Rethinking Power in a Hospital Setting
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Abstract

Hospitals have been described as the most complex human systems ever devised[1]. They have become so complex that one Canadian politician suggested that they resembled a bumblebee: according to all the laws of aerodynamics, they should never be able to fly, but they do. In the same way, hospitals continue to deliver quality patient care despite their complexity. This article describes a process improvement process that dramatically decreased the number of admitted patients in the emergency department in a large, urban hospital. Rather than leaving the development of strategy with physician chiefs and hospital administration, those who typically hold "power", the challenge was given to a team of nurses, porters, physicians and housekeepers: those closest to the problem and with a personal stake in finding an effective resolution. A brief examination of the literature related to power and hospitals reveals some interesting patterns that I then frame through a case study of a Toronto hospital that has demonstrated a commitment to interprofessional collaboration and distributed leadership. The case study involved a series of interviews with participants involved in a process improvement program (PIP) Initiative, which dramatically reduced wait times in the emergency room. The case study suggests that there are significant opportunities to improve care processes when power is redistributed.

Introduction

The health care system in Canada is going through what Alvin Toffler once referred to as a 'power shift': a deep-level change in the very nature of power[2]. It can be argued that

this power dynamic was not merely accidental or a result of the mores of the time but rather it had its origins in medical and nursing school training.

> While medical school training can be seen as a 'toughening up' process preparing students for the rigours of a doctor's life, nursing training is an object lesson in submission. In nursing training *others* get tough. The nurse is taught to follow rules, to be deferential to doctors, and the importance of routine is emphasized[3].

Given that the historic lineage of our modern hospital system often goes back to the military and the church, it should come as no surprise that hospitals adopted a fairly rigid command-and-control power model.

The Nature of Power

As Mintzberg points out, traditional assumptions about power are deeply rooted in the dominant modernist metaphor of the organization as a machine: all the parts running smoothly but with all the power vested in the hands of a few individuals.

> In sealing itself off [from its environment], the machine bureaucracy concentrates its power in its administrators, those people who run its systems of authority and control. Commitment, in the form of culture or ideology can temper that power. Everyone works for the common good. But when that force is removed, power becomes corrupting. The large bureaucratic organization becomes a closed system in service to its administration[4].

When the word 'power' is raised, our minds often gravitate to the rampant abuses of power that litter the pages of history and are still present in today's headlines. We can become obsessed and appalled by these excessive displays of brute force and power. As Northouse suggest that, "in discussions of leadership it is not unusual for leaders to be described as wielders of power, as individuals who dominate others. In these instances, power is conceptualized as a tool that leaders use to achieve their own ends"[5]

We get a little closer to a more engaging construct of power when we consider it simply as the capacity to get things done. Northouse would simply say that, "power is the

capacity to influence. People have power when they have the ability to affect others' beliefs, attitudes and courses of action"[6].

Power in A Health Care Setting

As early as 1962, Georgopolous and Mann noticed that, "the hospital is dependent very greatly upon motivations and voluntary, informal adjustments of its members"[7]. Despite its complexity and the need for voluntary, informal adjustments of members, there is little literature that actually describes the construct of power in a health care setting. That said, Fried did explore the concept of power acquisition in a health care setting through the lens of strategic contingency theory, suggesting that, "power acquisition is a function of one's centrality to organizational functions, substitutability, and ability to cope with uncertainty"[8]. He notes the limitations of applying organizational theories to health care organizations because of the unique nature of physician roles and attributes. His analysis demonstrates the distinction between doctors and nurses when it comes to the acquisition of power. Doctors achieve their power because they are perceived to be irreplaceable while nurses "must be central and cope with organizational uncertainty in order to achieve power"[9]. This distinction is exacerbated in Ontario where physicians are recruited by hospitals because they have a required skill in a medical sub-specialty but they are not employees of the hospital in the formal sense. They are given privileges but have no formal accountability to the hospital and are not paid by the hospital. This gives them the potential for enormous power. Nurses, on the other hand, are hired, and can be fired as normal employees. As a consequence, nurses have historically tended to focus career development on one of two distinct tracks. On the one hand, some pursue management roles in order to increase their centrality. Alternatively, they move into

advance practice roles that are beginning to fill the gap between physicians and nurses. This enhances both their centrality and the difficulty in replacing them. Ironically, the replaceability may be more myth than fact as Ontario, like many other jurisdictions is facing a "pandemic" nursing shortage[10] brought on by an aging work force.

The power dynamics that exist between physicians and nurses can have a trickle down effect on the power dynamics between nurses and patients. In this case, "power has been viewed as the right of professionals that they exercise to inform (informational power) clients on the basis of their knowledge (expert power), even to persuade them to change their behavior"[11]. In health care relationships, power has also been examined through asymmetry, in which case, health care providers indicate their power by using jargon, dictating the topics, disregarding the patient's initiative, interrupting, questioning, and controlling the time[12]. Fortunately, these power dynamics are beginning to change. Today, virtually every hospital has begun to think in terms of patient-centered care, which ensures that the patient is viewed as central to, not excluded from, any discussion about their care. The case study affirms the importance of taking a patient-centered perspective, even when trying to solve a complex, hospital-wide challenge.

A Case Study: The PIP Initiative

Over the course of two days I interviewed 11 people in connection with the Process Improvement Program (PIP) initiative at a hospital in Ontario. The Ministry of Health and Long Term Care (the Ministry) in the Province of Ontario sponsored the PIP initiative in the sense that it provided two 'coaches' who had experience in LEAN process improvement methodology.

The PIP initiative brought together two teams of front line staff who were to look for process improvements that would reduce wait times in the Emergency Department (ED) and improve the flow of admitted patient from the ED to the Medicine floor. This shift occurred because it became clear that the challenges in the ED could not be resolved if there was not a concurrent effort to improve bed capacity on medical units. A key measure in the ED is the number of patients who have been admitted for observation and care but for whom there is not an available bed on a medical unit. They end up waiting, sometime for several hours, in the ED on a gurney, thus limiting the capacity of the ED to care for new, incoming patients.

Interviewees described PIP as an initiative that was provincially stimulated in response to media reports of unacceptable wait times. The goal was to improve inpatient flow throughout the whole hospital. One difference in the way that this initiative was framed was that it was an intentional attempt to look at the process from the patient perspective, not the provider. While this may seem obvious to outsiders, hospitals can be so complex that it is common for providers to feel like they are the only ones who fully understand what is going on. This change in perspective created a powerful common point of focus.

A second difference was that the people who were most directly involved in the processes related to patient flow were identified as the ones to drive the initiative. This was part of the framework provided by the Ministry and to which the hospital had to adhere. A third key element that became clear from the interviews was that any proposed changes must be driven from a careful analysis of available data. Hospitals, like many other institutions, build up layers of myths and assumptions that then guide decisions.

Given the ‘bottoms-up’ nature of this initiative, it was critical to combat these myths with unassailable data.

The PIP initiative was limited to an eight-month time frame and the Ministry set out very clear guidelines: maximum four-hour time limit for treatment for patients not being admitted and eight hours to an inpatient bed for those requiring admission. Patients being admitted typically have a more complex diagnosis and require more tests prior to admission, which accounts for the difference in time expectations. The structure was required of the organization by the Ministry and delivered through Ministry-provided training for the two project leads and then for the two project teams. This ensured that all team members had training in the appropriate rapid cycle improvement methodologies. According to interviewees, the importance of this training cannot be underestimated. The end result was that the metrics that were established at the beginning were met or exceeded – and continue to exceed expectations 2 ½ years later!

The executive team all saw their role as one of sponsorship. They formed the steering committee and they met with the PIP teams weekly, but only for updates and to find ways to remove barriers and provide resources as required. In part, this included providing backfill for all the team members for two days per week over the eight months. Both they and the teams were clear in the interviews that the executive team was not to be involved in the specifics. What mattered was that the teams felt supported. As one member of the executive team said, “I knew the current outcomes and they were unacceptable. What I didn’t, and couldn’t know, were the problems that led to those outcomes. That had to come from the people much closer to the problem. I wanted the

outcomes to change, so that meant letting the people close to the processes identify and fix the problems."

In the interviews, one of the central questions I was curious about was how participants perceived power in a general sense and what power dynamics were in evidence in the initiative. As pone participant noted, "Traditional, positional power in which the physician assumes he is in charge and that he has all the right answers was not going to solve this problem. The Lean Process put the power in the *data.* Clear, accurate data dissolves power relations and politics. Lean ensures that we bring data, structure and the appropriate tools to deliver validated improvements. That's where the power is. Interestingly, it allowed us to be comfortable giving people who might resist change a legitimate voice because we always had the data to challenge them."

The power of data was contrasted with the potentially destructive power of myths and assumptions. One person noted that, "For years hospitals have lived on the basis of urban myths, assumptions and distorted mental models. Key decisions were made based on someone's 'gut feeling' or well-worn assumptions that were taken as truth. The data challenged and changed all that." Another participant described this as creating a level playing field, which was seen as important in a setting where clinical expertise is generally held in very high esteem. In the same way, physicians and others were willing to engage in process change when the data was clear and when they had a clear indication of what one interviewee called 'off ramps'. They needed to know what data was required to indicate that a change was not working as anticipated and people would be willing to rethink the approach.

This initiative challenged the executive team to think about their power in a very different way. The CEO indicated to me that, in the past if he saw negative data related to patient flow he would immediately assume the 'lead', convene a meeting and try to solve the problem. "This process has really affirmed that that approach not only doesn't work but it is completely counter to any rhetoric about empowering people. I had to learn a whole new level of patience."

I received some really interesting feedback on the nature of physician power. As one doctor commented, "A physician's power comes from their 'separateness' from the hospital [in terms of their employment relationship]. Doctors can appear to others to be behaving irrationally or using their power inappropriately, but it is because they have a very different agenda. They have different incentives and not all of them are savory."

I ended up most of the interviews asking participants to reflect on the key lessons learned from the PIP initiative in terms of power. There were four themes that immediately emerged. The first was clearly the power of data. The Director of the ED commented, "Today, data and the transparency of that data drive power. The CEO is very much driven by real time data, especially when it comes to the ED. I know that, good or bad, I will get a call between 7:15 AM and 7:30 AM every day, so I need to be prepared to explain the data and think about who the people are that need to be engaged in driving any change."

The second theme was the importance of clarity of focus and of roles. One member of the executive team suggested that, "You need every one to be very clear about what it is you want to achieve. We [the executive team] needed to be clear and consistent

in defining what needed to be done, why it needed to be done now, and who needed to be involved. What we didn't do – and can't do - is define how something was to get one."

There is also a need for everyone to be very clear on the various roles, and in a new setting like this, that can be challenging. As one member of the executive team put it, "When you're new to something, its easy for people to trip over each other. You need to have patience and discipline to let people get on with it and not feel like you have to interfere."Another member of the executive suggested, "Distributed power is great but it does require very clear parameters. I believe that the majority of changes are distributable, but only if you provide clarity."

The third theme was that Lean methodology works. As one interviewee commented, "it is not 'voodoo management' and, while it was first developed for the automotive industry, the same approach to looking at simplifying processes can work in a health care setting". However, it requires a fundamental change in the culture of an organization. This begins with getting people across the system to work together in a highly collaborative way across departments. As one team member put it, "Lean demands a blame –free environment in which people feel safe to try new approaches. However, the media immediately wants to attach blame if anything goes wrong. Freedom of information is an important concept, but it leads to headlines and kneejerk responses. Its vital that we find the right balance."

The final theme related to the power of collaborative learning. It started right at the beginning with a significant investment in the time required to train the two PIP teams so that they were confident and comfortable with the tools and processes. This initial learning was clearly well supported by the external coaches. Then, as the initiative

unfolded and began to get some successes, the teams became more and more comfortable sharing their learning, experimenting, and developing very novel solutions. As one interviewee suggested, “New knowledge was being created at the front end of the process, with the PIP teams. Learning by doing can exclude some in the hierarchy and they may not have the knowledge that front line staff are developing but then the question is, do they need it or is this an example of wanting knowledge for the power it may provide? When you invert the knowledge pyramid, really interesting things happen. There can be comfort in the bubble thinking that you know what is going on and that things are getting done your way, but the inversion process forces formal leaders to go out and see what’s actually happening.”

“We have learned the collective power of working and learning across systems” commented one interviewee. “We have taken huge steps forward in the relationship between ED and Medicine. We have a better understanding of each others’ challenges, people are much more respectful, and people have clear accountabilities for their piece of the process. The results tell the tale.”

“I think that one of the things we have all learned about power,” suggested an interviewee “Is that any one person has actually very little power – even the CEO. What you need is for a couple of things to converge and then recognize the power that you have to take advantage of the convergence. The wins at the end of the day were not based on one thing but on a whole bunch of smaller changes converging at the same to produce a transformational change. That has been significant learning for all of us: Don’t look for the one magic bullet.”

Conclusion: Creating the Structural Conditions for Empowerment

The case study demonstrates the efficacy of intentionally designing the structural conditions through which people have the opportunity to empower themselves, thus creating sustained change. What is particularly significant is that, in the four years since the PIP initiative new structures evolved into disciplined strategies to: the organization continues to review data and performance; they bring content experts together to create "tests of change"; together they set targets for improvement based on current evidence; they have developed lead and lag measures that are monitored over time and then re-evaluated in order to set new goals. As a result, the cycles of improvement continue to evolve.

References

[1] Glouberman, S., & Mintzberg, H. (2001). Managing the care of health and the cure of disease--part I: Differentiation. *Health Care Management Review, 26*(1), 56-69.
Edersheim, E. H. (2007). *The definitive Drucker*. New York: McGraw-Hill.
[2] Toffler, A. (1990). *Powershift: Knowledge, wealth, and violence at the edge of the 21st century*. New York: Bantam Books. P. 19.

[3] Mackay, L. (1993) *Conflict in care: Medicine and nursing.* London: Chapman & Hall. p. 43
[4] (Mintzberg, H. (1989). *Mintzberg on management: Inside our strange world of organizations*. New York; London: Free Press; Collier Macmillan.p. 365- 366).
[5] Northouse, P. G. (2007). *Leadership: Theory and practice* (4th ed.). Thousand Oaks: SAGE Publications., p. 9).
[6] Northouse p. 7
[7] Cited in Skjorshammer, 2001, p. 7.
[8]Fried, B. J. (1988). Power acquisition in a health care setting: An application of strategic contingencies theory. *Human Relations, 41*(12), p. 915.
[9] Fried p. 924.
[10] Faulkner, J., & Laschinger, H. (2008). The effects of structural and psychological empowerment on perceived respect in acute care nurses. *Journal of Nursing Management, 16*(2), 214-221.

[11]Kettunen, T., Poskiparta, M., & Gerlander, M. (2002). Nurse-patient power relationship: Preliminary evidence of patients' power messages. *Patient Education and Counseling, 47*(2). p. 101
[12] (Kettunen et al. p. 101.