Customers of the Anesthesiology Group: Notes From 2006 Conference on Practice Management

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Twenty-six anesthesiologists, practice administrators, consultants and lawyers presented a broad variety of topics at the 2006 ASA Conference on Practice Management, which was held in Orlando on January 27-29. Among the many talks were several covering aspects of customer service in anesthesiology: recognizing the different customers' needs, defining excellent service, and dealing with group members who disrupt the service. The column below summarizes those presentations, with the intention of attracting readers' attention to the entire collection of excellent abstracts from the conference, available on the ASA Web site.

Customer Needs

Assessing Customer Service in Anesthesia: Why It Is Not Enough Just to Have Good Clinical Outcomes *— Jody Locke, CPC, Vice President for Anesthesia and Pain Management Services, Anesthesia Business Consultants, LLC, Jackson, Michigan.*

Customers of anesthesia services have come to view high quality care as a given. In a competitive environment where hospitals issue more and more requests for proposals from outside anesthesiology groups, an incumbent group must attend to the service needs and wants of all of its customers.

Among anesthesiology's customers are patients and, just as important, surgeons and hospitals. Hospital administrators, in fact, expect anesthesiologists to treat the surgeons as their number-one customer — while the CEOs are the ones who hold the purse strings and set the priorities. CEOs' challenge is to increase the number and types of services provided at their facilities, and they want anesthesiology groups to participate in their efforts to make the surgeons as comfortable as possible.

Mr. Locke identified seven domains on which hospitals implicitly (or explicitly) rate their anesthesiology groups: clinical competence, availability and responsiveness, ownership of operating room (O.R.) management, support for new clinical services, intra-group collaboration, collaboration with hospital administration, and innovativeness. His informal survey of hospital administrators showed that a group earning 10 out of 10 points on clinical competence could just as easily earn a 3 as an 8 on ownership of O.R. management. One administrator listed his challenges in managing his long-tenured anesthesiology group, among them: "Engagement of anesthesia providers in driving operating room efficiency including start times, turnover times, the development of standard processes, etc." and "The perception articulated by a number of surgeons that anesthesia providers are not willing to do certain kinds of cases."

Becoming attuned to the customer service expectations of hospitals and surgeons requires considerable adaptability on the part of anesthesiologists. Like most physicians, they tend to be autonomous and independent in providing patient care, but contributing to the hospital enterprise in the areas of utilization, efficiency and profitability means teamwork

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and accountability — as well as a willingness to share in the risk. This business-partner relationship with the hospital starts with good communication.

Mr. Locke offered three pieces of advice to promote the relationship:

- **Inspect, don't expect:** Establish customer service standards for the anesthesiology group members and hold them accountable.
- **You cannot change what you cannot measure:** Anesthesiologists are very familiar with the value of reliable physiological monitoring data but need to measure the "environmental response to the activities of the practice" through such mechanisms as surveys and 360-degree reviews.
- **Be prepared to act on the feedback you get:** The anesthesiology leaders must send a clear message that the entire group membership is willing to make appropriate changes and is committed to the customer's satisfaction.

Defining Excellent Service

Defining Moments in Medical Staff Leadership: Are You Front and Center or Trying to Get Lost in the Crowd? *— Joanne M. Conroy, M.D., EVP and COO, Atlantic Health System/Morristown Memorial Hospital, Morristown, New Jersey.*

Dr. Conroy moved to hospital administration from her position as chair of the anesthesiology department at the University of South Carolina. She presented a close-up view of the ways in which anesthesiologists can best serve their hospital customer.

The major concerns for hospitals, according to survey data, are reimbursement (70 percent of hospitals reported this as an issue), workforce issues (57 percent), medical liability (26 percent) and physician issues (26 percent). Strategies to remain competitive include:

Strategies

- Capitalize on development of higher margin services
- Partner with other hospitals and physicians to manage patient populations
- Standardize and automate internal businesses and patient care processes
- Emphasize patient satisfaction and quality of care
- Develop measures of performance

Anesthesiologists can be particularly valuable because of their great leadership skills. Dr. Conroy distinguished between executive and legislative leadership, the latter being more appropriate to not-for-profit environments. With their experience in managing the group, anesthesiology leaders are accustomed to consensus-building.

The hospital administration needs anesthesiologist leaders' hearts, heads and spines. Using his or her heart, an anesthesiologist feels a commitment to the hospital and with the administrator can address the physician apathy that is "a death knell for hospital health and growth." In the optimum setting, the wrong physician will never run unopposed for elected office within the medical staff. The anesthesiologist's "head" will lead him or her to develop or outsource the practice management skills necessary to attract high quality clinicians and to cover enough rooms. Having backbone, the anesthesiologist will be able and willing to address problem behavior on the part of heavy admitters.

Dr. Conroy's advice for leaders appeared in the following slide:

Being a Great Leader

- Create a kitchen cabinet … advisors whom you can trust to be honest and who are your eyes and ears in the hallways
- Put your personal needs aside in you leadership role … rewards will come
- Remember the key is to build positive enthusiasm and momentum … build on small successes. People want to feel the excitement of being involved in a success story

Leadership and Problem Physicians

Managing the Disruptive Physician: The Responsibilities of Leadership *— James S. Hicks, M.D., M.M.M., Associate Professor of Anesthesiology and Perioperative Medicine, Oregon Health and Science University, Portland, Oregon, and Chair, ASA Committee on Quality Management and Departmental Administration.*

Among the anesthesiologists least able to provide customer service are those considered "disruptive." The group leadership serves all of the department's customers — the disruptive anesthesiologist, patients, surgeons, hospital,

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O.R. staff and other group members — by properly managing the disruptive physician.

Stress is the culprit in causing physicians to engage in the behavior that identifies them as "disruptive:" intimidating coworkers or staff; blaming or shaming others for adverse outcomes; making threats of violence, retribution or lawsuit; making sexual comments or ethnic or socioeconomic slurs; not responding to calls or pages; and losing one's temper in front of staff or patients. The result, when a stressed-out physician responds in these aggressive ways, is a charged O.R. atmosphere in which the team cannot function well or effectively. The greatest concern is the decrease in patient safety resulting from the potential increase in medical errors and poor outcomes.

Judith Jurin Semo, Esq., shared the podium with Dr. Hicks, discussing the legal responsibilities of the group leadership, including advance planning (e.g., suggested provisions in the employment agreement) that can assist a group in dealing with a disruptive physician. Dr. Hicks showed that the anesthesiology group executives and managers have professional responsibilities not just to patients, but also to the disruptive colleague, which require these leaders to attempt to interrupt the destructive cycle. He noted that "DPs" rarely seek help on their own "so it may be like some pediatric anesthetics…you've got to hold them down first." In other words, an intervention similar to the interventions used for substance abusing professionals has a definite place in the strategies for dealing with DPs.

An intervention involves a diverse group of interested parties — family, friends, colleagues, departmental leadership, hospital leadership and mental health professionals — who set out the goals in advance. Each participant presents his or her personal concerns and describes the specific behavior necessitating intervention. The team describes the acceptable assessment, therapy or educational options, emphasizing the gravity of the situation. The goal is to have the disruptive physician accept responsibility for the problem behavior and commit to specific remediation.

Dr. Hicks, who chairs ASA's Anesthesia Consultation Program, observed that difficult anesthesiologists are a common reason for hospital requests for consultations. The consultants' recommendations are adapted to the specific stressor, and they sometimes call for an independent medical evaluation of the subject's ability to function professionally without oversight.

His last point was that strong department leadership is essential to coordinate the plan and deal with the DP in a fair and timely manner.

Ms. Semo noted that this very issue of leadership is critical to strengthening a group's relationship with a hospital: If a group does not demonstrate leadership in dealing with its disruptive members, the hospital can lose confidence in the group's ability to deal with other challenges in its practice.