We tend to shun conflict in work settings. We find dealing with abrasive people difficult because they question our assumptions and make us feel defensive about our actions and values. In return, we attribute qualities to them such as, "He is not a team player," that allow us to downgrade their advice or ignore them.

There are, however, advantages of engaging rather than avoiding abrasive health care professionals who question assumptions and may not share hospital administrators' perspectives. One way to foster that engagement is through structured dialogue.

Structured dialogue is a process that helps a group of practicing physicians articulate their collective, patient-centered self-interest.1 Structured dialogue can help physicians improve physician/physician communication, understand more fully the complexity of hospital operations, and articulate clinical priorities for their communities and their practices.

Unlike hospital-centric change efforts, the structured dialogue process is led by a medical advisory panel (MAP) of high-performing, well-respected clinicians who review and recommend clinical priorities based on presentations by the major clinical sections and departments.

Contrary to the apprehensions of some hospital executives, the recommendations generally include performance improvements and minor expenditures that support these improvements, rather than a list of capital-intensive budget items.

In return for giving physicians a say in clinical priority setting, the hospital is able to enlist physicians to attend meetings and outline their priorities.
One doctor’s experience

I (Thomas R. Allyn, MD) spend a great deal of my time working with dialysis patients in an outpatient setting. Dealing with someone else’s dialysis center, hiring practices, policies and procedures grew ever more frustrating to my partner and me, so we purchased the center in 1988. That purchase and subsequent control vastly simplified our lives.

My frustration mirrored the frustration of physicians who work at hospitals and cannot influence scheduling, staff, equipment or policies sufficiently to predict procedure starting times, room turnover and training of staff assistants.

If you had told me then that I would be a member of the hospital’s strategic planning committee in 2005, I would have told you that you were crazy, since I never felt that any physician could really influence what a hospital was doing or where it was going.

In retrospect, my journey began late in 2002, when a medical colleague with whom I did my residency asked me to serve on the medical advisory panel to evaluate and recommend clinical priorities for our community for the next three to five years. I was skeptical and, not wanting to commit to attending weekly 7 a.m. meetings for the next six months, said that I would attend the first meeting and make a decision afterward.

I joked that, for the MAP process to work, the hospital would have to undergo a cultural enema for physicians to feel that their ideas mattered.

But I was wrong. I returned to subsequent meetings because I was impressed by the quality of my fellow panel members and trusted the commitment made by the board and CEO to give serious consideration to implementing the MAP recommendations.

I enjoyed the data-driven presentations where physicians from all major clinical areas discussed strengths, weaknesses, opportunities and threats that they faced and proposed recommendations to improve care and enhance physician-physician and physician-hospital communication.

In addition, the MAP heard from the hospital CEO, directors of nursing and finance, and the chief information officer to gain a perspective of the hospital and the complexity of its operations that we never had before.

During the presentations and the report writing that followed, the MAP members thought openly and frankly about new programs and
measures to improve operational efficiency without being encumbered by the hospital's traditional business model and apparent “group-think” approach to operations.

Our report, presented to the hospital board of directors in September 2003, represented the first time that the hospital received a consensus report from practicing physicians about what the hospital should do in the future. Before, the process involved squeaky wheels pursuing individual agendas.

We evolved from a self-interested view of what the hospital should do for us as physicians to a more empowered view of how the hospital could employ limited resources to improve care for our community.

Through the process of discovery, we began to think and act more as long-term partners and co-owners than short-term customers and renters. The MAP process allowed us to evolve beyond maintaining a level playing field for all physicians to leveraging hospital resources to meet community needs.

That clinicians who prided themselves on patient care could come to consensus on long-term priorities gave the board and hospital administration the confidence to accept the MAP recommendations.

The results

The report recommended creation of an acute stroke center and improvement of throughput in the operating room and emergency department. Both are being implemented. The MAP has continued as an advisory body, meeting monthly with members of the administration and leaders of the medical executive committee and reporting to the board of directors annually.

During the implementation phase, the MAP encouraged orthopedists to consolidate vendors, which resulted in a $1.2 million savings in 2004. In addition, the MAP is spearheading an ambitious program to limit sepsis mortality by accelerating identification of septic patients and antibiotic administration and taking measures to curtail ventilator-associated pneumonia.

With these achievements, I feel that the MAP is making a difference. Previous service on hospital committees felt like wasted time because I did not feel that anyone who had the power to do anything was listening, and nothing was implemented in a timely fashion. No one person seemed accountable and the communication loop rarely was closed.

Now, after each MAP meeting, a scut list—similar to what I used during residency—is created containing the tasks, the one person responsible and a timeline for action. The list is reviewed at subsequent meetings. In so doing, we have built on previous successes and avoided death of innovation via the “slow go,” or “let's study this some more” scenarios.

The MAP process reinvigorated physician communication and made me realize the value of pooling ideas and talent. Previously, I did not realize how often we were talking at each other rather than to each other. Through the processes of dialogue, active listening and discovery, I am dealing with some of the complexities in health care administration and have begun to think, work and act more interdependently.

Case analysis

Hospitals of varying size have used the time-tested, structured dialogue process successfully by meeting the following three prerequisites:

1. Physicians and hospital executives must be interested in exploring how they can jointly improve care for their communities.

2. Practicing physicians must recognize the benefit of making time to prepare for and attend meetings based on their need to use their time better, increase practice revenues, improve processes of care and leave a lasting legacy.

3. Hospital administrators and the board must agree to make every effort to implement the physicians' carefully thought-out recommendations, even if the physicians’ suggestions represent a change in the hospital's business model.

During the structured dialogue process, physicians engage in face-to-face dialogue with one another and hospital leaders and learn to view their individual practices within a larger context. The structured dialogue process is sufficiently flexible to be effective in a variety of settings regardless of size, geography, culture and teaching status.

A MAP co-chair at a 58-bed Southern hospital wrote: “We... came to realize that the stresses we faced were unique neither to our profession nor our community. What emerged was a viewpoint for the greater good, which greatly facilitated making difficult decisions and compromises.”

A CEO of a 400-bed Northeastern hospital stated, “The MAP process works because, in the process of discovery, practicing physicians (whom the hospital does not employ) begin to think and act as owners.”

The co-chairs of an 86-bed Western hospital stressed the importance of working collaboratively: “MAP members have had a unique opportunity to consult with their colleagues and take stock of current medical practice. It has become abundantly clear that we have lost touch with each other. Forces are being brought to bear which many of us have ignored or
dismissed because we have felt powerless to influence them. Our professional, ethical charge is to provide our services in the manner that is most beneficial to the welfare of our patients. We are now reminded that the hospital has the same responsibility. Our task is to work together to find solutions that will benefit all three—patient, physician, and hospital—and in so doing, gain strength from one another."

**Common steps for structured dialogue**

Over 30 hospitals and hospital systems in the U.S. have successfully undertaken a structured dialogue process by pursuing the following steps:

- The hospital CEO and practicing physicians engage in a discussion of issues affecting care at their hospital.
- Practicing physicians agree to participate in the structured dialogue process in return for assurance that the CEO and the board make every effort to implement the physicians’ recommendations.
- The CEO appoints two co-chairs who are outstanding clinically, flexible in their outlook and willing to invest time to improve care processes.
- The co-chairs pick a panel of five to 14 similarly talented physicians from different clinical areas.
- The panel hears presentations from physicians in all major clinical areas after being briefed by administrators, including the CEO and vice-presidents of finance, nursing, and information technology.
- The chief medical and nursing officers attend MAP meetings to listen to the presentations and to provide information, as needed.
- An administrative assistant assists with scheduling, room reservations, and other aspects of communication, on average five hours per week in the beginning of the process.
- MAP members compile a data-driven, consensus-based report that outlines the top three or four major clinical initiatives and list the top five recommendations of every physician presenter, which they discuss with physician colleagues, administrators and the board.
- A joint task force of physicians, nurses, allied health care professionals and administrators implements the major MAP recommendations in a timely fashion within the next two years.

The structured dialogue process re-energizes physician/physician communication and collaboration, resulting in specific ideas for improving care processes, the practice environment, and the institution’s referral network. New revenue flows from improved physician relationships and decreased outpatient migration.

By giving physicians on the MAP timely information about hospital operations, the structured dialogue process enables physicians to understand and appreciate the complexities of operating a modern hospital, improves physician/hospital communication and collaboration, and serves as an effective training environment for new physician leaders.

The structured dialogue process can help rebuild physician loyalty to a hospital at a time when both primary care physicians and specialists are pursuing outpatient care opportunities.

**References**