PHYSICIAN-EXECUTIVE LEADERSHIP AND RISK MANAGEMENT
[Human Nature, Medical Ethics and Modern Principles]

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In any textbook of *gravitas* on medical risk management, asset protection and insurance planning, a chapter on human nature is usually placed at the end of the book, or as an appendix, or an afterthought if included at all. However, we elected to prominently place this material as the premier chapter of our textbook.

Why? In the end, the success of any risk management endeavor ultimately comes down to changing human behavior - helping a doctor/nurse/technician alter whatever s/he was doing toward something that will better allow them to avoid errors and pursue quality care and practice management goals. Yet, there is still remarkably little education or training for medical professionals focused directly on motivation or change theory, in any related area except psychiatry/psychology or perhaps professional liability. Instead, doctors are increasingly turning to professional consultants to learn best practices on how to help them actually make the behavioral changes necessary to achieve their quality improvement and risk reduction goals; as we attempt to answer these questions:

- Are you and your medical practice, or clinical, ready for change?
- How to transition from [traditional] solo practitioner B-models to modern forms?
- What are leadership, management and governance?
- In group practices, how is leadership shared?
- What issues need be considered when hiring a practice administrator or clinic CEO?
- What is medical ethics and munificence? Why is it needed? How does it work?
- What are the types of risk?
- How are risks managed in the medical practice space?

In addition, medical practitioners need to strive to avoid what Zenger and Folkman describe as the 10 most common leadership shortcomings based on a survey of 11,000 leaders. They include:

1. Lacks energy and enthusiasm
2. Accepts mediocre self performance
3. Lacks clear vision and direction
4. Poor judgment
5. Not collaboration
6. Not following standards
7. Resistant to new ideas
8. Doesn't learn from mistakes
9. Lacks interpersonal skills
10. Fails to develop others.

INTRODUCTION

This chapter aims to focus on a number of different psychological issues considered critical for any form of medical practice, or healthcare organization. For that matter, it also deals with the differences between management and leadership, medical ethics, and risk management classifications, types and principles.

EMOTIONAL INTELLIGENCE [EQ]

Many of us have encountered a person who may intellectually be at upper levels, but whose ability to interact with others appears to that of one who is highly immature. This is the individual who is prone to becoming angry easily, verbally attacks co-workers, is perceived as lacking in compassion and empathy, and cannot understand why it is difficult to get others to cooperate with them and their agendas [THINK: Sheldon Cooper PhD D.Sc MA BA of the *The Big Bank Theory* TV show].

The concept of Emotional Intelligence [EQ] was brought into the public domain when Daniel Goleman authored a book entitled, *Emotional Intelligence."* According to Goleman, emotional intelligence consists of four basic non-cognitive competencies: self awareness, social awareness, self management and social skills. These are skills which influence the manner in which people handle themselves and their relationships with others. Goleman's position was that these competencies play a bigger role than cognitive intelligence in determining success in life and in the workplace. He and others contend that emotional intelligence involves abilities that may be categorized into five domains:

1. *Self awareness*: Observing and recognizing a feeling as it happens.
2. *Managing emotions*: Handling feelings so that they are appropriate; realizing what is behind a feeling; finding ways to handle fears and anxieties, anger and sadness.
3. *Motivating oneself*; Channeling emotions in the service of a goal; emotional self control; delaying gratification and stifling impulses.
4. *Empathy:* Sensitivity to others' feelings and concerns and taking their perspective appreciating the differences in how people feel about things.
5. *Handling relationships*: Managing emotions in others; social competence & social skills.

In 1995, Goleman then expanded on the works of Howard Gardner, Peter Salovey and John Mayer. He further defined Emotional Intelligence as a set of competencies demonstrating the ability one has to recognize his or her behaviors, moods and impulses and to manage them best, according to the situation. Mike Poskey, in "The Importance of Emotional Intelligence in the Workplace." continued this definition by stating that emotional intelligence is considered to involve emotional empathy; attention to, and discrimination of one's emotions; accurate recognition of one's own and others' moods; mood management or control over emotions; response with appropriate emotions and behaviors in various life situations (especially to stress and difficult situations); and balancing of honest expression of emotions against courtesy, consideration, and respect.

Source: Emotional Intelligence: what is and why it matters" - Cary Cherniss, PhD, presented at the annual conference of the Society of Industrial and Organizational Psychology, April 2000.

EQ differs from what has generally been considered intelligence which is described in terms of one's IQ. Traditional views of intelligence focused on cognition, memory and problem solving. Even today individuals are evaluated on the basis of cognitive skills. Entrance tests for medical, law, business, undergraduate and graduate schools base admissions in large part on the scores of the SAT, GMAT, LSAT, MCAT, etc. Without question, cognitive ability is critical but has been demonstrated, it is not a very good predictor of future direct job performance and indirect liability management. In fact, in 1940, David Wechsler the developer of a widely used intelligence test made reference to "non-intellective" elements. By this Wechsler meant affective, personal and social factors.

Source: Non-Intellective factors in intelligence. *Psychological Bulletin, 37, 444-445.*

Goleman became aware of the work of Salovey and Mayer having trained under David McClelland and was influenced by McClelland's concern with how little traditional tests of cognitive intelligence predicted success in life. In fact, a study of 80 PhDs in science underwent a battery of personality tests, IQ tests and interviews in the 1950s while they were graduate students at Berkeley. Forty years later they were re-evaluated and it turned out that social and emotional abilities were four times more important than IQ in determining professional success and prestige.

Source: Feist & Barron: *Emotional Intelligence and academic intelligence in career and life success.* Paper presented at the Annual Convention of the American Psychological Society, San Francisco, 1996.

Undoubtedly, we want to have individuals work with us who have persistence which enables to them have the energy, drive, and thick skin to develop and close new business, or to work with the patients and other members of the staff. It is important to note that working alongside one with a "good" personality may be fun, energetic, and outgoing.

However, a "good personality does not necessarily equate to success. An individual with a high EQ can manage his or her own impulses, communicate effectively, manage change well, solve problems, and use humor to build rapport in tense situations. This clarity in thinking and composure in stressful and chaotic situations is what separates top performers from weak performers.

Poskey outlined a set of five emotional intelligence competencies that have proven to contribute more to workplace achievement than technical skills, cognitive ability, and standard personality traits combined.

A. Social Competencies: Competencies that Determine How We Handle Relationships Intuition and Empathy – Our awareness of others' feelings, needs, and concern. He suggested that this competency is important in the workplace for the following reasons:

1. *Understanding others*: an intuitive sense of others' feelings and perspectives, and showing an active interest in their concerns and interests
2. *Patient service orientation*: the ability to anticipate, recognize and meet customer's' (patients) needs
3. *People development*: ability to sense what others need in order to grow, develop, and master their strengths
4. *Leveraging diversity*: cultivating opportunities through diverse people.

B. Political Acumen and Social Skills: Our adeptness at inducing desirable responses in others. This competency is important for the following reasons:

1. *Influencing:* using effective tactics and techniques for persuasion and desired results.
2. *Communication:* sending clear and convincing messages that are understood by others
3. *Leadership*: inspiring and guiding groups of people
4. *Change catalyst*: initiating and/or managing change in the workplace
5. *Conflict resolution:* negotiating and resolving disagreements with people
6. *Collaboration and cooperation*: working with coworkers and business partners toward shared goals
7. *Team capabilities*: creating group synergy in pursuing collective goals.

C. Personal Competencies: Competencies that determine how we manage ourselves

D. Self Awareness: Knowing out internal states, preferences, resources, and intuitions. This competency is important for the following reasons.

1. *Emotional awareness*: recognizing one's emotions and their effects and impact on those around us
2. *Accurate self-assessment:* knowing one's strengths and limits
3. Self-confidence: certainty about one's self worth and capabilities
4. *Self-Regulation:* managing one's internal states, impulses, and resources. This competency is important in the workplace for the following reasons.
5. *Self-control*: managing disruptive emotions and impulses
6. *Trustworthiness:* maintaining standards of honesty and integrity
7. *Conscientiousness*: taking responsibility and being accountable for personal performance
8. *Adaptability:* flexibility in handling change
9. *Innovation:* being comfortable with an openness to novel ideas, approaches, and new information

E. Self-Expectations and Motivation: Emotional tendencies that guide or facilitate reaching goals. This competency is important in the workplace for the following reasons.

1. *Achievement drive*: striving to improve or meet a standard of excellence we impose on ourselves
2. *Commitment*: aligning with the goals of the group or the organization
3. *Initiative:* readiness to act on opportunities without having to be told
4. *Optimism:* Persistence in pursuing goals despite obstacles and setbacks

A note of caution is necessary. Goleman and Salovey both stated that emotional intelligence on its own is not a strong predictor of job performance. Instead they contend that it provides the bedrock for competencies that are predictors.

Obviously, EQ is an important attribute and it behooves each of us to promote emotional intelligence in the workplace. A number of guidelines have been developed for the Consortium for Research on Emotional Intelligence in Organizations by Goleman and Cherniss. The guidelines cover 21 phases which include preparation, training, transfer and evaluation.

1. *Assess the organization's needs*: Determine the competencies that are most critical for effective job performance in a particular type of job. In doing so, us a valid method, such as the comparison of the behavioral interviews of superior performs and average performers. Also make sure the competencies to be developed are congruent with the organization's culture and overall strategy.

2. *Assess the individual:* This assessment should be based on the key competencies needed for a particular job, and the data should come from multiple sources using multiple methods to maximize credibility and validity.

3. *Deliver assessments with care:* Give the individual information on his/her strengths and weaknesses. In doing so, try to be accurate and clear. Also, allow plenty of time for the person to digest and integrate the information. Provide feedback in a safe and supportive environment in order to minimize resistance and defensiveness. Avoid making excuses or downplaying the seriousness of deficiencies.

4. *Maximize choice*: People are motivated to change when they freely choose to do so. As much as possible, allow people to decide whether or not they will participate in the development process, and have them change goals themselves.

5. *Encourage people to participate*: People will be more likely to participate in development efforts if they perceive them to be worthwhile and effective. Organizational policies and procedures should encourage people to participate in development activity, and supervisors should provide encouragement and the necessary support. Motivation will be enhanced if people trust the credibility of those who encourage them to undertake the training.

6. Link learning goals to personal values: People are most motivated to pursue change that fits with their values and hopes. If a change matters little to people, they won't pursue it. Help people understand whether a given change fits with what matters most to them.

7. *Adjust expectations*: Builds positive expectations by showing learners that social and emotional competence can be improved and that such improvement will lead to valued outcomes. Also, make sure that the learner has a realistic expectation of what the training process will involve.

8. *Gauge readiness:* Assess whether the individual is ready for training. If the person is not ready because of insufficient motivation or other reasons, make readiness the focus of intervention efforts.

9. *Foster a positive relationship between the trainers and learners:* Trainers who are warm, genuine, and empathic our best able to engage the learners in the change process. Select trainers who have these qualities, and make sure that they use them when working with the learners.

10. *Make change self-directed:* Learning is more effective when people direct their own learning program, tailoring it to their unique needs and circumstances. In addition to allowing people to set their own learning goals, let them continue to be in charge of their learning throughout the program, and tailor the training approach to the individual's learning style.

11. *Set clear goals*: People need to be clear about what the competence is, how to acquire it, and how to show it on the job. Spell out the specific behaviors and skills that make up the target competence. Make sure that the goals are clear, specific, and optimally challenging.

12. *Break goals into manageable steps: change*. That is more likely to occur if the change process is divided into manageable steps. Encourage both trainers and trainees to avoid being overly ambitious.

13. *Provide opportunities to practice*: Lasting change requires sustained practice on the job and elsewhere in life. An automatic habit is being unlearned and different responses are replacing it. Use naturally occurring opportunities for practice at work, and in life. Encourage the trainees to try the new behaviors repeatedly and consistently over a period of months.

14. *Give performance feedback*: Ongoing feedback encourages people and direct change. Provide focused and sustained feedback as the learners practice new behaviors. Make sure that supervisors, peers, friends, family members-or some combination of these- give periodic feedback on progress.

15. *Rely on experiential methods*: Active, concrete, experiential methods tend to work best for learning social and emotional competencies. Development activities that engage all the senses and our dramatic and powerful can be especially effective.

16. *Build in support: Change* is facilitated through ongoing support of others who are going through similar changes. Programs should encourage the formation of groups where people give each other support, throughout the change effort. Coaches and mentors also can be valuable in helping support the desired change.

17. *Use models:* Use modern webinars, patient portals, live or videotaped models that clearly show how the competency can be used in realistic situations. Encourage learners to study, analyze, and emulate the models.

18. *Enhance insight*: Self-Awareness is the cornerstone of emotional and social competence. Help learners acquire greater understanding about how their thoughts, feelings, and behavior affect themselves and others.

19. *Prevent relapse:* Use relapse prevention, which helps people use lapses and mistakes as lessons to prepare themselves for further efforts.

20. *Encourage use of skills on the job*: Supervisors, peers and subordinates should reinforce and reward learners for using their new skills on the job. Coaches and mentors also can serve this function. Also, provide prompts and cues, such as through periodic follow-ups. Change also is more likely to indoor. When high status persons, such as supervisors and upper-level management model it.

21. *Develop an organizational culture that supports learning*: Change will be more enduring if the organization's culture and tone support the change and offer a safe atmosphere for experimentation.

Finally, see if the development effort has lasting effects evaluated. When possible, find a true set of measures of the competence or skill, as shown on the job, before and after training, and also at least two months later. One-year follow-ups also are highly desirable. In addition to charting progress on the acquisition of competencies, also assess the impact on important job related outcomes, such as performance measures, and indicators of adjustments such as absenteeism, grievances, health status, etc.

These abilities are important for one to be successful as a manager and even more so as a leader, or physician executive. But, before we begin an examination of strategic leadership, it is necessary to make a deeper distinction between a manager and a leader. There are many different definitions as well as descriptions regarding leadership and management. Many people talk as though leadership and management is the same thing. Fundamentally, they are quite different. Management focuses on work. We manage work activities such as money, time, paperwork, materials, equipment, and personnel, among other things. As can be found in any basic book on management, management focuses on

planning, organizing, controlling, coordinating, budgeting, finance and money management as well as decision making. In effect, managers are generally those individuals who have been given their authority by virtue of their role. It is the function of a manager to ensure that the work gets done as well as to oversee the activities of others. In many healthcare organizations we find that those individuals elevated to a managerial position occur as a result of being a high performer on their previous assignment. A manager receives authority on the basis of role; while a leader' authority is more innate in nature.

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CLASSIFICATION OF RISKS

As we review the concept of Emotional Intelligence, it is possible to set up five risk classes, based on the economic consequences of the occurrence of specific individual risks:

1. Prevented risks: Risks whose cost of occurrence is higher than their cost of management and whose occurrence may invoke additional legal sanctions. This class would include intentional torts and injuries caused by gross negligence.

2. Normally prevented risks: Risks whose cost of occurrence is greater than the cost of their management but whose occurrence will be considered only as negligent. This class includes most negligent injuries and most types of product liability actions.

3. Managed risks: Risks whose cost of occurrence is only slightly greater than their cost of management. The plaintiff usually has the burden of showing that the defendant owed the plaintiff a special duty to recover for one of these risks.

4. Un-Prevented risks: Risks whose cost of occurrence is less than their cost of management. The classic example of this class is the cost of railroad crossing barriers compared to the cost of people being hit by trains.

5. Un-Preventable risks: Risks whose occurrence is unmanageable.

The assignment of a risk to one of these classes is a major problem in medical and healthcare quality control, because the class of a risk determines how much effort must be expended to prevent the risk. The misclassification of a prevented or normally prevented risk as a managed or un-prevented risk can result in large financial losses.

For example, a medical clinic that does not update obsolete equipment, such as inaccurate oxygen monitors, would be liable for any injuries attributable to the obsolete equipment. The classifications of risk must be reviewed periodically to determine if the cost of the risk-taking behavior has changed, thereby altering the classification. OR, a small hospital in a rural area would not be expected to have the sophisticated equipment as a major hospital in a city. If an accident victim is brought into the rural facility, the hospital's duty may be to transfer the patient to a better-equipped facility. The patient will face the risk of dying because of the delay in treatment, but the risk of insufficient treatments outweighs the risk of transfer. If the same victim were brought into a hospital in a major metropolitan center, the duty would be to treat the patient without a transfer. The risk of transfer has not changed, but the risk of insufficient treatment has disappeared

The classification of risks is also complicated by the dependence upon the historical treatment of the risk by similar providers and any EQ limitations of the doctor making the classification decision.

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LEADERSHIP vs MANAGEMENT

Leaders are more strategically focused and rather than directing employees through tasks, they inspire and motivate employees to drive themselves. Leaders are schooled and adept in the use of EQ.

The latter function is a somewhat limited for a manager and generally refers to day to day functions. To differentiate between a leader, and a manager, the focus of leadership is on more abstract concepts such as vision, inspiration, persuasion, motivation, team work and listening. Additionally, leaders are also involved in coaching, and mentoring. Edgar Shein focuses on the differences between management and leadership by stating, "Leaders work on the culture of the organization, creating it or changing it. Managers work within the culture of the organization. One difference what which has been widely quoted has been presented by Warren Bennis who states, "Managers are people who do things right and leaders are those do the right thing." Additionally Bennis states that "underperforming organizations are usually over managed and under led (University of Maryland symposium, January 21, 1988). A follow up to this is that "leadership maintains a focus on: creating a vision and developing strategies; engaging, motivating and inspiring people' building trust and having courage; and creating action.

Source: Trish Jacobson: "What it Takes to Be an Effective Leader', in *Canadian Manager;* Winter 2002

In the 1940s, the Ohio State Leadership suggested that "consideration" is an important aspect of effective leadership. The researcher at Ohio State suggested that those leaders who are able to establish "mutual trust, respect, and a certain warmth and rapport" with members of their group will be more effective

Source: Fleishman & Harris, 1962; Patterns of leadership behavior related to employee grievances and turnover. *Personnel Psychology*, 15, 43-56.

Often, this includes the principles of shared Boyer Education Model decision-making; and Miller-Heiman life-long-learning initiatives, combined with the following three proven leadership and organizational skills.

1. *Sensitivity does matter* **-** A leader treats each employee with respect and dignity, regardless of race, gender, cultural background or particular role they actually perform in the practice. Consider how many legal suits are filed against any type of organization, whether it is a medical practice or a large manufacturing facility due to perceived disparate treatment towards the employee based on race, religion, gender sexual preference or other non-work related issues.

2. *Real respect is earned* - Having initials after one's name and the wearing of a lab coat does not automatically entitle an individual to respect. Formal authority has been found to be one of the least effective forms of influence. Only by earning the respect of your staff as well as your patients can you be sure that your intent will be carried out when you are not present. Setting the example in performance and conduct, rather than 'do as I say, not as I do," level of activity enables one to exert influence far greater than titles.

3. *Trust and challenge your employees* **-** How many times have practices sought to hire the best and brightest only to second guess the employee. Eric Schmidt, the CEO of Google, describes his management philosophy as having "… an employee base in which everybody is doing exactly what they want every day." Obviously there are certain policies and procedures, but at the same time, the leader enables decision making to the lowest possible level. This also enables employees to question why certain policies and procedures are still being followed when more effective and efficient methods are available [How the Army Prepared Me to Work at Google, Doug Raymond, Harvard Business Review].

The phrase "Physician, heal thyself" (Luke 4:23, King James Version) means that we have to attend to our own faults, in preference to pointing out the faults of others. The phrase alludes to the readiness of physicians to heal sickness in others while sometimes not being able or willing to heal themselves. By the same token, it now is necessary for medical professionals to learn how to manage themselves. It suggests that physicians, while often being able to help the sick, cannot always do so, and when sick themselves are no better placed than anyone else.

Developing New Leadership Skills for Health 2.0

Medicine today is vastly different than a generation ago, and all healthcare professionals need new skills to be successful and reduce the emerging risks outlined in this textbook, as well as the "unknown-unknowns" elsewhere. Traditionally, the physician was viewed as the "captain of the ship". Today, their role may be more akin to a ship's navigator, using clinical, teaching skills and knowledge to chart the patient's course through a confusing morass of insurance requirements, fees, choices, rules and regulations to achieve the best attainable clinical outcomes.

This new leadership paradigm includes many classic business school principles, now modified to fit the PP-ACA, the era of health reform, and modern technical connectivity. Thus, the physician must be a *subtle guide on the side; not bombastic sage on the stage.* These, health 2.0 leadership philosophies might include:

•**Negotiation** - working to optimize appropriate treatment plans; ie., quality of life versus quantity of life.

•**Team play** - working in concert with other allied healthcare professionals to coordinate care delivery within a clinically appropriate and cost-effective framework;

•**Working within the limits of competence** - avoiding the pitfalls of the medical generalist versus the specialist that may restrict access to treatment, medications, physicians and facilities by clearly acknowledging when a higher degree of service is

needed on behalf of the patient - all while embracing holistic primary care;

•**Respecting different cultures and values** - inherent in the support of the medial *Principle of Autonomy* is the acceptance of values that may differ from one's own. As the US becomes more culturally heterogeneous, medical providers are called upon to work within, and respect, the socio-cultural and/or spiritual framework of patients, students and their families;

•**Seeking clarity on what constitutes marginal care** - within a system of finite resources; providers are called upon to openly communicate with patients regarding access to marginal medical information and/or treatments.

•**Supporting evidence-based practice** – healthcare providers, should utilize outcomes data to reduce variation in treatments to achieve higher efficiencies and improved care delivery thru evidence based medicine [EBM];

•**Fostering transparency and openness in communications** – healthcare professionals should be willing, and prepared, to discuss all aspects of care, especially when discussing end-of-life issues or when problems arise;

•**Exercising decision-making flexibility** - treatment algorithms, templates and clinical pathways are useful tools when used within their scope; but providers must have the authority to adjust the plan if circumstances warrant;

•**Becoming skilled in the art of listening and interpreting** -- In her ground-breaking book, *Narrative Ethics: Honoring the Stories of Illness*, Rita Charon, MD PhD, a professor at Columbia University, writes of the extraordinary value of using the patient's personal story in the treatment plan. She notes that, *"medicine practiced with narrative competence will more ably recognize patients and diseases; convey knowledge and regard, join humbly with colleagues, and accompany patients and their families through ordeals of illness."* In many ways, attention to narrative returns medicine full circle to the compassionate and caring foundations of the patient-physician relationship.

These thoughts represent only a handful of examples to illustrate the myriad of new skills that tomorrows' healthcare professionals must master in order to meet their timeless professional obligations of compassionate care and contemporary treatment effectiveness; all within the context modern risk management principles.

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TYPES OF PURE RISKS

Fundamental Risk versus *Particular Risk*

Fundamental risk affects a large number of people in the economy. Earthquakes and war are good examples. If originated from the nature of

society, namely acts of war and unemployment, then they are not insurable. Meanwhile, fundamental risk as a result of physical or natural causes may be insurable. On the other hand, particular risk affects only individuals; especially managers and leaders. For instance, fire, robberies and thefts. These risks, like professional liability and medical malpractice, are all insurable.

Dynamic Risk

Dynamic risk occurs due to changes in economy that cause financial loss to certain people. It exists as a result of adjustment to the misallocation of resources in the economy. In modernity, one of the clearer examples is the rapid change in health information technology. Many companies are victims while others emerge with new successes.

Static Risk

Static risk, on the other hand, happens even though there are no changes taking place. During a stock market boom or collapse, there are people experiencing losses. These types of losses are due to natural perils like earthquakes, typhoon or moral hazards like cheats. Static risk brings no benefits to the society, only pure losses.

Pure versus *Speculative Risks*

In pure risk, there is either a possible loss or no loss. In contrast, there are possibilities of gain or loss in speculative risk. Pure risk can be insured while speculative risk cannot be insured against. However, the pure risk consequences of speculative risk are insurable. For instance, the decision to manufacture a new medical product involves speculative risk, either gaining from the product, or achieving losses. So, it is not insurable. But, if the factory burns down by fire, and as a result cannot supply the durable medical equipment dealers; then the losses are considered a pure risk and therefore insurable.

1. Personal Risks

Now, there are basically 3 types of pure risks that concern individual physicians. These incur losses like loss of income, additional expenses and devaluation of property. There are 4 risk factors affecting them:

- *Premature death.* This is death of a breadwinner who leaves behind financial responsibilities.
- *Old age / retirement*. The risk of being retired without sufficient savings to support retirement years.

- *Health crisis*. Individual with health problem may face a potential loss of income and increase in medical expenditures.
- *Unemployment*. Jobless individual may have to live on their savings. If savings are depleted, a bigger crisis is awaiting.

2. Property Risks

This means the possibility of damage or loss to the property owned due to some cause. There are two types of losses involved.

- Direct loss which means financial loss as a result of property damage.
- Consequential loss which means financial loss due to the happenings of direct loss of the property.

For instance, a medical practice that burned down may incur repair costs as the direct loss. The consequential loss is being unable to run the practice business to generate income.

3. Liability Risks

A doctor is legally liable to his wrongful act that cause damage to a third party; physically, by reputation or property. S/he can be legally sued with no maximum in the compensation amount if found guilty.

Knowing how risks are classified, and the types of pure risks an individual is exposed to, will provide a fundamental overview on these risk topics and prepare you to further acquire the knowledge of how to deal with and manage them as a physician executive, leader, or manager.

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MEDICAL ETHICS

In today's health care environment, physicians face a myriad of ethical dilemmas in their daily practice. Time constraints, diminished professional autonomy, declining incomes, explosive growth in technology, increasing institutional and payer pressures to lower length-of-stay and costs, and deteriorating public trust *combined with* increasing public demands for access to services, are only some of the most obvious problems plaguing practitioners. **S**ome have been adversely impacted by these changes and were quick to blame Managed Care Organizations (MCOs) of the last decade, and more recently the PP-ACA; this anger may be, to some extent, misdirected.

While there were ample concerns with managed care as it was implemented, its theory and principles remained ethically sound. Healthcare should be "managed" - for

continuity, quality, effectiveness, value, and optimal outcomes - regardless of the mechanisms by which the caregivers are paid. Practicing medicine within managed care entailed obligations to care for patients and to respect their autonomy; but providers were also placed in a disquieting role as resource managers. This role required new approaches to finding better, more cost-effective ways to meet these obligations; while being held accountable to a larger community to which the individual belonged (e.g. a health plan or employee group) for the costs incurred in delivering care.

The physician's apparently conflicting role seemed to impinge on the fundamental tenets of patient advocacy articulated in the Hippocratic Oath. By the terms of many insurance plans, physicians' incomes are directly related to savings generated in the delivery of care, a tactic criticized by Marcia Angell, M.D., former executive editor of *The New England Journal of Medicine*, who noted in a Public Broadcasting interview, that "our health care system creates ethical dilemmas that no health care system should create, doctors are paid for doing less" [capitation environment]. As if in reaction to the principles of population health, there is a growing call for a return to the more traditional, market based model for healthcare referred to as "consumer-driven" care. Proponents argue that medical decisions should be made by patients, in consultation with their physicians, based on the individual's self interest and resources. Components of such a system might include individually directed health savings accounts (HSAs) for routine treatments, combined with insurance for catastrophic medical expenses. Economist John Goodman PhD argues, that in this model, "consumers occupy the primary decision-making role regarding the health care they receive. Others argue that many consumers will not have resources to adequately fund HSAs and, as a result, will defer or delay needed treatments due to high out-of-pocket costs. University of North Carolina political scientist Jonathan Oberlander noted that this model simply shifts "the cost of health care on the backs of patients." Especially hard hit would be consumers with chronic illnesses who may never save enough in their HSAs to meet the costs of care.

Whether it is managed care's emphasis on care of populations or the PP-ACA's subsidized care's focus on individual decisions, the issue of cost will continue to drive debate in this troubled environment. In this context, let us examine some specific dilemmas confronting physicians in their daily practice.

And how they fit into your specific medical risk management equation is to be explored throughout the remainder of this book.

Patient Advocacy

Few areas of life are as personal as an individual's health and people have long relied on a caring and competent physician to be their champion in securing the medical resources needed to retain or restore health and function. For many physicians, the care of patients was the foundation of their professional calling. However, in the contemporary delivery organization, there may be little opportunity for generalist physician "gatekeepers" or "specialty hospitalists or intensivists" to form a lasting relationship with patients. These

institution-based physicians may be called upon to deliver treatments determined by programmatic protocols or algorithm-based practice guidelines that leave little discretion for their professional judgment. In addition, the physician's personal values may be impeded by seemingly perverse financial incentives that may directly conflict with their advocacy role, especially if a patient may be in need of expensive services that may not be covered in their insurance plan, or are beyond the resources of a patient's HSA or savings. Marcia Angell MD., noted during her previously mentioned PBS interview that the "financial incentives directly affecting doctors…put them at odds with the best interests of their patients…and it puts ethical doctors in a terrific quandary."

Conflicts of Interest

Conflicts of interest are not a new phenomenon in medicine. In the fee-for-service system, physicians controlled access to medical facilities and technology, and they benefited financially from nearly every order or prescription they wrote. Consequently, there was an inherent temptation to over-treat patients. Even marginal diagnostic or therapeutic procedures were justified on the grounds of both clinical necessity and legal protection against threats of negligence.

While it could be construed that this represented a direct conflict of interest, it could also be argued that most patients were well served in this system because the emphasis was on thorough, comprehensive treatment - where cost was rarely a consideration. It was a well known adage that physicians "could do well, by doing good." In managed care, the potential conflicts between patients and physicians took on a completely different dimension. By design, in health plans where medical care was financed through prepayment arrangements, the physician's income was enhanced not by doing more for his or her patients, but by doing less. Patients, confronted with the realization that their doctor would be rewarded for the use of fewer resources, could no longer rely with certainty on the motives underlying a physician's treatment plans. One inevitable outcome was the continuing decline in patients' trust in their physicians. This has been exacerbated to some degree by revelations of significant financial remuneration to physicians by pharmaceutical and medical products firms for their services as researchers or active participants on corporate-funded advisory panels, calling into question the physician's objectivity in promoting the use of company products to their peers or patients.

Communications

In contemporary medicine, ethical dilemmas in communications are increasingly common and may come in many different forms:

- Physician's failing to communicate necessary clinical information to patients in terms and language the patients truly understand;
- Physicians' offering only limited treatment choices to patients because alternatives may not be covered by the patient's insurance plan;

- Failure to disclose financial incentives and other payment arrangements that may influence the physician's treatment plans and recommendations;
- Time constraints that limit opportunities for in-depth discussions between patients and their doctors; and,
- Lack of an ongoing relationship between the patient and physician that would foster open communications.
- Physician's failure to present treatment alternatives to a patient due to conflicts with his or her personal moral or spiritual beliefs.

Another area where communication is critically important is in disclosure of medical error or cause of adverse occurrences. In the years since the 1999 publication of the Institute of Medicine's Report "To Err is Human: Building a Safer Health System", there has been increasing awareness that the growing complexity of the nation's health care system, combined with the tightening financial restrictions on treatment, sometimes results in a "perfect storm" of actions that may lead to patient harm. According to the report, more than half of the adverse events affecting hospitalized patients are the result of medical errors; and between 44,000 and 98,000 persons die each year as a consequence of such errors.

Especially challenging for physicians is the disclosure of errors that may have caused a patient harm. According to Emory University bioethicist, John Banja, Ph.D., author of *Medical Errors and Medical Narcissism*, "realization that an error has seriously harmed a patient is one of the most psychologically painful experiences a health professional can have." Unfortunately, given malpractice concerns, disclosing such errors to patients may often be as painful as the error itself. Nonetheless, such disclosure is vital to maintain the trust required for supporting the patient through such an experience.

Recent federal regulations have heightened awareness of errors and adverse occurrences through changes in Medicare that now prohibit reimbursements to health care facilities for extended stays and additional treatments directly related to serious, preventable incidents or occurrences, dubbed "never events." Among more than two dozen identified events are wrong-site surgery, blood incompatibility, medication errors, decubitus ulcers, air emboli, and many more. The economic consequences of these restrictions could prove to be significant.

Confidentiality

Whether it is an employer interested in the results of an employee's health screening; an insurer attempting to learn more about an enrollee's prior health history; the media in search of a story; or health planners examining the potential value of national health databases, the confidential nature of the traditional doctor-patient relationship may be compromised through demands for clinical information by parties other than the patient and treating caregivers.

In addition, without clear safeguards the growth in use of electronic medical records may put personal health information at risk of tampering or unauthorized access. Clearly, employers and insurers are interested in the status of an individual's health and ability to work; but does this desire to know, combined with their role as payers for health care, constitute a right to know? The patient's right to privacy remains a volatile and unresolved issue.

Counter to this concern is the recognition that electronic records may one-day dramatically improve communications by offering greater accessibility of information to clinicians in the hospital or office potentially reducing medical errors through elimination of handwritten notes, increased use of built in prompts and clinically-derived triggers for orders and treatments, and development of pathways for optimal treatments based on clinically valid and tested best practices.

Cultural Sensitivity

While America has often been called a "nation of immigrants," it has never been more true than today. Consequently, the challenge for physicians and other health care providers, in both large cities and small communities, is meeting the health care needs of increasingly diverse and multi-cultural populations who speak different languages and have social norms, traditions, and values that may substantially differ from their own. Problems arise when clinicians expect, even demand, that patients and their families discard their cultural foundations and adhere to the health care provider's view of the care and decision-making process.

Instead, the health care team should be more aware of and sensitive to the values and beliefs of patients who come from other cultures; working within to assure that the patient's individual rights are supported and wishes honored to the fullest extent possible. In her award-winning book, *The Spirit Catches You and You Fall Down*, Ann Fadiman chronicled this tragic clash of two cultures in medical care for a child of the traditional Hmong people of Laos, transplanted to California after the Vietnam War. In the book, Fadiman recounts a conversation with Professor Arthur Kleinman of Harvard University, a highly regarded expert in multicultural relations and conflict, who noted that "If you cannot see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else's culture?"

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Former U.S. Surgeon General David Satcher, M.D., Ph.D., now Director of the Satcher Health Leadership Institute at Morehouse College of Medicine in Atlanta, Georgia, helped develop a special curriculum designed to foster greater cultural competence among physicians and health care providers. Called the "CRASH Course," the program emphasizes:

• *Cultural Awareness.* Acknowledging the diversity and legitimacy of the many cultures that make up the fabric of American Society;

• *Respect.* Valuing other cultural norms, even if they differ or conflict with your own;

• *Assess and affirm.* Understanding the points of both congruence and difference among cultural approaches to decision-making; learning how to achieve the best outcomes within the cultural framework of the patient and family unit;

• *Sensitivity and self awareness.* Being secure in your own values; while willing to be flexible in working through cultural differences with others;

• *Humility.* Recognizing that every culture has legitimacy and that no one is an expert in what is best for others; being willing to subordinate your values for those of another to achieve the goals of treatment.

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There is little doubt that multi-cultural sensitivity will continue to grow as an increasingly integral component of medical education and risk management in health care practice.

Being a Patient Educator, Facilitator and Mentor

It is no longer enough for physicians to be healers, intervening when a patient appears at their door with an acute or chronic illness. They must be proactive educators, providing patients with the information needed to change poor health habits like smoking, drinking, and obesity; and encouraging the adoption of healthier lifestyles. Unfortunately, this task is more difficult than it appears.

Historically, Americans have refused to accept the consequences of their poor health habits, preferring to seek medicine's help in repairing the damage after it has been done. Results from the Gallup-Healthways Well Being Index (WBI) Poll released in February 2009 showed only marginal improvements in the overall health of Americans, with the most gain among those 65 years of age and older, and those with higher incomes. Nonetheless, the report showed that only 46% of Americans consistently follow good health habits. The report's summary concluded that "it is clear that millions of Americans are in need of continued education and encouragement around critical healthy behaviors."

One aspect of this educational process that has both advocates and opponents is direct-to-consumer (D2C) advertising, notably by pharmaceutical firms. In the past, information on medications was provided to physicians who then made a decision regarding appropriateness for their patients. Today, consumers are bombarded by almost never-ending radio, television, and print advertisements for products to treat almost everything from high blood pressure and intestinal discomfort to erectile dysfunction. These ads, combined with nearly inexhaustible sources of information – some good some bad – on

the internet, have changed the dynamics of the patient-physician discussions of treatments choices and preferences. On balance, the greater access to information may be of great value to patients and their physicians, but only if it leads to more informed and coherent medical decision making.

Even when confronted with the time constraints and discontinuity inherent in frequently changing health insurance plans, it is clear that physicians must be diligent in assessing their patients' health habits and helping them articulate their health goals; assuring that patients understand the terms, limitations, and costs associated with their health plan, and serving as mentors and partners to provide them with the knowledge and self- motivation to change for better long term health.

Instead of being "gatekeepers" charged with limiting access to the system, physicians should view their roles as that of "facilitators" - guiding patients through an increasingly confusing maze of treatment alternatives, and leading them in the direction of informed choices and optimal outcomes. In today's health care environment, the principle of beneficence is inextricably woven into the premise that physicians must do more to help patients help themselves.

Becoming Quality Driven

Whether care should be "managed" is no longer a legitimate question. The fundamental question now is for what purpose is medical care to be managed, and by whom? The moral vulnerability of managed care rested with its apparent overriding concern with cost reduction through limitations on access and service; possibly at the expense of clinical appropriateness, quality, and the health needs of the individual patient.

If physicians are to be credible advocates for their patients, they must unwaveringly stand for quality and against arbitrary and unjustifiable restrictions on access to clinically justified and appropriate care. This does not imply a return to unregulated, fee-for-service medicine, but rather a demand that providers and payers be held accountable for *both* cost effectiveness *and* quality. To date, unfortunately, this has not taken place in a coordinated fashion with any clear goal of establishing a cohesive, seamless healthcare system. Consequently, we have a fragmented, patchwork system, described by Marcia Angell MD as a "hodgepodge of temporary alignments, existing independently, often working at cross purposes..." that leaves many patients and providers with inadequate tools and information to make truly informed health care choices. Physicians, other care providers, payers, and regulators should work in concert to develop a system of care that is integrated and coordinated, epidemiologic-data dependent, consumer-focused , sensitive to privacy and confidentiality concerns, and clearly responsive to the legitimate health care needs of individuals and the general population.

As a nation, we can have a health care system that embraces compassionate, clinically appropriate, cost-effective care, with universal access to basic services, if we are willing

to make difficult, but publicly informed and debated, choices regarding our health care priorities. Physicians must be proactive and central to this process.

Demanding High Moral Standards of Self … and Economics Organizations

It has been argued that physicians have abdicated the "moral high ground" in health care by their interest in seeking protection for their high incomes, their highly publicized self-referral arrangements, and their historical opposition toward reform efforts that jeopardized their clinical autonomy.

In his book *Medicine at the Crossroads*, Emory University professor Melvin Konnor, MD noted that "throughout its history, organized medicine has represented, first and foremost, the pecuniary interests of doctors." He lays significant blame for the present problems in health care at the doorstep of both insurers and doctors, stating that "the system's ills are pervasive and all its participants are responsible." In order to reclaim their once esteemed moral position, physicians must actively reaffirm their commitment to the highest standards of the medical profession and call on other participants in the health care delivery system also to elevate their values and standards to the highest level.

In the evolutionary shifts in models for care, physicians have been asked to embrace business values of efficiency and cost effectiveness, sometimes at the expense of their professional judgment and personal values. While some of these changes have been inevitable as our society sought to rein in out-of-control costs, it is not unreasonable for physicians to call on payers, regulators and other parties to the health care delivery system to raise their ethical bar. Harvard University physician-ethicist Linda Emmanuel noted that "health professionals are now accountable to business values (such as efficiency and cost effectiveness), so business persons should be accountable to professional values including kindness and compassion." Within the framework of ethical principles, John La Puma, M.D., wrote in Managed Care Ethics, that "business's ethical obligations are integrity and honesty. Medicine's are those plus altruism, beneficence, non-maleficence, respect, and fairness."

Incumbent in these activities is the expectation that the forces that control our health care delivery system, the payers, the regulators, and the providers will reach out to the larger community, working to eliminate the inequities that have left so many Americans with limited access to even basic health care. Charles Dougherty clarified this obligation in *Back to Reform*, when he noted that "behind the daunting social reality stands a simple moral value that motivates the entire enterprise. Health care is grounded in caring. And, managing risk is a component of caring. It arises from a sympathetic response to the suffering of others."

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RISK MANAGEMENT PRINCIPLES

As we have seen, to manage risk properly in an ethical environment, there first must be an awareness of it. The risk can be in the form of loss of income due to death or disability, loss of possession or property, property damage; or professional liability, and the like. Second, the measurement of the potential losses associated with the risk must be assessed; as in medical malpractice litigation. And finally, an appropriate method for managing medical practice risk needs to be analyzed to mitigate, reduce or eliminate it. In general, there are four methods of dealing with risks.

1. *Risk Avoidance:* Some risks can be avoided. The risk of airplane accidents can pretty much be avoided by not flying. The risk of a sport-related injury can be avoided by not playing sports. For the majority of us, however, risk avoidance is not a practical solution for the multitude of risks involved in our daily routines.

2. *Risk Assumption:* Risk assumption occurs voluntarily; or involuntarily due to failure to properly identify risk exposure. The assumption (or retention) of risk can occur from denial, ignorance of the risk, or after careful consideration as a form of self-insurance. If you raise the deductible on your homeowner's policy to lower the annual premium, you are practicing risk assumption. Knowingly driving without a spare tire is another example of assuming a risk.

3. *Risk Reduction:* Taking specific precautionary steps may lessen some risks. Within this category we could include certain aspects of daily living such as thoroughly cooking meat, the scheduling of periodic maintenance on our vehicles, and the installation of smoke or radon detectors within our living environment. The overall risk remains, but in a somewhat modified, and possibly diminished, capacity.

4. *Risk Transfer***:** Some of the most important risks faced by individuals and businesses cannot be intelligently avoided or assumed, and reduction doesn't provide adequate peace of mind. A method must then be identified to shift the risk to others willing to accept it. Purchasing an extended warranty on an automobile is one method of risk transfer. Another method could be to form a corporation with which to conduct business. Here the stockholders would limit their risk to their investment, while any creditors would assume much of the remaining risk. Another 'non-insurance' method would be subcontracting. In this case, the general contractor shifts a portion of the risk to the subcontractors.

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*NOTE: Health 2.0 is information exchange plus technology. It employs user-generated content, social networks and decision support tools to address the problems of inaccessible, fragmentary or unusable health care information. Healthcare 2.0 connects

users to new kinds of information, fundamentally changing the consumer experience (e.g., buying insurance or deciding on/managing treatment), clinical decision-making (e.g., risk identification or use of best practices) and business processes (e.g., supply-chain management or business analytics.

ASSESSMENT

The erosion of trust expressed by the public for the health care industry may only be reversed if those charged with working within or managing the system place patient and community interests ahead of their own. We must foster an ethical and governing culture within health care that rewards leaders with integrity and vision; those who encourage and expect ethical excellence from themselves and others; and leaders who recognize that ethics establishes the moral framework for all organizational decision making and risk reduction methodologies.

And, when it comes to profession liability and medical malpractice; compassion and empathy may be the best risk management strategy when combined with the tools, techniques and strategies outlined in this textbook.

CONCLUSION

Keep these Emotional Intelligence, managerial and leadership, and medical ethics related risk classifications, risk types and risk management principles in mind as you read the upcoming chapters on insurance planning; as well as the entire textbook. We trust you and your patients - and clients - will benefit by it.

COLLABORATE

Discuss this chapter online with others at: www.MedicalExecutivePost.com

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To Rebekah Prather, The Doctors Company, Napa, CA.

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THE END