
Many General Internal Medicine divisions are moving to incorporate the Affordable Care Act’s (ACA) patient-centered care models into their clinical operations. Although the ACA is commonly viewed as raising the primary care agenda, not all of the changes in the ACA may be equally welcomed by the primary care clinicians and staff who are asked to implement these changes. How can leaders successfully introduce change without alienating their staff? The authors examine the powerful role that an organization’s culture plays in its strategy. Their examples, many from the health care industry, illustrate the 5 principles that organizations can use to create transformative change.

The authors begin with the example of Aetna, a 150-year-old company that in the early 2000s was suffering from a bad reputation, lawsuits, and a daily loss of nearly $1 million dollars. Aetna’s culture at the time—one that was wary of change and okay with its average-ness—rebelled against the efforts of 3 CEOs in five successive years.

That is, until John Rowe became CEO. Rowe did not exhaust his employees with a top-driven, dictatorial style. Instead, he started his tenure by having conversations with staff and employees who were respected and attuned to the existing culture. This investment in understanding his company’s culture allowed him to build on Aetna’s strengths—concern for patients and pride in the company’s history—while improving its efficiency. Remarkably, because Rowe embraced Aetna’s cultural strengths, his major workplace changes were accepted by employees and he turned the company around.

The authors present 5 key principles for successfully implementing change based upon an understanding of an organization’s culture:

1. Match Strategy and Culture. The first principle involves an understanding of the specific cultural traits that are desired and how they match the strategy of the organization.

2. Focus on a Few Critical Shifts in Behavior. This principle suggests having candid conversations with employees at all levels, in order to focus on what behaviors are affected most by the organization’s culture. Academic medical directors could implement this principle by engaging in conversations with clinical personnel, at all levels—from MDs to LPNs to clinical staff- who are both official leaders (nurse managers), and unofficial leaders (senior individuals who others go to for solutions).

3. Honor the Strengths of Your Existing Culture. By highlighting the positive aspects of an organization, change can feel like movement towards a goal shared by all. For example, implementing co-management of patient care by physicians and nurses has the potential to be met...

continued on page 2
by resistance from both nurses and MDs. However, emphasizing how co-management builds on existing cultural strengths (e.g., respect or excellent patient care) can ease the transition.

4. Integrate Formal and Informal Interventions. Oftentimes, leaders use formal interventions, such as reporting structures, compensation, and committees for creating cultural change. But in doing so they may neglect informal structures like ad hoc gatherings, which can be important niduses for change. One strategy for emphasizing the significance of ad hoc gatherings is to rethink the work environment to encourage spaces for clinicians and staff to intermingle during the workday.

5. Measure and Monitor Cultural Evolution. This principle emphasizes linking critical performance indicators, behaviors, and achievements to the underlying beliefs, feelings, and mind-sets that allowed for their success or failure. Thus, instead of focusing only on standard performance metrics, leaders should also consider the performance of its culture, and the role it plays in determining an organization’s progress or setbacks.

At GIM divisions that are adopting new ACA models, division chiefs would be wise to work collaboratively with their staff, rather than simply dictate from above. An institution’s path of change, if guided by the positive aspects of its existing culture, can be smoother and more effective.

Reference:

Leadership, like writing, is an art. The experiences we, as medical students, shared as members of the Narrative Medicine Interest Group (NMIG) reflect this principle. NMIG is a student-led organization encouraging medical students to read literature and write about their clinical experiences. We set to publish a literary journal for our medical school. I was lucky to be asked by the NMIG group to lead the Literary Journal Subcommittee; I accepted the position with alacrity. Such a publication would provide an avenue for medical students to reflect on their fledgling careers, and we planned to publish the journal in January 2012.

At this juncture, a key principle of leadership became apparent to us. Leadership entails not only effectively executing a project, but also observing the professional standards of the institution supporting that project. By printing the journal without consulting the deans of the school. The central issue was protecting the confidentiality of patients and doctors referenced in the journal in order to observe privacy guidelines. Some students opposed this motion because it would delay the journal’s publication. We were very close to meeting our objective, and our peers were eager to see the finished product.

Voices in Words, the first literary journal for our medical school

By January 2012, we were ready to send the journal to the printing press. The hard copies would be available in a matter of weeks; however, we were hesitant to print the journal without consulting the deans of the school. The central issue was protecting the confidentiality of patients and doctors referenced in the journal in order to observe privacy guidelines. Some students opposed this motion because it would delay the journal’s publication. We were very close to meeting our objective, and our peers were eager to see the finished product.

Leadership, like writing, is an art.
Patients’ lives form storylines. The stage of the story and the self-perceived identity of the patient influence the harm that ailment inflicts and the response to care. By providing structured discussion centered on close readings of stories by and about patients and physicians, Narrative Medicine allows physicians to develop and practice skills to identify these aspects of their patients and make informed decisions about patient care.

Jacob Riis illustrates the nature of medical work in The Stonecutter’s Credo: “When nothing seems to help, I go and look at a stonemason hammering away at his rock perhaps a hundred times without so much as a crack showing in it. Yet at the hundred and first blow, it will split in two, and I know it was not that blow that did it, but all that had gone before.” Most saliently, Riis learns that he must work harder. More subtly, he finds a lesson about cognition in manual labor. He must observe attentively and “go and look” for solutions. Effective physicians act in the same way. They ponder, question, and search for clues, piecing together the history. Then, they judge the impact upon their patients and tailor treatment to patients’ needs.

Injuries can be similar, but their role in narrative is not. When my favorite athletes suffered similar injuries, the contexts of their careers altered treatment decisions. Brandon Roy tore his meniscus in April 2009, late in the NBA season, and his team the Trail Blazers expected him to miss the playoffs. But, after surgery, he returned in eight days, sooner than the four to six weeks normally projected, and labored through two playoff series. That summer, news came that no menisci remained in either knee—his cartilage had been excised, including from operations during college. He struggled the next season, underwent further surgeries, and retired at age 26 in 2011 when told he might be unable to walk years later. He is now attempting a comeback, deemed risky, on a new team. In contrast, when Jordan Farmar, a reserve for the Lakers, tore his meniscus in December 2010, early in the season, he had cartilage stitched into place, sat out four weeks, and has since maintained his customary level of play without reported pain. Both teams’ physicians probably wished to extend the players’ careers. However, Roy’s more immediate goal changed treatment. Though he likely made his intentions obvious, other patients do not, compelling physicians to perform detective work to make their care align with patients’ goals.

At Narrative Medicine meetings, students and physicians foster these investigative skills, reading stories by Anton Chekhov, William Carlos Williams, and more. They create and answer questions covering theme, character arc, and conflict; cite text to support insights; diagram connections among observations; and orally present findings. By sharpening perception and judgment, these cognitive tasks enable practitioners to grasp and address the role of illness in patients’ narratives. Hence, Narrative Medicine keeps its practitioners properly equipped, ensuring that their hard scientific work does not go to waste.

Narrative Medicine Resources
3. The Pharos. Alpha Omega Alpha’s quarterly journal publishes scholarly essays covering a wide array of nontechnical medical subjects, including medical history, ethics, and medical-related

continued on page 3
literature http://www.alphaomegaalpha.org/the_pharos.html
5. Blood and Thunder. Oklahoma University Health Sciences Center’s journal dedicated to the art of medicine. http://www.ouhsc.edu/bloodandthunder/