Corporate Culture: The Missing Piece of the Healthcare Puzzle

J. DEANE WALDMAN, HOWARD L. SMITH, and JACQUELINE N. HOOD

Abstract. The U.S. healthcare system requires radical, not incremental, change. Management issues in healthcare delivery are fundamentally different from those in the business world. *Systems thinking* forces a focus on corporate culture, about which there is little hard data. The use of cost/benefit analysis suffers from the lack of any accepted measure of *long-term* "benefit." The authors make four observations: (1) corporate culture is both part of the cause and part of the cure for healthcare; (2) *long-term* financial and functional measures are necessary to make evidence-based decisions; (3) valid, nationwide data must be developed regarding the corporate culture of medicine; and (4) direct (unmodified) application of management theory or practices will not achieve sustainable improvements.

Key words: healthcare policy, organizational behavior, outcomes, staff turnover

The healthcare industry has achieved an unenviable consensus: nearly everyone is unhappy with it. Patients complain about lack of access, the high cost of insurance premiums, the inability to determine differential quality among providers (are all doctors equally competent?) because of insufficient information, and excessive error rates and mistakes. Caregivers—doctors, nurses, and therapists—are angry about having responsibility without commensurate authority, the increasing hassle factor associated with trying to deliver quality, compassionate care, heightened stress, the loss of respect, declining income, and lack of professional satisfaction. Applications to U.S. medical schools have decreased 21 percent since 1996 (Barzansky and Etzel 2001). Experienced physicians are taking early retirement (Krauthammer 1998; Bass 2000), and young, recently graduated doctors are leaving medicine (Beedham 1996). There is an unprecedented rate of turnover among nurses, pharmacists, and support staff (Prescott 1986; Borda and Norman 1997; Tai, Bame, and Robinson 1998; Mott 2000; Wilson and Stranahan 2000).

Disenchantment extends well beyond what is felt by patients and clinicians. Boards of directors and healthcare managers generally view physicians as uncooperative, government regulations as excessive, and costs as uncontrollable. Payors such as insurance companies, large employers with self-insurance, and government agencies complain about the lack of quality control and the inflation rate in medical costs.

Herzlinger (1997) noted that "American corporations' profits after taxes almost equaled their healthcare expenses" (103). Although she advocates use of the free market as a solution to the healthcare crisis, vibrant market forces do not seem to exist. In addition to a malfunctioning marketplace, litigation is rampant. Lawyers decry the lack of consistent quality control or accepted standards and the perceived conspiracy of silence among doctors. The current tort system neither deters negligence nor adequately compensates for adverse events (Waldman and Spector 2003).

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Such trends vividly depict a healthcare system in dire need of change. However, public confidence that systematic, comprehensive solutions will surface is limited (Bryan-Brown and Dracup 2001). In this article we examine the potential for using corporate culture as a foundation for sweeping, effective, and lasting solutions to the healthcare industry's numerous problems. Systematic corporate practices and principles show substantial promise for renewing public trust in the ability of healthcare providers and organizations to deliver high quality care at a favorable cost. We examine several strategies for improving the application of business concepts and establishing corporate-based cultures in healthcare organizations.

Business and Healthcare: Two Different Worlds

The culture present in successful business corporations—exemplified by the achievement of value and profitability through emphasis on efficiency, productivity, and high quality—is decidedly foreign to and seldom seen in care delivery settings (Arndt and Bigelow 2000). Attempts to integrate business practices incrementally in healthcare systems often fail or at best produce modest, temporary improvements. If financial inconsistencies are resolved, concerns about quality remain. If the tort system becomes more effective, lack of access and high costs are still problems. Managed *care* has become managed *cost* (Klienke 1998). In solving one problem, new problems are created and existing ones exacerbated. Only when we approach the system as a whole and use *synthesis* can healthcare problems be "dissolved" (Ackoff 1999) and outcomes improved.

Klienke (1998) observed, "If healthcare is a business, then the tools that fixed other businesses will fix this one" (9). Even if healthcare is more a public service than a business, management principles and solutions can apply (Jones 2000). The volume and magnitude of public and private expenditures on health services reflect a reality at odds with the romantic myth that many providers still hold dear—the one-on-one personal-practice cottage industry that died decades ago (Wittkower and Stauble 1972). That myth has been replaced by a multibillion-dollar industry that is a major driver of our national economy. As such, healthcare should be assessed, analyzed, and managed like other service industries. A bridge must be built between the two cultures, as illustrated in figure 1.

Arndt and Bigelow (2000) reviewed the literature on the effectiveness of business practices applied to healthcare, and their research suggests a recurring pattern. Many hospital boards, most managers and regulators, and the public all assume that hospitals function like other businesses, meaning that high costs equate with inefficiency. Business practices such as continuous quality improvement (CQI) and total quality management (TQM) are then advocated as a means to achieve financial improvement. Promulgating such practices is considered equivalent to implementing them. When no significant fiscal improvements result, leadership is blamed and the next business fad is proposed as *the* answer. Arndt and Bigelow make a strong case for returning to the basics. They suggest asking primary questions regarding vision, purpose, objectives, culture, and incentives before adopting any solutions. Without clearly delineated priorities, without overt concurrence on *long-term* objectives, and without clear understanding of the determinants of behavior, leaders cannot achieve effective change.

Corporate Culture in Healthcare

Healthcare organizations are social groups composed of people who pursue a common purpose and share values and beliefs, and who, therefore, possess a similar culture. Theory and concepts of organizational culture have particular applicability to the healthcare industry, because the ability to achieve a common goal depends to a great extent on effective interrelations among people (Denison 1990). As Eubanks (1991) tersely wrote about a hospital, "You've got a corporate culture whether you like it or not" (46). In effect, understanding the corporate culture of healthcare is fundamental to accomplishing *any* effective, sustainable change in care delivery. We prefer the phrase *corporate culture* to *organizational culture,* because it emphasizes that the altruistic calling of healing also has a business side.

Different organizations often have unique cultures and subcultures (Deal and Kennedy 1982; Louis 1983), and groups within an organization can possess their own values, attitudes, languages, and patterns of behavior (Van Maanen and Barley 1984; Frost et al. 1991). At the upper levels of management in most organizations, there is a single, pervasive culture created by progressive screening, filtering, and socialization. Such cultural homogeneity is due more to a common vision, philosophy, and management style than to the

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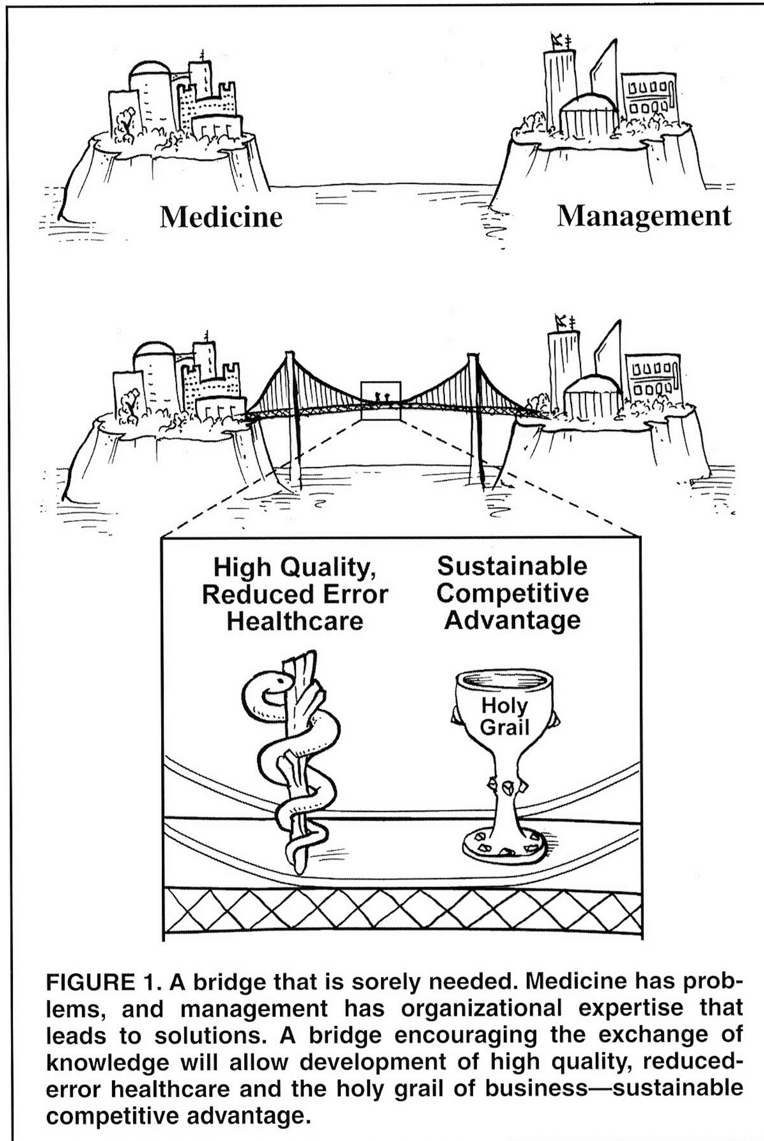

FIGURE 1. A bridge that is sorely needed. Medicine has problems, and management has organizational expertise that leads to solutions. A bridge encouraging the exchange of knowledge will allow development of high quality, reduced-error healthcare and the holy grail of business—sustainable competitive advantage.

demography—gender, age, race, etc.—of the upper managers. At the mid and lower levels of organizations, especially healthcare systems, diverse, even conflicting or competitive, corporate cultures can and often do coexist (Van Maanen and Barley 1984; Black and Stephens 1988; Gregory 1983; Martin and Siehl 1983; Wiener 1988; Davis 1951).

It is necessary to manage the corporate culture of a healthcare organization to achieve sustainable change in care delivery and, hence, improved outcomes. Cultural change can be studied at three levels: sociocultural, organizational, and individual. At the sociocultural level, change involves large systems, such as nations, regions, cultural groups, and the largest organizational entities (e.g., Hofstede et al. 1990). At the organizational level, changes occur in the organization's culture (Berry 1980). At the individual level, change takes place in the attitude, motivation, and cognition of the worker (e.g., LaFromboise, Coleman, and Gerton 1993). Systems thinking, which considers the interrelationships among these three levels (Ackoff and Emery 1972), indicates that a change at one level induces changes at all levels.

Corporate culture in hospitals has been variously described as a myth (i.e., nonexistent) (Brockschmidt 1994), weak (Hume 1990; Thomas et al. 1990), unique (Klingle et al. 1995), common across institutional lines (Kissick 1995), dysfunctional (Johnson 1997), a corporate mob (May 1993), and residing in the many informal entities that exist in any complex formal organization (Phillips 1974; Bender, De Vogel, and Blomberg

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1999). Nevertheless, however one defines it, corporate culture is essential to organizational success (Shortell 1988; Shortell et al. 1993). Suh Young, chief executive officer (CEO) of Genesys Health System of Flint, Michigan, took on the task of revamping the organization to make it more competitive. Reporting on his experience, Young said, "Attempting to influence organizational culture is one of the toughest things I've done in my career. I totally underestimated the magnitude of the effort required. . . . There are few reference points to rely on. So much of what we have done to date has been by trial and error" (Lawry 1995, 23).

Why is understanding and managing the corporate culture of healthcare so important? The answer is threefold. First, if the typical healthcare organization's corporate culture is seriously dysfunctional, this dysfunction may be at the root of health system problems. For example, culture is supposed to help counter stress, and yet in healthcare, it may *cause* job stress (Merry 1998). Consider the error rate in medicine. Leape (1994) noted that the most important reason for the prevalence of errors is the culture of medical practice. Senge (1990) argues that healthcare is an "anti-learning" industry because of its dysfunctional culture; our data supports this contention (Waldman, Yourstone, and Smith 2003).

The second reason for understanding corporate culture in healthcare involves human resource management. Staffing problems in healthcare, specifically, excessive turnover and professional withdrawal, are becoming serious (Bass 2000), and these symptoms are often traced directly to job dissatisfaction and cultural conflict. The third reason underlying the importance of culture relates to change, especially when drastic changes are needed (Conner 1990; Coeling and Simms 1993; Desjardins 1997; Lawry 1995; Leape 1994; O'Connell 1999; Proenca 1996). Corporate culture tends to resist change, seeking to preserve the status quo. In medical terms, culture is homeostatic (Litwenko and Cooper 1994; Neuhauser 1999). Despite the critical role that culture plays as an element in the change process (Shortell 1988), there is a paucity of hard data on which to make evidence-based decisions. The data available support the importance of culture as a key performance determinant in healthcare organizations. Effective change in the healthcare system requires detailed, accurate knowledge of the culture. Whatever systemwide changes are planned, fresh thinking and new socialization are required for them to be realized. Implementation requires knowledge of where and how to apply leverage; in other words, a sophisticated reading of cultural issues is essential before effective change becomes possible.

Systems Thinking in Healthcare

Since the 1960s, Ackoff has emphasized the need for what he calls *systems thinking,* suggesting that optimizing the components or parts of a system, particularly a purposeful system such as healthcare, may actually harm total performance (Ackoff and Emery 1972). For example, if a hospital wants to improve the function of its operating rooms by increasing utilization and reducing excess capacity, it might pare down the nursing budget by reducing full-time equivalents. The net (systemwide) effect would be delays in surgical schedule that lengthen hospital stays and result in greater expenditures (under managed care contract) than that saved in the operating room budget. This scenario does not, of course, take into consideration the medical or psychological effects of delaying necessary operations.

Hammer and Champy produced a *Manifesto for Business Revolution* (1994), in which they offered an analysis, similar to Ackoff's (1998), that recommended looking at the whole process rather than parts in isolation—focusing on system output, not the interim outputs of component elements. This approach has three implications for healthcare. First, healthcare leaders need to recognize that the desired system output is the *long-term* health of the population, not simply short-term objectives such as reduced mortality from bypass surgery. Second, although the technical and physical resource elements in the healthcare process (the value chain) have been analyzed well, the cultural component "seems curiously understudied" (Merry 1998). Third, there is a fundamental societal question that cannot be answered by healthcare leaders alone: What is the primary goal of the healthcare system—well-being of patients or national resource stewardship? If it would cost more than $8 million to save one patient from death from a ruptured appendix, should society spend the money? (Donabedian 1985). "Irresolution as to whether healthcare is first and foremost a business or a public service is at the heart of major contemporary [healthcare] public policy problems" (Jones 2000, 290).

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Creating Core Philosophies and Ideologies

In their book *In Search of Excellence,* Peters and Waterman (1982) proposed eight general management concepts to achieve "excellent" quality outcomes, most of which resonate with the culture of healthcare. Some of them are *(a)* a bias for action, *(b)* entrepreneurship and autonomy of employees, *(c)* productivity through people, and *(d)* minimal administrative structure. Other characteristics of "excellent" companies are that executives keep in close touch with core processes and businesses stay close to their customers (i.e., remain cognizant of their needs). The authors stressed what they termed the *loose/tight* configuration of an organization, which means loose controls but tight consistency of values. Twelve years later, Collins and Porras (1994) explored the importance of core ideology as an unvarying foundation upon which employees are encouraged to make decisions, take risks, and learn. A key element in the culture of a "visionary" company was the "genius of the *and,*" in contrast to the either/or thinking (e.g., high quality *or* low cost) that limits what is possible.

These philosophical concepts of excellence and core ideology have relevance for healthcare. What if multiple, strong, and conflicting sets of core ideologies ("cult-like cultures") exist within healthcare? What if doctors and nurses—paradigms of Peters and Waterman's "bias for action" (1982)—have a poor tolerance for ambiguity, the concept at the core of the "genius of the *and*"? In those cases, healthcare practitioners may be culturally disinclined to make use of the two powerful management tools, consistent core ideology and ambiguity, to implement innovations and improvements.

Leading a Culture of High Performance

A number of authors have written about leadership—its attributes, the role of charisma, what types of individuals are successful, and how leadership is measured. An important distinction is the difference between a leader and a manager (Kouzes and Posner 1997); the latter deals with what *is,* whereas the former creates what *will be.* Thus, leaders undertake the more difficult tasks of making things different, taking the organization into the future, and creating change. As Secretary of the Treasury and former CEO of Alcoa Paul O'Neil said recently, "Leadership is really about creating the conditions where people are comfortable with change and know that they have an opportunity to make a contribution" (Broder 2001, B2). Given these definitions, one might ask, How many leaders as opposed to managers are there in healthcare?

The second half of Secretary O'Neil's remark focuses attention on employees, who are the direct value adders in the system. In manufacturing, these are the assembly line workers; in healthcare, they are the doctors, nurses, and therapists. In a review pamphlet correlating high-performance work practices with actual business outcomes, Baker (1999) concluded, "Most of the evidence points to the clear possibility that changes aimed at building a skilled workforce, permitting people to make contributions beyond the day-to-day routine, and rewarding them for their results, can pave the road to stronger financial performance and greater competitive advantage" (2).

The works of Heskett (Heskett, Sasser, and Schlesinger 1997) and Rucci (Rucci, Kirn, and Quinn 1998) are significant, because they directly link the status of the workforce—specifically employee attitudes—to customer behaviors and, in turn, to predictable, quantifiable financial outcomes. The following conceptual excerpts have potential applicability to healthcare: "Customers do not buy products or services. They buy results" (Heskett, Sasser, and Schlesinger 1997, 17). "What do frontline service employees value most on the job? There is increasing evidence that it is their ability and authority to achieve results for the customers" (29). Describing a turnaround in corporate financial performance at Sears, Rucci concluded that "[f]or the 200 managers at the top of the company, Sears took the truly revolutionary step in 1996 of basing all *long-term* incentives on the TPI"—the total performance indicator scale, a measure of employee attitudes and behaviors (Rucci, Kirn, and Quinn 1998, 96). Note that the company did not link the bonuses to financial downstream or derivative measures but to its perceived key ingredient for *long-term* success: employee attitude.

Given strong evidence that employee attitude affects corporate culture and vice versa (Kotter and Heskett 1992), and given that we seek to improve the outcomes of the healthcare system, an adjustment in the corporate culture of medicine seems inevitable. Although corporate culture can be a means to accomplish change, it can also be a barrier to change, because it fosters organizational inertia. In 1982, Deal and Kennedy wrote that "[c]ultural change is only needed when the culture

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doesn't fit the environment and even then, change is very difficult" (175). Seventeen years later, they put it this way: "Cultures change only when they need to and are *damned well ready* to change" [italics added] (1999, 35).

One does not need to read the management literature to know that incentives affect behavior. What is surprising is the frequency with which people "reward A while hoping for B" (Kerr 1975). Unfortunately, this is common practice in healthcare. Although patients and physicians want to communicate with each other, establish a relationship, and achieve good understanding, doctors are now judged on productivity—how many patients they see in a day. So the question is, Should doctors "run them through" or sit and talk?

Studying the Corporate Culture of Healthcare

Numerous challenges exist in any study of the corporate culture of healthcare: *(a)* demographic decisions, *(b)* evaluation of organizational attitude and behavior, *(c)* methodological issues, and *(d)* appropriate outcome measures. Ultimately, to understand systemwide dysfunctions in healthcare and to develop public policy recommendations grounded in an effective corporate cultural setting, healthcare leaders need a compilation of such data.

In research, decisions on demographics in the corporate culture of healthcare revolve around complex sampling issues. In measuring the presence of a common culture in healthcare, researchers must ensure that the organizations and individuals studied and data acquired are representative of the diverse elements that characterize healthcare—from eleemosynary, faith-based care facilities to Veterans Administration hospitals and academic medical centers, from doctors to allied health personnel, managers, and support staff. Furthermore, given the performance of this research in healthcare settings that have required institutional review processes, attention must be paid to the balance of data collected versus confidentiality.

Fruitful studies of attitude and behavior will use previously tested methodologies to ensure measurement of distinctive perspectives and viewpoints. Useful methodologies include traditional market research and organizational behavior studies (Hoppock 1935; Lodahl and Kejner 1965; McNichols, Stahl, and Manley 1978; Black and Stephens 1988; Thomas et al. 1990; Zammuto and Krakower 1991; Klingle et al. 1995; Ashkanasy, Broadfoot, and Falkus 2000; Cooke and Szumai 2000). These studies can be benchmarked against studies from other service industries (and even manufacturing). To assess healthcare organizational cultures, specific instruments must be designed and incorporated into the research as well.

Observational studies may provide useful insights, whether the elements be rites, rituals, and ceremonials (Deal and Kennedy 1982; Moore 1991; Brooks 1996); socialization techniques (Bender, De Vogel, and Blomberg 1999); or informal groupings (Phillips 1974; Coeling and Wilcox 1988). Although previously established methodologies may be applicable—for example, the hospital culture scale (Klingle et al. 1995), the Sears TPI index (Rucci, Kirn, and Quinn 1998), the employee-service-profit chain questionnaire (Heskett, Sasser, and Schlesinger 1997), and the return-on-management assessment (Simons and Davila 1998)—new instrumentation is also necessary. Another useful assessment technique involves studying organizational writings, for example, annual statements, promotional materials, newsletters, and mission statements. Studying what is written compared to what has actually been implemented should also provide useful insights into organizational culture. In general, people accept the organizational structure of a medical center as a given; this is an important component of the culture and must be studied.

Selecting appropriate outcome measures is also key. The measures should relate directly to the cultural variables under study. Financial outcomes such as centerwide or even divisional profit and loss are affected by too many other variables to be used meaningfully. The measures need to be inherently useful to the end user and formatted for ease of analysis. The best measures have immediate quantifiable consequences, allowing the results to be translated into useful numbers. Turnover is a good example, because it has direct costs that can be calculated (Jones 1990; Buchan and Seccombe 1991; Berger and Boyle 1992; Irvine and Evans 1995; Gray, Phillips, and Normand 1996; Tai, Bame, and Robinson 1998; Buchbinder et al. 1999; Stoller, Orens, and Kester 2001). The terminology associated with corporate culture writings—such as *turnover, collection,* and *complication rates*—though considered standard, is usually applied with little precision and less consistency. For example, employee turnover is commonly tracked (calculated

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using multiple different methods) when what we *want* to know about organizations is their retention rate—a very different measurement. Finally, which outcome measures are chosen reflects what the investigator considers important; if people are important, then employees should be studied as individuals rather than in aggregate.

Finally, any study of corporate culture can present methodologic problems. First, there is bias—sample, selection, and procedural (e.g., the interview process). Of particular concern is the low response rate of indirect, survey-type studies, which yield a median response of 24 percent (Baker 1999). Low response rates create an initial bias (flawed primary data) that most scientists consider unacceptable. Powerful mathematical algorithms have been developed in an attempt to eliminate this bias, but the real problem is in the design, not the analysis. If a survey approach is used to study the corporate culture of healthcare, some method must be developed to eliminate bias in the primary data. The matter of causation is a second methodologic problem: temporal association versus true cause-and-effect, direction of causality, and time horizon of interactions. Adequacy of outcome measures is the third major concern—their consistency and appropriateness.

Potential Outcomes and Implications

Ackoff (1999), one of the deans of management theory, wrote, "How can managers reasonably be held responsible for the financial performance of their units when they neither know nor control a large portion of their costs, especially costs of capital in particular?" (258). Paraphrased for healthcare, this might read, How can healthcare managers reasonably be held responsible for the medical or financial performance of their units when they neither know a commonly accepted calculus of outcome measures nor control the resources necessary to achieve good outcomes? A desired outcome of corporate culture studies in healthcare is to identify and quantify the imbalance between responsibility and authority that is a major source of both stress and dysfunction.

In addition to obtaining cultural data from the proposed research, numerous medical outcome measures must be generated. These need to be expressed in both functional and financial ways. Neither has been well researched, and certainly no calculus of healthcare outcomes has been broadly accepted, despite the compelling need for such a basis of comparison.

At present, widely used medical outcome measures tend to be negative ones: mortality and morbidity rates, complication rates, incidence of malpractice claims, and length of stay. They are all measures that can be translated into short-term financial consequences. Little attention is given to positive medical outcomes such as increased longevity or restored or improved productivity—those with *long-term* financial consequences. Therefore, most calculations of medical outcomes and resultant financial effects amount to half of a cost-benefit ratio: A numerator of short-term financial costs lacking any accepted denominator of benefits—*short-* or *long-term*, functional, or financial—to the patient or to society.

Outcome measures from medical studies have financial and, by extension, sociopolitical effects. What are the boundaries of social obligation, expressed in dollars? Once we understand the culture and the medical-financial outcomes, a dialogue should take place, followed by decision making. Who will make the decisions and what incentive structure will be developed to assure congruence of public policy with healthcare workers' behavior?

"Ever since the passage of Medicare legislation in 1965, it seems that creative healthcare financial wizards have figured out how to 'game' every cost-containment idea the payors have invented" (Merry 1998, 9). Doctors play this game, too, often resorting to "score-card medicine" (Waldman, Ratzan, and Pappelbaum 1998, 14). One cannot legislate or manipulate this tendency out of people. Rather, the system must be restructured so that healthcare is not a zero-sum game. Accomplishing this requires understanding the values, beliefs, behavior, incentives, and communication—the culture—before instituting redesign. Then, when a patient gets better or errors are minimized, the doctor wins, resources are optimally utilized, and investors make money.

The healthcare industry is plagued with problems that ultimately affect every citizen. At present, it is usually anecdote and opinion, however well-intentioned, that are being tapped for solutions. An analogy would be treating a patient's liver disease on the basis of what your grandmother says worked for her next-door neighbor. If healthcare is to become a learning industry (Senge 1990), if physicians truly seek to heal themselves and their patients, the first step toward those goals

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is acquisition, organization, and analysis of accurate information. Evidence-based medicine must include data on the culture of medicine itself. Only when armed with hard data and used in association with management experts, can those who understand the ethos of medicine—those who are "called" to medicine (Loop 2001, S28)—hope to develop a system in concert with the needs of all stakeholders.

Recommendations for Healthcare Executives, Planners, and Managers

Healthcare leaders must recognize the need to focus on building effective cultures that embrace all the stakeholders involved, particularly those who deliver the care. Some managers responsible for establishing strategic directions and overseeing operations understand the cultural conflicts within their organizations. They are the lucky ones, because their job is clear: managing corporate culture in healthcare. The less fortunate are those who do not understand the nature or the magnitude of the problem: the wedge, the frank disconnect, between managers and clinicians—the *blue suit–white coat war.* For those managers, only a careful look at reality, perhaps facilitated by an impartial outsider, will enable them to address fundamental causes rather than merely to palliate symptoms. Several strategies may then be used to change healthcare organizational culture.

An effective strategic plan should enable the diverse components of a medical system to move in a common direction. Too often, strategic planning is conducted in a formulaic manner without energy or enthusiasm. In many cases, stakeholder input is limited or completely ignored, leaving clinicians out of the process. Because the plan seems dictated from on high, it meets resistance and foments staff rebellion. Employees then build obstacles that prevent sound ideas from becoming reality. The well-intentioned strategic plan thus generates an effect opposite of what was intended and becomes a divisive element that further separates clinicians from managers. Arndt and Bigelow (2000) documented the vicious cycle of dysfunctional planning and implementation that seems to be the norm in the healthcare setting.

Effective strategic planning is not achieved simply by checking off or refining the mantra of "Vision, Objectives, Strategy, Implementation" (Thompson and Strickland 2001) or by the application of the latest management fad or theory, such as TQM, CQI, and six-sigma. To improve healthcare corporate culture, there should be a forum for frank and open discussion throughout the organization while the strategic plan is being developed. The forum should elucidate differences and help members arrive at a consensus. As a focal point for building desirable shared concepts, the strategic plan (and the planning process) should foster an effective corporate culture, one that blends clinical and managerial imperatives.

To build more effective cultures in medically oriented organizations, leaders must establish a common vocabulary and conceptual framework among staff. High-performing healthcare executives and managers invest time in learning basic medical terminology and medical care guidelines, and in understanding the fundamental processes, outcomes, and difficulties that surround commonly performed procedures in their organization. Clinicians need a similar vocabulary and more familiarity with management terminology and concepts to have effective dialogue about an organization's direction and to blend clinical needs with managerial aspirations. Workshops, seminars, and tutorials can be offered to establish a consistent language and conceptual framework. These educational efforts should be jointly sponsored and delivered by top management and medical officers. A common language creates fertile ground for discussions about the inevitable trade-offs that affect medical decision making and resource allocation; together, these two elements are the driving factors in medical outcomes and financial performance.

Another strategy that healthcare executives can use in constructing a workable organizational culture involves the application of evidence-based improvement. By methodically collecting, analyzing, and disseminating data on structure, processes, and outcomes in service delivery, the staff's attention can shift from obsessing with personalities and divisive philosophical argument and focus more attention on improvement. Clear and widely disseminated information about performance unmasks hidden agendas and directs attention to the factors responsible for less than exemplary performance. When problems are thus clearly articulated and calibrated, responsibility for creating solutions can be decentralized to the most effective point of correction. To conclude, clinicians and managers can create an effective corporate culture in service delivery by focusing on facts, rather than suppositions, and by monitoring performance metrics, learning, and then improving results in both medical and financial terms.

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Caveat Medicus atque Publicus atque Civis

The warning that follows comes from our comparison study of healthcare and education (Waldman, Yourstone, and Smith 2003). We believe this warning bears repetition. "Anyone who offers simple, inexpensive or painless solutions is lying, exaggerating or does not understand the complexity of problems in healthcare. . . . Anyone who expects such solutions will be disappointed."

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