used with permission)

The results of the survey indicate that hospital CEOs make the transition from a managerial role to a chief executive role through a variety of professional backgrounds. The two most common backgrounds include administration and finance at 60% and 24% respectively, in the last job prior to ascending to the CEO position. The table also indicates that both direct patient and support care are two of the least common fields in which CEOs work before transitioning to become executives. What can be deduced from this chart is the following:

1. Healthcare managers' professional backgrounds are much more diverse than that of healthcare providers.

2. An overwhelming majority of healthcare managers and CEOs have no background in direct or support care.

3. The educational background of healthcare managers is just as diverse as their post-graduate professional experience.

These three observations in large part reveal vital differences that are a major source of conflict. Medical doctors' educational and professional experience is much more structured and predetermined. Medical students have precise paths forward to become practicing physicians. These structural differences in career and educational paths create divisions and have the potential to create conflict. Healthcare managers early in their educational careers are trained to look at issues from an organizational perspective, while a physician's technical training is much narrow in scope. Physicians are trained to be singularly focused on an individual patient (Waldman, Smith, & Hood, 2006). The substantial difference in educational and professional mindset is perpetuated through a manager's and a physician's career. Mangers continue to address problems and formulate resolutions based on a systems thinking approach, while physicians concentrate on achieving positive outcomes on a case-by-case approach.

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2.3   Reimbursement

The contention between doctors and healthcare managers could be substantially mitigated if each party understood the historical evolution of hospital and physician reimbursement systems. To use a sports analogy, the game has changed, the players have changed, but until recently, the rules have not.

In the early 1900s, the idea of health insurance and hospitals as legitimate centers of science was just beginning to take root (Hawkins, 2010). During this period, it was typical that when patients were discharged from a hospital, they would likely receive two separate bills. That is, one bill would be generated from the physician for his service and another bill would be generated by the hospital for the patient's stay (Preskitt, 2008). This is assuming that any money was exchanged at all. Most hospital patients during the early 1900s were unable to pay for any services due to the fact that most patients were poor, elderly, or mentally ill (Sultz & Young, 2011). If the patient could pay during this time in healthcare, the patient would pay for services in cash. It is also important to note that the use of administrative staff was very limited. The hospital or physician's office was predominantly staffed with doctors and nurses. The payment for services structure was not adversarial at all to healthcare managers during this time so there was no conflict between physicians and managers.

As the 1920s approached, hospitals became more widely recognized as centers of learning and science (Preskitt, 2008). This transition was mostly due to advancements that were taking place in technology and science. As hospitals and doctors were becoming more respected by the general populous, more people were taking advantage of their services. Hospital reimbursements were made on a cost-plus basis, eliminating any need to monitor costs. Doctors were paid on the basis of reasonable and customary charges, which turned out to be a powerful incentive to add to the charges and a powerful disincentive against offering lower fees. During this phase, hospitals were thriving. The main objective of hospitals was to fill as many beds as possible to maximize profits.

With the rise of third party payers in the 1930s, physicians were paid by insurers, but their payments were kept separate from those of hospitals in Blue Cross/Blue Shield plans. This design was maintained when Medicare, beginning in 1965, developed its part A (hospital) and part B (physician) payments (Preskitt, 2008). In Medicare's early days, it followed the same approach as private insurance carriers, whereby doctors were paid retrospectively for "usual, customary and reasonable charges" (Preskitt, 2008). The more services they provided, the more they could bill for with no cost containment incentive and no consideration of quality. In the following years, use of public and private insurance increased and accounted for only 25 percent of all personal healthcare spending in 1965, reaching 54 percent by 1982 (Preskitt, 2008). However, this type of payment could not continue.

In 1982, actuaries announced that Medicare's Hospital Insurance Trust Fund would go bankrupt in five years (Preskitt, 2008). The following year, the Prospective Payment System (PPS) was implemented. Using a mechanism called diagnostic related groups (DRGs), the hospital's payment was fixed for a particular visit, no matter how many services were rendered. This put pressure on hospitals to contain costs and had the potential to cause conflict with physicians, as physicians might want more services and longer inpatient stays for their patients than the hospital thought were necessary to provide. After the PPS program was put in place for hospitals, physician spending began to grow faster than hospital spending, and policymakers were already considering how to change Medicare physician payment. A change was made in 1992 in an effort to help reverse the trend of increasing physician reimbursements. A new rate-setting mechanism began to be used, called the Resource-Based Relative Value Scale (Preskitt, 2008).

Up until the passage of the Patient Protection and Affordable Care Act in 2010, the United States perpetuated a physician and hospital reimbursement system that had limited controls in place to curb costs and monitor quality of healthcare delivery. The fact that a healthcare manager's core job functions are to control costs and monitor quality leads to an adversarial relationship with physicians due to the very basis of the reimbursement system.

In an article entitled, "Billing Schadenfreude," Waldman (2006) expounds on the dysfunction of the reimbursements system by using the figure below.
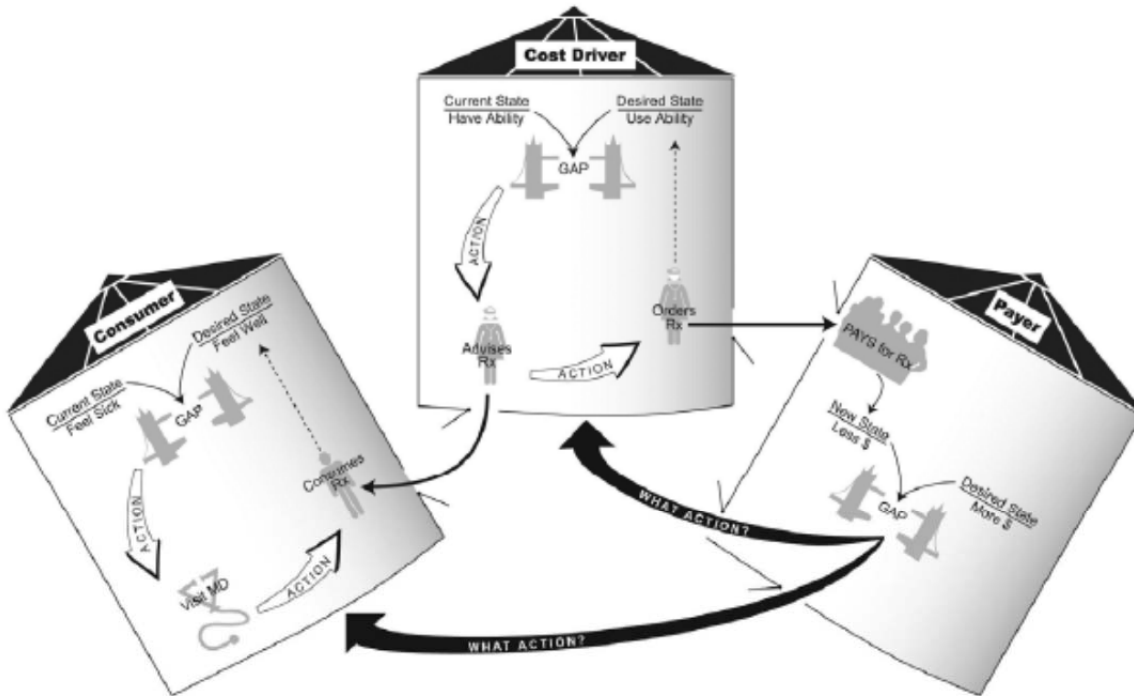

Figure 2. Healthcare – Silos and Micro-Economic Disconnection.

There are three separated systems or silos: Consumer (patient), Cost Driver (provider) and Payer. There is very limited interaction between silos, but the major feedback is contained within the silo and does not accomplish system-wide purposes:

- The Consumer experiences a gap between desired state (feeling well) and current state (feeling sick). The gap induces an action – going to the doctor (provider) – who recommends a treatment (viz., a medication) that the patient consumes and thereby feels better, achieving a resolution of the initial gap.

- The Cost Driver's gap – between having ability and using ability to heal – causes her to care for the patient. Consulting with the patient is followed by a recommendation for treatment such as a medication that creates an expense – a financial outlay that neither she nor the consumer pays.

- The Payer covers the cost of treatment and this creates a gap between the desire to have money and the obligation to spend money. To resolve this gap, the payer takes some action, affecting either the Consumer silo, the Cost Driver silo, or both.

Consider what action(s) are available to the Payers to resolve their Gap. Note the absence of effective feedback loops between Payer, Cost Driver, and Consumer. Contrast this system of three silos to the McDonald's loop in Figure 1.

Figure 2. Healthcare-Silos and Micro-Economic Disconnection

(Waldman, 2006; Re-used with permission)

Waldman's interpretation regarding the dysfunction of the system is based on the idea that the system is structured in such a way that it lacks a systems thinking approach. The three major players involved are the consumer, cost driver, and payer. However, each participant operates in a vacuum, or as

he refers to them as "silos," with little to no interaction with or feedback from the other parties involved in the process. These factors create the basis for conflict between healthcare managers and physicians.

2.4   Regulatory Oversight

Another contributing factor to the ongoing contentious atmosphere between healthcare providers and healthcare managers was the introduction of regulatory oversight bodies. Healthcare delivery used to place a primary focus on the building and continuation of the patient-doctor relationship. Quality was maintained through an ongoing association with primary care providers who considered hospitals an extension of their services. It was the physical structure that was built in order for physicians to have a place to see their patients when more serious conditions or ailments arose. The hospital was a necessary physical asset in the continuum of care provided by a doctor. As technology has improved and sub-specialties have increased dramatically, the concept of hospitals makes them less of an extension of a physician's practice and more of an employer of healthcare providers.

The past 15 to 20 years have seen a transition from private physician practices to a trend of large integrated health systems. The transition of services from private practice settings to large hospitals employing providers has also included the introduction of a multitude of regulatory oversight bodies. Hospitals have regular interaction with federal regulatory agencies such as the Food and Drug Administration, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration. In addition to these federal agencies, hospitals must also be accredited by organizations such as the Joint Commission, the National Committee for Quality Assurance, and the Accreditation Commission for Healthcare. While receiving accreditation from these agencies is not always mandatory, most of the time they are required by the payer organizations in order to be reimbursed.

With the creation of oversight agencies, hospitals have had to make a conscious effort to hire sufficiently more healthcare administrative personnel to remain in compliance. Positions such as

compliance officers and in addition to large human resource departments have become an integral component of a hospital's corporate structure. A subsequent side effect of the enhanced mandatory oversight has been an increased level of animosity and tension between physicians and managers (Merritt, 2012). As mentioned in previous sections, doctors want to practice autonomously in order to achieve their primary objective of delivering quality patient care. However, the number of regulatory and accreditation bodies in existence and the bureaucratic workload initiated by oversight agencies make it challenging if not impossible for doctors to function autonomously.   Healthcare providers understand the complexities and oversight now mandated, but this certainly does not preclude them from feeling micro-managed. This issue is a definite source of conflict.

3.0   TOOLS FOR CONFLICT RESOLUTION

Healthcare providers and managers need to focus on building better working relationships. Finding improved and more effective means of communicating will accomplish both parties' end goals of providing quality care in an efficient manner. Although it is unrealistic for healthcare providers to completely reeducate themselves, they can, however, be professionally developed to utilize and implement tools and strategies for effective collaboration within the work environment. Likewise, managers have the ability to develop a better understanding of what motivates physicians professionally. By both parties putting forth the effort to gain insight into each other's work ethics and motivating factors, tools can be learned to help reduce conflict and increase mutual respect.

Certain aspects that have contributed to the deterioration of the healthcare provider and manager relationship over the years are impossible for individual providers to change alone. Issues discussed in previous sections such as educational differences, career paths, and reimbursement structures are out of

the control of individual physicians. These are institutional roadblocks that need a much broader level

push than that of any individual. Physicians, however, on a personal level can have a dramatic positive

effect by focusing on and developing tools in areas such as communication skills, teamwork, systems

thinking, and mutual professional respect. To many healthcare providers, these topics might seem trivial

and more importantly very unfamiliar. This is to be expected. One must always remember that a

physician's educational path is very different in comparison to others. Medical students' overall set of

courses is very focused on developing highly technical skills in a somewhat narrowly based curriculum

that is suited for a single profession.

Managers need to develop a better understanding of the differences in process between

themselves and physicians. There is a lack of recognition of how little training physicians receive in

teamwork and interpersonal skills while in medical school or on the job. Managers must develop

communication tools that are effective in specifically interacting with physicians. Effective strategies

exist for establishing processes to communicate and to resolve conflicts. Those are active listening,

structured dialogue, appreciative inquiry, and positive deviance.

3.1   Active Listening

Active listening is a key component for effective communication, yet many physicians fail to engage in

this process. The United States Department of State (2013) contends that there are four rules of active

listening. These rules include the following:

1. Seek to understand before you seek to be understood.

2. Be nonjudgmental.

3. Give your undivided attention to the speaker.

4. Use silence effectively.

The first rule is an important one for physicians and managers to follow because when an individual makes an effort to understand another's perspective rather than having his perspective understood first it reveals empathy and mutual respect. When this is an individual's response when engaging in conversation, it allows the other person to feel validated and understood. Using this first step will allow participants to engage in a balanced exchange of ideas.

Rule number two, being nonjudgmental, allows the free flow of conversation and displays to your speaking partner that while you may not necessarily agree with her approach or solution to a particular problem, you are willing to hear any possible ideas. Failure to be nonjudgmental may put your conversational partner into a defensive mode and stifle the chance of coming to a mutually beneficial outcome.

Giving your undivided attention is the third rule. This step in the process of active listening displays a level of mutual respect and professionalism. The decision to use certain non-verbal behaviors, such as eye contact and nodding, shows an individual that you are being an active listener. By contrast, non-verbal actions such as avoiding eye contact or fidgeting can indicate to a speaker a lack of empathy or caring about what the person says.

Using silence effectively is the final rule for active listening. Maintaining silence is essential as it allows a speaker to fully develop and articulate complete thoughts. When interrupted, a speaker is unable to clearly vocalize her position. That is, constant disruptions interrupt the flow of an individual's thought process and verbalization. Using the tool of silence also allow the listener to process and formulate thoughtful responses.

3.2   Structured Dialogue

Many if not all practicing physicians feel that the major source of conflict between themselves and their managers is that they are rarely asked to be involved in the many administrative decisions that have a

direct impact on their daily duties and performance. In addition, physicians believe that their input should

be considered the most valuable as they are the ones who have the most direct relationships with patients

and their families (Cohn, 2002). Likewise, healthcare managers all clearly understand that physicians

have the potential to have the most impact as change agents within an organization. It is the physicians

who wield much of the power to effect change across an organization. All of these facts lead to the

conclusion that the process of structured dialogue within a healthcare organization is an invaluable tool to

maintain effective working relationships between managers and physicians. Structured dialogue as a

process is not a complicated methodology. At its core, it is a simple approach to formalize the

discussions and brainstorming processes that are taking place all the time within organizations but in

much more informal professional circles or group atmospheres. The basic developmental steps needed in

order to develop a structured dialogue process are depicted in Figure 3 below:

The Structured Dialogue Process
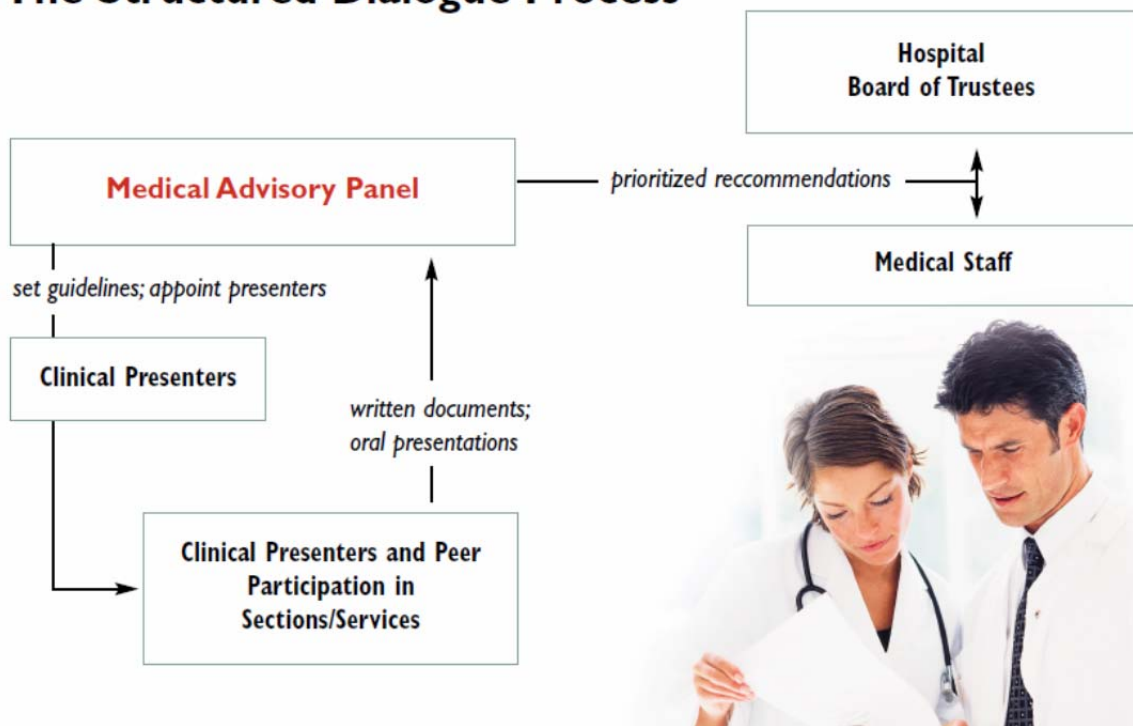
Figure 3. The Structured Dialogue Process

(Fitzgerald, 2008; Re-used with permission)

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The process of structured dialogue accomplishes the following:

1. It provides a formally recognized process within healthcare institutions that is specifically set up to allow healthcare providers a direct forum to verbalize and report their concerns and ideas to the administration.

2. The unique structure of a physician led process is much more effective than typical administrative constructs physicians might be asked to be involved in such as committees or boards, due to the fact that it appeals to a physician's sense of synergy that she believes occurs when being allowed to communicate and brainstorm with colleagues.

3. It facilitates resolution of many issues that if left ignored could have the potential to cause major disruptions that could be cost drivers.

3.3   Appreciative Inquiry

Judy and Hammond (2006) define appreciative inquiry (AI) as the process which "encourages groups to inquire about, learn from, and build on what is working when they are at their best, rather than focusing on what's gone wrong and fixing problems" (Judy & Hammond, 2006, p. 1). Additionally, Judy and Hammond (2006) purport that the use of AI can he a helpful tool for organizations to "understand their capabilities and resources, organizations cultivate and sustain positive change" (Judy & Hammond, 2006, p. 1).   Appreciative Inquiry was originally developed in the mid 1980s primarily by students and faculty of the Department of Organizational Behavior at Case Western Reserve University (Judy & Hammond, 2006). Since its development it has been utilized by many different types of groups including but not limited to non-profit organizations, businesses, families, schools, health care organizations, and governments. The basic premise is that individuals within an organization formulate committees or groups that from the very beginning intentionally focus on the positive processes that are in place rather than the negative or failing programs. By using this approach, the actual longevity of the group increases

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as do the chances that effective programmatic change are developed and implemented within a healthcare organization. Appreciative Inquiry is a very effective tool within a healthcare setting that can alleviate the animosity that exists between physicians and manages. If both physicians and management agree to the basic tenets of AI before even a first meeting is scheduled, the tool's success rate is high. If groups are appropriately utilizing AI, then the tone is set from the first meeting. Attendees are constantly making sure participants are maintaining focus on successes that have been achieved and how the group can extrapolate within those areas. This process of trying to effect organizational change is in stark contrast to alternative deficit-based models. Judy and Hammond (2006) describe a typical AI process that follows a five dimensional cycle. This cycle includes the following steps:

1. Define– With the help of an AI facilitator, this step involves a steering committee developing the basic grounds rules and structures that will allow the meeting to take place. Components such as frequency, location, and permissible attendees are discussed and agreed upon.

2. Discover– During this exploratory stage, participants are using many different approaches to unlock the goals, desires, and needs of participants. They gather information on what sort of outcomes are desired by participants. In many cases, this involves the use of structured interviews.

3. Dream– This stage holds true to its name. Participants are asked to envision the perfect outcome. They are asked to visualize and express what that vision would look like. The results are expressed in many forms.

4. Design- This is where the rubber meets the road. Participants are asked to develop actual methods that can allow their dreams to be actualized in whole or in part.

5. Deliver- Participants develop formalized plans to achieve the goals set out in the previous steps. This step is where work on the most practical level takes place. Items such as budgeting and workflow are discussed.

Appreciative Inquiry is a relatively new methodology being used to help facilitate organizational change. While a lot literature exists describing its implementation in a variety of different types of business models, very little has been reported on its implementation within healthcare settings. One useful paper reported on the results of nine separate implementations in a healthcare setting (Trajkovski, Schmied, Vickers, & Jackson, 2012). The results indicated that the methods used to facilitate each stage of the process were not precise, rather each organization tailored the process to suit individual needs. The conclusion of the review indicated that overall participants in all nine cases indicated positive feelings toward the process.

3.4 Positive Deviance

According to the Positive Deviance Initiative (2010), positive deviance (PD) is defined as an "asset-based, problem-solving, and community-driven approach that enables the community to discover these successful behaviors and strategies and develop a plan of action to promote their adoption by all concerned" (Health Resources in Action, 2010, p. 1).

Positive Deviance methodology consists of five basic steps carried out by members of the organization or community. In a healthcare setting, the community would consist of clinical and management staff. The steps are as follows:

1. Define the problem, current perceived causes, challenges and constraints, common practices, and desired outcomes.

2. Determine the presence of PD individuals or groups.

3. Discover uncommon but successful behaviors and strategies through inquiry and observation.

4. Design activities to allow community members to practice the discovered behaviors.

5. Monitor and evaluate the resulting project or initiative which further fuels change by documenting and sharing improvements as they occur, and help the community discern the effectiveness of the initiative.

The PD method has been used in healthcare to bring about both clinical change and organizational behavior changes.   This method is highly suited for physicians due to their inherent need for independence. Physicians at their core are technical out-of the box thinkers. Employing PD sets up a system that promotes physicians' need for independence and creativity. Additionally, an environment is created in which non-traditional methods of clinical or administrative changes can be explored without participants feeling threatened or judged.

At its core, the basic fundamentals of the PD process are very familiar to healthcare managers. As reported in an early section, a large percentage of managers come from a business administration background. The educational curricula within these types of programs may vary to some degree, but the idea of maximizing efficiency and quality is a shared educational component. Most healthcare managers are familiar with process improvement strategies such as Lean Six Sigma, Statistical Process Control, and Engineering Process Control. Because of this familiarity, the process of PD is a quality tool that can be viewed as beneficial by managers as well.

4.0   MULTIDISCPLINARY CURRICULUM

Atul Gawande has commented on the stereotypical attitude with which physicians operate (Morse, 2010).
When asked about the changing face of healthcare delivery to a more teams-based approach Gawande
said, "We've celebrated cowboys, but what we need is more pit crews. There's still a lot of silo mentality
in health care—the mentality of 'That's not my problem; someone else will take care of it'—and that's
very dangerous." Gawande's commentary on the silo mentality is not a new revelation. Doctors from the
very roots of their profession have been celebrated as being heroes and masterminds who work alone.

Traditionally society has had very little tolerance for questioning physician bedside manner or
methods. A patient's primary concern is that she is cured of her particular ailment or condition. Not
many patients leave a physician's office after just having a successful lifesaving or life improving
procedure with an attitude of disappointment because of their physician's poor bedside manner or lack of
teamwork. However, times are changing. The healthcare delivery paradigm has become one in which
teamwork between physician and manager is much more important. Its success can have direct impacts
on patient outcomes. When asked how the medical field can start a transition to make teamwork in
healthcare delivery more of a priority, Gawande says, "Part of the answer is a change in medical training.
Most medicine is delivered by teams of people, with the physician, in theory, the team captain. Yet we
don't train physicians how to lead teams or be team members. This should begin in medical school"
(Morse, 2010, p. 1).

Currently, there are more than 50 MD/MBA programs in existence (Avakian, 2011). However,
many physicians decide not to enroll in dual degree programs. These typical medical school graduates
get exposed to very few if any business administrative curricula while matriculating through their
programs. Medical schools must change their curriculum to better align with the changing healthcare
delivery paradigm. A multidisciplinary curriculum must include tools that help equip physicians with the

core technical skills that are needed to practice medicine, as well as the competencies that are needed to work within a healthcare organization. Competencies such as teamwork, emotional intelligence, interpersonal communication skills, systems based thinking, and resource management must be added to the curriculum in medical schools.

In the same vein, graduate study programs that focus on business administration in health care must also add curricula that focus on the medical field. Classes that focus on medical terminology and the basics of healthcare delivery would help healthcare managers gain needed perspective on the core functions of direct healthcare providers. Physicians and healthcare managers need to be provided with the tools that will help foster teamwork and reduce conflict. This in turn, will improve the chances of providing higher quality care and ensuring positive health outcome for patients.

5.0   CONCLUSION

The delivery of health care has become a very integrated and complex task involving many stakeholders. For a single patient to receive care, it is no longer just a process that involves the relationship of the patient and doctor. Many systems and processes are involved to ensure quality care is delivered. Until recently, the paradigm of healthcare delivery allowed physicians to operate and function independently while relying on peripheral players to serve in mainly supportive capacities. In the past, doctors had minimal interaction with managers. Certain structural components of the system, such as reimbursement mechanisms, help support a physician's autonomous delivery system of providing care. However, as healthcare costs continue to spiral upwards towards unsustainable levels, public policy makers, physicians, and healthcare managers agree that there is a need for systematic change. Effective and sustainable change is only achievable if healthcare providers and managers are able to work together in an

atmosphere of mutual respect and empathy. Physicians and managers must abandon long held stereotypes, prejudices, and misconceptions that breed an atmosphere of contempt and serve as a roadblock to achieving the mutual goal of quality healthcare delivery and cost containment. In order to achieve this outcome, one must recognize the issues that cause conflict and the tools that can help facilitate change.

Conflict between physicians and managers can arise from issues based in structural components of how the United States healthcare system operates such as reimbursement methodologies and regulatory oversight. Likewise, mutual distrust and discord can also develop due to differences in educational background and prior career paths. No matter what the source of conflict, tools and strategies exist that can help physicians and mangers build better working relationships. Utilizing methods such as active listening, structured dialogue, positive deviance, and appreciate inquiry will result in building better communication pathways and ultimately leading to less conflict. Minimizing conflict between physicians and managers has a direct impact on the quality of healthcare delivery in our nation and therefore our overall public health status. The passage of the Patient Protection and Affordable Care Act revealed a mandate of our citizens. United States citizens want access to affordable and quality healthcare. This proposition will only be possible with the combined cooperation teamwork of physicians and managers.

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