Chapter 18
A New Model for Strategic Leadership in Healthcare: The A–G Model

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Abstract Healthcare systems around the globe face the common challenges of rising medical costs, lagging quality and limited access. Improving medical care worldwide will require new leadership and innovative solutions. This article sets forth a brave leadership strategy designed to help clinicians overcome their fears of change and embrace the best solutions for their patients. The A-G model presented in this article gives leaders a powerful tool to help achieve meaningful transformation within a healthcare organization by allowing them to articulate a bold vision, generate the trust of their colleagues and demonstrate the courage needed to overcome the inevitable resistance they will encounter.

18.1 Introduction

Healthcare systems around the globe face a common and growing set of challenges. They include rising medical costs, growing unaffordability and shortcomings in the areas of quality, access and patient convenience. This chapter focuses on the U.S. healthcare system. Although American medicine is unique in some ways—which include a financing system wherein employers, not the government, cover more than half the population—approaches that have improved the structure and delivery of medical care in the United States can be directly applied to industrialized nations everywhere.

Despite its incredible scientific, medical and pharmaceutical advances in recent decades, the American healthcare system most closely resembles a nineteenth-century cottage industry. In every community, there is widespread fragmentation—doctors and hospitals operate in silos, disconnected from one another. Every service rendered is paid piecemeal; what healthcare providers call "fee-for-service." Technology—and, specifically, information technology—is held over from the last century. Doctors sit behind clunky computers powered by operating systems designed primarily for billing purposes and the most common way they transmit important

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medical information to colleagues in the community is via fax machine. Most important, there is little formal structure or leadership within medical settings, a reality that serves to perpetuate the problems already besetting American healthcare.

The consequences of this outmoded system are both predictable and deadly. Each year, hundreds of thousands of people die prematurely from preventable medical errors, omissions in preventive services (Lee et al. 2018) and the avoidable complications of chronic disease (Makary and Michael 2016). National healthcare expenditures in the United States now account for 18% of the Gross Domestic Product (GDP). With actuarial projections of $5.7 trillion in healthcare costs by 2026, economists fear that the expense of medical services could surpass the ability of the government, businesses and individuals to pay within 10 years, and might therefore lead to rationing of care as the lone remaining option (Tozzi and Tracer 2018). Furthermore, physicians are frustrated and burned out. One-third of doctors suffer from anxiety or depression, resulting in more than 400 suicides each year—among the highest rate of any U.S. profession (Andrew and Brenner 2018).

The need for strategic and operational improvements in healthcare has reached a fever pitch. Accomplishing them will demand new leadership and innovative approaches. To understand the challenges and opportunities of American medicine today, it is essential to begin with the evolution of medical practice since the mid-twentieth century.

18.2 Medical Care, Then and Now

Until the 1950s and ‘60s, doctors could do little to heal or help patients, save for prescribing basic antibiotics like penicillin, administrating immunizations against a few childhood diseases and performing a limited number of routine surgeries.

Due to the limited diagnostic and therapeutic approaches available, the cost of care delivery at the time was low—accounting for less than 5% of U.S. GDP. For most of the last century, nearly all patients who came to the doctor’s office suffered from acute problems, such as pneumonia, influenza or appendicitis. Treatment of these diseases led either to full recoveries or quick death. The term “chronic disease” was nowhere to be found in medical books of the era because few people lived long enough to acquire them. In 1960, the average man died at 66 years old, 10 years younger than the average male today.

Bed rest was the treatment for heart attack, and most patients spent seven to 10 days in a hospital following a myocardial infarction, twice as long as they do now. After childbirth, mothers and their babies stayed a full week in the hospital compared to a day or two now. Back then, doctors had fewer than 100 drugs in their armamentarium. Procedures such as angioplasty—performed to unblock the coronary vessels to the heart—were still decades away from being perfected.

The health system was structured to meet the demands of that era’s medical practice, which was far simpler and less sophisticated. The uncomplicated nature of care delivery at the time led doctors to work in solo practices and even make house

calls. The absence of cutting-edge machines, expensive medications and complex procedures made a day in hospital relatively cheap, thereby allowing for extended inpatient stays. And with the exception of basic X-ray machines, simple blood tests and a rudimentary understanding of genetics, doctors relied primarily on their intuition and clinical experiences when diagnosing or treating a patient. Empathy and compassion were two of the most powerful remedies they offered, and patients were grateful for the care and concern they received.

All that began to change in the 1970s and '80s. Sophisticated MRIs, along with CT and PET scanners became powerful diagnostic tools, replacing much of the intuition doctors relied upon in the past. The history and physical exam, along with the highly personal doctor-patient relationship, progressively ebbed in importance as technology came to dominant medical practice. By the turn of the century, the human genome had been fully sequenced and analyzed. Specialty care eclipsed primary care as both the dominant force in healthcare and the most lucrative. With the introduction of ever-more expensive drugs and complex procedures, physicians were soon capable of extending human life far beyond what previously could have been imagined. As patients lived longer, chronic diseases like diabetes, heart failure and arthritis became more prevalent—an upward trend that continues today (Jones et al. 2012). It's estimated that by 2050, one-third of Americans will have diabetes (https://www.cdc.gov/media/pressrel/2010/r101022.html) (Fig. 18.1).

The challenges of medical practice are starkly different in the twenty-first century than in the twentieth. The physician's armamentarium is now stocked with more than 5000 available medications. Multimillion-dollar diagnostic and therapeutic machines can both find and treat cancer more effectively than before. Heart surgeries are routinely performed on patients over the age of 90 as people unable to get out of bed or feed themselves can be kept alive for years with machines and tubes. The electronic health record has made reams of data available at computer stations in hospitals, offices and even doctors' homes, so that physicians spend progressively less time at the patient's bedside, eroding the doctor-patient relationship.

One might think that broad access to these advances in the U.S. would make it a world leader in quality outcomes, but that promise has not been fulfilled. As a result, despite leading the world in healthcare spending, America ranks last among developed countries in almost every measure of clinical quality, from childhood mortality to life expectancy—with U.S. longevity even decreasing in recent years. Meanwhile, the American system's fundamental structure, reimbursement model and information technology systems have failed to evolve at the same pace of advancement as the rest of medical science.

The need for strong leadership is far greater today than in the last century. Back when the cost of care delivery was low, the goal of achieving operational excellence was less urgent and important. When chronic diseases were minimal, so was the need to implement systems of care that maximized coordination and collaboration among physicians. In fact, when intuition and personal experience dictated medical decision-making, there was little need for doctors to organize into teams or follow the limited research-based practices of the time.

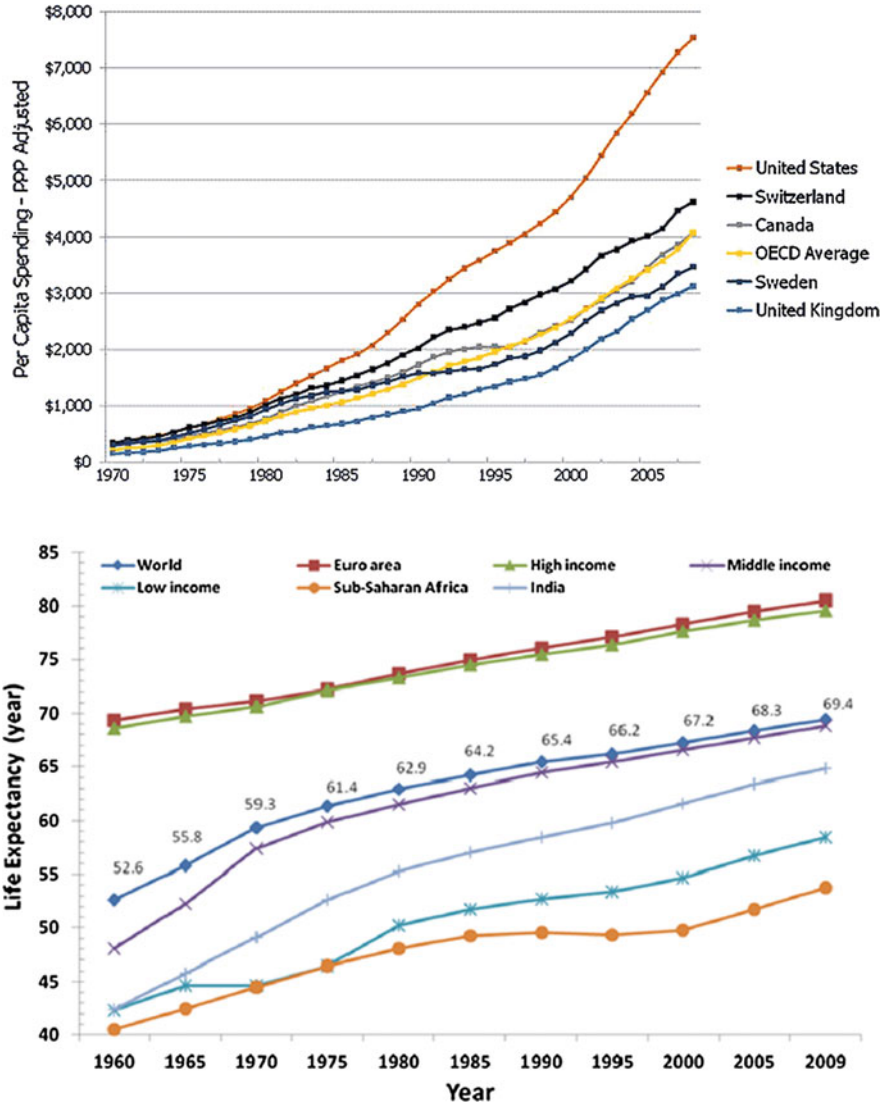

Fig. 18.1 Comparing the upward trajectories of healthcare costs and life expectancy around the world. Table 1 (https://www.kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/) shows per capita spending for all OECD nations. Table 2 (https://en.wikipedia.org/wiki/Life_expectancy#/media/File:LifeExpectancy.png) shows life expectancy in years based on global location and income levels

Yesterday's approaches are inadequate for today's problems. Medical care has become so complex and expensive that the best outcomes are dependent on teamwork, communication and evidence-based medical practice. The demands of the twenty-first century to lower costs, prevent medical errors and implement system-wide operational improvements will require more effective leadership.

And yet despite widespread discussion and agreement about the need to move from fee-for-service reimbursement to pay-for-value approaches, change is slow. Most healthcare leaders today are focused on maximizing the *quantity* of medical care delivered and the prices they can charge. Across the country, hospital administrators want to fill beds more than they want to find efficient, high-quality practices to empty them. Hospitals of today advertise the newest multimillion surgical robots and proton beam accelerators to attract highly remunerative patients, rather than questioning the clinical value in purchasing the machines in the first place (O'Neill and Scheinker 2018). Rather than developing a reputation for prevention and disease avoidance, doctors of today have staked their "brand" on offering miracle cures and life-saving surgeries for the sick and dying. If these problems were confined to the U.S., it would be possible, even logical, to blame the nation's unique culture, politics or private insurance system. But new data from around the world suggest that every industrialized nation is facing a similar healthcare-economic crisis. Addressing it will require skilled and innovative leadership everywhere.

18.3 Difficult Times Demand Bold Changes

If businesses in other industries worked similarly to American healthcare, the consequences would be disastrous (Parks 2016). It is impossible, for example, to imagine a capital-intense factory with expensive employees and machinery operating at 70% of capacity during the workweek. Yet, this is what happens in many community hospitals, operating rooms and radiology suites across the country (Pearl 2018). Or try to imagine that instead of hiring five skilled operators for particularly complex machines, you let everyone try their hand at each, rotating from one to the other throughout the week. None of the operators would gain maximum expertise and quality would suffer. And yet, that is how surgery in most specialties is performed in hospitals today—all the physicians in a single specialty doing a little bit of everything. Doing a procedure once a month creates variety for the surgeon but leads to poorer outcomes and more medical errors for the patient. Finally, try to think of a company whose employees spend huge amounts of time doing work that adds billions of dollars of added costs, but no value for its customers. It might sound absurd but, in healthcare, 30% of what physicians do (tests, visits and procedures) has been proven to add no value for patients or improve clinical outcomes (Lallemand 2012).

18.3.1 Physician Resistance to Change

Inspiring and implementing change is difficult in any industry, but it is particularly problematic in healthcare. A major reason is the powerful role doctors play, accounting for 70% of all healthcare costs. It's not that the contributions of everyone else, including nurses, staff and pharmacists, are not crucial to patient outcomes. It's that without the support of physicians, any improvement effort is doomed to fail. Unfortunately, leaders who try to change physician practices meet resistance for a variety of reasons:

1. ***Sense of entitlement***. During their years of training, physicians make huge sacrifices, often working 100 h a week while accumulating an average debt of $200,000 to earn their medical degrees. They spend the majority of their twenties and early thirties studying, training and working toward the mastery of their trade, often missing out on the more enjoyable experiences of their friends. After more than a decade of training, they feel entitled to practice as they choose.
2. ***Knowledge differential***. Because physicians spend so many years training after graduation, they possess far more expertise than their patients, creating a "doctor knows best" mindset. Within healthcare's fragmentated environment, this mentality leads many doctors to believe their judgment and decisions are always right, even when the data offer evidence to the contrary.
3. ***Fear of mistakes***. Although many doctors are overly confident, fear lurks inside all of them. In Silicon Valley, a failed venture can be perceived as a rite of passage if not a badge of honor. In medicine, where lives and professional reputations are on the line, failure is not an option. Mistakes result in pain and suffering for families and, in some cases, a malpractice suit and even the loss of a doctor's medical license. As a result, doctors are incredibly risk averse, particularly when it comes to embracing change.
4. ***Outside threats***. For more than a decade now, doctors have felt as though their jobs and livelihood are under constant attack. Cost-cutting measures from both private insurers and the government have made physicians leery of "improvement programs." Getting anyone to see the wisdom of embracing change when it will negatively impact their income and their lives proves extremely difficult. Doctors are no exception.
5. ***Personal Gain***.

Ultimately, it's difficult to shift dollars in the healthcare system from areas of relative ineffectiveness to ones with major impact. That's because individuals who will be negatively impacted consistently resist change. For example, studies show that investments in primary care and preventive medicine help patients avoid cancer, heart attacks and strokes far more successfully than investing in more complex, specialty care. However, any attempt to shift the dollars will be labeled by specialists as "rationing." They will lobby hard to stop it. Similarly, consolidating hospitals and clinical services to increase expertise and experience would maximize efficiency, improve clinical outcomes and lower costs, but attempting to shutter an underutilized

facility or close a clinical service in a community will be contested by administrators, community leaders and the doctors who practice there.

Of course, physicians aren't the sole resisters to change. Hospital executives can be just as recalcitrant. They will lobby against any approach that moves patients out of their expensive inpatient OR suites into a community "surgicenter." They'll fight anything that limits their freedom to build additional hospital rooms in their facility when space already exists in a competitor's. Rather than looking for ways to increase efficiency and lower the cost of hospital care, hospitals and their leaders have increasingly sought to gain market power through mergers and the bulk purchasing of physician practices. With monopolistic control, they can raise prices and enrich their bottom lines with relative impunity. As a result, inpatient expenses in the U.S. have grown even more rapidly than overall medical inflation.

Over the past decade, medical care has become unaffordable for a growing percentage of the population, even for those with insurance. The out-of-pocket costs that patients are expected to pay in any given year now exceed the savings of 40% of Americans. In the United States, the number one reason families declare bankruptcy is the inability to pay medical bills. Although this is less of an issue for patients in countries with universal government-provided healthcare, economic challenges are making it harder for all developed nations to cover the medical needs of their citizens, thus diverting needed investments away from education, infrastructure and social welfare.

Opportunities to raise quality and lower costs abound. What is lacking are not ideas or proven solutions, but the leadership to translate opportunity into reality.

18.3.2 The Four Pillars of Healthcare Transformation

In healthcare, leadership requires vision of what is possible. The next generation of leaders will need to help their organizations transition from the failed structure, reimbursement and deficient technology left over from the last century, to solutions capable of solving the healthcare problems of the future. To that end, the "Four Pillars of Healthcare Transformation" can serve as a foundation for achieving what is possible (Salber 2017).

Together, these pillars facilitate solutions to the growing set of economic difficulties through improved quality of care and application of technological alternatives, rather than rationing. Each pillar seems straightforward, but all are complex. Understanding each is a crucial first step for any leader who will be leading the change process.

1. ***Integration***. When physicians, both in primary and specialty care, work in a single medical group, collaboration and cooperation increase. Horizontal integration within a specialty encourages mutual support, implementation of best practices and added specialization. Vertical integration across primary, specialty,

and diagnostic care facilitates the rapid flow of information and supports innovative solutions to medical care.

2. ***Capitation***. When physicians and hospitals are reimbursed on a prepaid basis—and rewarded for quality not volume—they have incentives to maximize prevention, eliminate medical errors and achieve greater operational efficiency. There are different ways American insurance companies are approaching prepayment. today. The first involves a single total-dollar payment to a hospital for a specific procedure, such as a total-joint replacement, to cover the total cost for the surgeon, anesthesiologist, operating room and post-operative care. Another approach is an annual payment to a group of doctors to cover all of the expenses that a cohort of patients with a common disease will incur (e.g., diabetes). Finally, in a fully capitated arrangement, a single per member per month fee is paid either to a medical group or an accountable care organization (ACO) for an entire population of patients and expected to cover the totality of their medical needs.
3. ***Technology***. Information technologies in healthcare offer tremendous potential to lower cost, make care convenient and improve clinical outcomes, particularly for organizations that are integrated and capitated. Examples abound, including a single, comprehensive electronic health record system that provides the most up-to-date information on every patient regardless of where that individual is receiving care at the moment. Video and mobile technologies connect physicians with patients and with one another, inexpensively and regardless of geographic distance. The emerging field of data analytics can tell patients whether they are at risk of an impending medical problem, long-before providers recognize what is happening. And in the future, AI (Artificial Intelligence) will be capable of evaluating radiographs more accurately than clinicians, and sending the reports to doctors immediately, rather than hours or days later.
4. ***Leadership***. As important as integration, capitation and technology are individually, the synergy of all three generates the greatest value for patients and providers alike. The following sections examine the types of positive outcomes that are possible through effective leadership, and describe the best approaches leaders apply to achieve them.

18.4 What Leaders Do

Leaders make positive change happen that otherwise would not. This process begins with strategic thinking that creates a clear vision of where they want their organization to go. Then it involves strategic action as they engage with the people they lead to align them around that vision and motivate them to move forward with confidence.

Strategy is often confused with the series of binders generated at this year's leadership offsite, stuffed with ideas and initiatives that are likely to be replaced in next year's binders. In reality, strategy should be thought of as a future-oriented process through which leaders decide where to position their organization to maximize the probability of success. How best to translate strategic thinking into action can vary

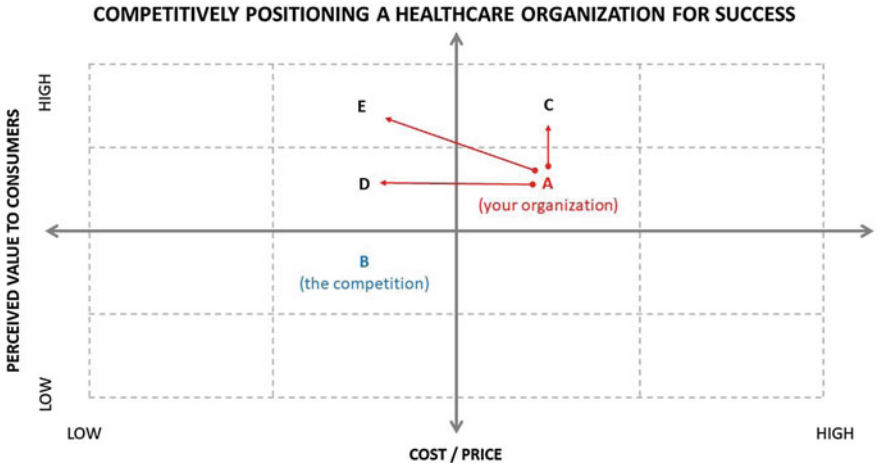

Fig. 18.2 Stratetic positioning in a competitive environment

year to year as new opportunities present themselves, but unless there are massive and unexpected shifts, the fundamental direction and competitive positioning should remain constant for most organizations.

In Fig. 18.2, we see a four-by-four matrix. One axis represents cost/price and, the other, perceived value in the mind of the consumer. The letter A represents where the leadership of the organization sees itself relative to its competitors (letter B). In this theoretical example, the organization shown is higher in perceived value (a combination of quality, access and personalized service), but also higher in cost than its competitors. The other boxes on the matrix represent future positioning opportunities: C (higher quality than today but at the same cost), D (same quality but at lower cost) and E (higher quality at lower cost). All are better competitive positions than exist today.

Of course, every organization would like to raise its perceived value as much as possible and lower its cost structure. But strategic thinking requires leaders to ask what is possible. How great are our competitive advantages? How fast can we implement technology, improve operations or change customer perceptions? How receptive will the people of our organization be to making the improvements required? In the end, leaders need to compare the relative risks of not improving fast enough (thus allowing the competition to leapfrog them) against creating unrealistic goals and failing to achieve them.

Having defined where leaders seek to reposition their organizations going forward, the final step is to identify the specific improvements they will implement to successfully achieve this new competitive positioning. Often, they realize that either (a) their plan is too aggressive and likely to fall short of full implementation or (b) it's overly conservative and risks losing market position. Phrased differently, leaders want a strategy that will "stretch" the organization without "breaking" its people.

Finding the right spot is a crucial skill in all industries, but particularly in healthcare, which is people-intensive. As simple as this four-by-four matrix looks, forces leaders to recognize and consider the magnitude of change required, the specific improvements needed and the impact the strategic plan will have on the people of the organization.

For relatively stable and static industries, the strategy of the past, one that made the organization success, often proves sufficient for the future. However, this is not the case for rapidly changing environments like healthcare. The rise of healthcare costs and the availability of new technology have created what can be titled a ***strategic inflection point***. And the solutions required under that circumstance must be more radical than those that proved effective previously.

Strategic inflection points are times when innovative, new approaches can disrupt the winners of the past. When this happens, traditional companies like Borders, Kodak and Blockbuster go out of existence. Failure to change in these circumstances can prove deadly. The same will be true in healthcare. If doctors, hospitals and insurance companies don't radically alter their business models, they could find themselves replaced by other providers of care and coverage who are willing to make the improvements needed. Better care coordination and improved results happen through (a) integration of doctors and hospitals, (b) a reimbursement system that rewards superior outcomes rather than simply added volume and (c) modern technology offering patients greater convenience and more timely access at lower costs.

Developing the plan is only the first step. Next is translating it into reality. Ultimately, strategic thinking without action is powerless.

Leaders need to recognize the main reason change is so difficult has to do with how our minds perceive the magnitude of losses versus gains over time. The psychological literature demonstrates that our minds perceive a negative event in the short-run as far worse than an even bigger positive gain in the future. This imbalance explains why dieting is so hard and why only 50% of people are vaccinated each year against the flu. Leadership success in healthcare requires helping people reduce their fear of short-term loss. For doctors, giving up autonomy and personal control over decision-making is terrifying. That's true even when preserving such autonomy would prove even more problematic in the future than losing it. But change can be achieved through leadership. The rest of this chapter includes an approach that proved successful in implementing change for the 10,000 physicians and 36,000 staff who provide care to 5 million Kaiser Permanente members.

18.5 Meeting Healthcare's Biggest Challenges with Bold, Empathetic Leadership

The definition of a good healthcare leader is someone (a) who can create positive changes that would not happen on their own and (b) whose workforce—doctors,

nurses, staff—would never wish to return to the approaches of the past once the improvements have been implemented.

The first step in aligning and motivating people is to understand their fears, including:

(1) Fear of the unknown.
(2) Fear the idea won't work.
(3) Fear they can't trust leadership.
(4) Fear others will see them as foolish for saying yes.
(5) Fear that too much will be asked of them.

The following model can be applied to a broad range of areas, from the doctor's office to the hospital to the patient's home. This model serves as a checklist to ensure leaders don't skip steps and helps them address the fears people have.

18.6 A New Model for Strategic Change

Aligning and motivating people is usually the hardest part of the change process. In other industries, some leaders try to drive change through what is called a burning platform—a crisis that's either natural or engineered and forces people to act. When crises are truly imminent, they can be effective motivators. But when they are not, people grow distrustful of leadership and will be even less willing to embrace change in the future.

Instead of leaning on catastrophe, effective leaders implement a more comprehensive set of steps that addresses people's fears and maximizes their trust. The following "A–G" model accomplishes that. Since all letters in the pneumonic need to be accomplished to overcome the five fears, the order is less important than the integrity and trustworthiness of the person leading the process.

To paint a clearer picture of this A–G pneumonic in action, the following example borrows from an approach that helped Kaiser Permanente reduce hospital utilization in half and inpatient costs by 30%. Although the A–G model itself works in any change-management situation, the specific actions required vary by circumstance. For this example, you should assume you are the leader of a 200-bed hospital in midsized market of the United States. A different set of steps would be needed for a small hospital in a rural area or a huge 500-bed facility in a highly populated urban setting. Regardless of the details, the leaders in each case would need to complete all the steps.

18.6.1 Introducing the Challenge

The opportunity for this particular transformative change begins with a little-known fact: Patients admitted to practically any hospital in the United States (or in the

world, for that matter) on a Friday night will spend a day longer in the hospital than if they were admitted on a Tuesday night (Pearl 2013). The reason is simple. Care slows down on the weekends since practically every inpatient facility on the planet functions as a "five-day" hospital, not a "seven-day" hospital.

Of course, every hospital administrator and doctor will tell people that emergency care and urgent interventions take place around the clock. What they won't admit is how often patients with more routine needs are kept in the hospital and made to wait until Monday morning to have them addressed. The operating room, the interventional radiology suite, and most procedural areas tend to shut down on weekend for anything other than emergencies. Specialists and required support staff are typically "on call" but not onsite. Therefore, when a patient arrives in need of emergent intervention, all necessary doctors, nurses and technical staff are called into the hospital from wherever they may be to provide medical care—an expensive and inefficient process, reserved for patients whose needs can't wait.

Ask most doctors about the dangers of delaying care until Monday for more routine interventions and procedures, and they'll tell you hospitals are the safest places to be. This assertion is false (Saposnik et al. 2007). When diagnoses and interventions get delayed, even by a day, patients may be exposed to hospital-acquired infections—the third leading cause of death in hospitals. They also face a higher threat of suffering from a medical error, which kills 200,000 patients annually. And they are at risk of sleep deprivation and delirium with long-term detrimental health consequences (Freemantle et al. 2012).

This so-called "weekend effect" is not merely a U.S. problem. A British study found that patients who were admitted to a hospital on a Sunday faced a 16% higher risk of dying within a month than those admitted on weekdays. And Canadian scientists found that ischemic stroke sufferers admitted to hospitals over the weekend were more likely to die within seven days than those admitted during the week.

And it's not just quality of care that suffers either. Service levels (and satisfaction net-promoter scores) diminish as patients are forced to wait restlessly, spend anxiety-filled nights fearful of the worst possible outcomes. And of course, costs rise as nurses, dieticians and housekeepers are required to care for hospitalized people, regardless of whether they are actively being treated or awaiting intervention. Across the U.S. hospital costs account for over 30% of medical expenses and continue to rise faster than any other component of healthcare expenses, outside of drugs.

For all of these reasons, if the strategic plan includes simultaneously raising quality, lowering costs and increasing patient satisfaction, deciding to move from a five-day hospital to a seven-day facility might be one of the operational changes planned. But how best to achieve this outcome?

18.6.2 Applying the A–G Model

Most hospitals perform three basic functions. First, is emergency department care. The number of patients admitted here is similar on weekends and weekdays. Second,

there are scheduled admissions, surgeries and procedures that will require hospital admission. In general, these are not done on weekends. In fact, facilities often front-load these functions from Monday to Thursday to keep the weekend census low. Finally, in many locations, routine outpatient procedures that require sedation (e.g., screening colonoscopy) are done at the local hospital on weekdays only. Only emergency colonoscopies to determine the exact cause and stop the bleeding are done Saturday and Sunday.

Perhaps your first thought in creating a seven-day hospital is that you would just add staff on Saturday and Sunday, similar to what you do midweek. This wouldn't work, since without the scheduled inpatient and outpatient procedures typically done on weekdays, there would not enough need to justify the added expense.

Another option would be to insist that on-call doctors, nurses and technical staff come to the hospital to provide the interventions the same day the need is identified. Once again, that solution would be inefficient and costly. That's because of the multiple times they would need to drive to the hospital, open a specialized room, and assemble the required supplies and instruments. Then, after they completed the procedure, they would need to put everything away, clean up and close the room, only to start once again a few minutes or a few hours later.

The best solution is to shift some of the elective work—the routine inpatient and outpatient procedures—from the weekdays to the weekend, reduce the Monday to Friday staffing and add people Saturday and Sunday. With this approach, there's no need to delay elective procedures until Monday since the clinicians and technical staff required would already be on hand and could add the patient on to that day's schedule with minimal extra cost or disruption.

Let's look at one example: a routine interventional procedure for an otherwise stable patient. This could be taking out the gallbladder or bringing additional blood supply to the heart. For the purpose of understanding the changes that would be needed, assume that there currently are 12 ORs in this hospital used for scheduled patients Monday to Friday and then none on the weekends (emergencies only). Shifting to a seven-day hospital would mean scheduling 11 rooms per day (Tuesday to Friday) and two each Saturday and Sunday. Note that both before and after the change, the weekly total is the same, 60 operative rooms for non-emergency procedures (Fig. 18.3).

On paper, the change appears fairly simple, logical and straightforward, so why has it not been universally adopted? The answer isn't scientific but, instead, personal. Most people want to spend weekends with their families. Doctors, nurses and technical staff are no different. As a result, they believe it is safe to keep patients with non-emergent problems in the hospital until it is more convenient to address them. As a leader wanting to lower cost without compromising quality or service, the picture looks different. To you, the delay is problematic and a major opportunity to make the care you offer more affordable and patient satisfying. But how do you get doctors, nurses and staff to see the necessity and make it happen?

Like most changes involving loss for those who must make them, this kind of transition proves difficult and cannot be achieved through fiat. Using the A–G model

Example of staffing a 5-day hospital for one month

MON	TUES	WED	THURS	FRI	SAT	SUN
12 ORs	12 ORs	12 ORs	12 ORs	12 ORs	0 ORs	0 ORs
12 ORs	12 ORs	12 ORs	12 ORs	12 ORs	0 ORs	0 ORs
12 ORs	12 ORs	12 ORs	12 ORs	12 ORs	0 ORs	0 ORs
12 ORs	12 ORs	12 ORs	12 ORs	12 ORs	0 ORs	0 ORs

Example of staffing a 7-day hospital for one month

MON	TUES	WED	THURS	FRI	SAT	SUN
12 ORs	11 ORs	11 ORs	11 ORs	11 ORs	2 ORs	2 ORs
12 ORs	11 ORs	11 ORs	11 ORs	11 ORs	2 ORs	2 ORs
12 ORs	11 ORs	11 ORs	11 ORs	11 ORs	2 ORs	2 ORs
12 ORs	11 ORs	11 ORs	11 ORs	11 ORs	2 ORs	2 ORs

Fig. 18.3 Moving from a five-day to a seven-day hospital

doesn't guarantee success, but it does increase the probability. Here's how it might be applied to moving from a five-day hospital to a seven-day hospital:

"A" is for Aspirational Vision. In healthcare, it's impossible to win over the brain, until you connect with the heart. As such, this truism must be front and center in any presentation you do or conversation you have. An aspirational vision needs to inspire, but if it doesn't include enough reality to be achievable, it's simply a dream. Improving quality, making care more convenient for patients and helping individuals avoid financial ruin are concepts that resonate with doctors and nurses and are possible. Improving a hospital's bottom line or meeting a regulatory requirement won't generate the same kind of enthusiasm. Your aspirational vision won't motivate everyone, but if it touches the hearts of enough people, you will begin the process of building a critical mass of believers.

At some point, everyone has experienced the anxiety of waiting in a hospital or doctor's office to find out whether a loved one will be okay. If hospitalized, we count the hours until the next test can be done, and lose sleep waiting to know if the diagnosis is cancer. Waiting from Saturday to Monday morning seems like a minimal delay to doctors but can feel like an eternity to patients and their families. Longer hospital stays on weekends add to the risk of complications and errors. Physicians learn in medical school to "First, do no harm." Delays in care do more than raise costs, they harm patients. Helping people recognize the lethal consequences of a five-day mentality is what is needed to generate a willingness for doctors to listen to the idea of a seven-day hospital.

Aspirational visions are not slogans, but rather destinations that others can see, feel and touch. Stories of personal experiences prove powerful when articulating your vision. They help people see the consequences of their resistance and the positive aspects of change. Most of us would resent delays in care if we were hospitalized. Then why should we want anything less for our patients? Once clinicians recognize this contradiction, they will be open to learning more.

Behaviors. Doctors are afraid that their leaders will ask too much of them or fail to understand how personally difficult this change will be. Hearing your plan to move from a 5-day to a 7-day hospital will activate a part of the brain called the Amygdala, which generates fear. Immediately, they will envision never seeing their partner or children again.

As a leader, you must anticipate this response and explain clearly what you are asking them to do differently in the future. Remember that behaviors are not attitudes. They are the visible actions people will need to take. For example, let's look back at the operating room. Assume the 12 elective rooms are staffed by 24 surgeons who spend half of their clinical time doing scheduled procedures Monday to Friday. Four OR rooms per weekend means that each physician would be asked to shift their patients from a weekday to a weekend once every three weeks. Operating an occasional Saturday or Sunday and having a free weekday will seem manageable to most physicians. Yes, it might mean they miss an occasional soccer game for their child, but it also would allow them to spend time at their kid's school. It's even possible some surgeons might prefer to work weekends, opting to ski or golf on weekdays when the slopes and courses are practically empty. By translating the idea of a "seven-day hospital" into the specific behaviors needed (one weekend day every three weeks), people begin to realize that their initial fears were overblown.

Context. Having engaged the heart and calmed the fear center of the brain, you must now win the intellectual argument. Remember doctors are accepted into medical schools because they study hard and ace the exams. They also love to engage in debate. As such, you may be asked, "Why not just continue to raise prices?" or "Why not buy a new multimillion-dollar diagnostic machine like the hospital across town and add revenue in that way?"

Hopefully, you considered all of these alternatives during your strategic analysis and concluded that greater efficiency is a safer path, more consistent with your facility's mission and an important step toward preparing your facility for the end of the price-inflation era. Providing context includes describing these external forces and explaining why the best time to act is now.

You might use Medicare, the source of most of your facility's revenue, as an example. The program pays American hospitals on a DRG (Diagnosis Related Grouping) basis, rather than by the day (per diem). Therefore, longer hospital stays not only delay patient recovery, but also cost more money without generating additional revenue. This combination limits the hospital's ability to purchase new technology and hire additional staff. And even for individuals whose insurance plan would pay more now, the businesses that purchase coverage are reaching the end of their financial ropes. They may begin excluding the most expensive hospitals and specialists from their networks and yours doesn't want to be left out.

Data. When it comes to their clinical practices, all doctors believe they are practicing at the top of their specialty. Of course, that's not mathematically possible. Data helps everyone more accurately assess their performance and learn from the best. Besides, physicians are scientists and, when confronted with the possibility of doing anything new, they insist on having the numbers to validate its effectiveness before they will commit.

The first step toward providing proof of concept is determining what you will measure. Comparing weekend length of stay for particular DRGs against weekdays is one possibility. Alternatively, you might decide to include this initiative with others and measure total inpatient days for similar sized Medicare populations.

What's even more important than the data itself is deciding in advance what you are going to do if the changes you outlined fail to produce the improvements required. One possibility is that you didn't do what needed to be done to support the operational transition. Maybe you failed to provide the nursing or pharmacy resources needed. If so, you need to acknowledge this and make the added investments required. But, assuming you have done so, you need to have planned what you will do next. If you simply continue to report no change in weekend length of stay compared to midweek, the message everyone will hear is, "Moving to a seven-day hospital isn't very important."

On the other hand, if the issue is that physicians in specific departments aren't performing the procedures on the hospitalized patients over the weekend, you will need to intervene to make it happen. For example, maybe you'll ask the nurses to immediately communicate the information to the nursing supervisor who can call you and tell you what is happening. Once you drive to the hospital and address the situation a few times, people will know you are committed to the success of the approach and will be unlikely to refuse to provide the added care in the future.

Engagement. No one will care how much you know until they know how much you care. Nowhere is this truer than in healthcare. Implementing change requires personally meeting with individuals and groups of medical care providers and, when necessary, intervening to ensure participation in supporting the change is broad and consistent. There is no other way to develop the trust needed and make sure your vision and ideas are understood. A study by the U.S. Dept. of Education demonstrated that it takes 17 exposures for students to learn a new word and integrate it into their vocabulary. It takes just as much repetition to master a new vision for the future and comprehend the actions needed to achieve it.

Trust is an essential ingredient in getting physicians to change their behaviors. They are afraid of what change could mean for their patients and for themselves. They worry that they will fail or look foolish to colleagues and friends alike. Trust in a leader is built over time. If your motivation is self-serving and not on behalf of patient outcomes, physicians will see it and their trust will wane. You can fool people once, but rarely a second time. Used-car salesmen can get away with it because they don't interact with the same customer more than once. Healthcare leaders, on the other hand, must maintain the highest integrity. And until they demonstrate it, those who must make the changes will withhold their trust. The only way to convince others of your sincerity and authenticity is through your actions.

If moving to a seven-day hospital is of major importance and central to your organization's strategy, then you need to look at your calendar, cancel some of your administrative meetings and carve out time to meet with clinicians individually and in small groups. Emails are good for delivering facts and data, but they do little to generate the trust needed to inspire meaningful change.

Remember that no one will be more committed to change than you are as the leader. As such, you need to be visible on weekends, thanking the physicians and staff and helping to smooth the transition. Being present builds trust in you, your word and your actions.

Faculty. The term faculty is usually applied to universities and describes the teaching or research staff that achieve the institution's mission. Here, it refers to the people on a healthcare leader's team who provide expertise and assistance in implementing the organization's strategy and fulfilling its mission.

Shifting from a five-day hospital to a seven-day one requires extensive clinical knowledge, financial analysis and operational redesign. None of us has enough time or expertise to do all of that alone. Finding others to help is an essential next step.

Clinical expertise is fundamental to medical training and physician culture. If you doubt the importance, go to a meeting involving doctors and ask them to make introductions. Everyone will include their specialty, even if the meeting has little to do with clinical practice. But expertise in one medical field rarely translates to credibility in another. If, for example, you are a practicing surgeon, an audience will accept your ability to opine on the operating room, but attendees will doubt you the moment you begin to talk about radiology.

Before trying to implement a complex program like the seven-day hospital, you will need to gain the buy-in of experts in each of the areas for which change is critical and, likely, challenging. Bring these experts with you to hospital-wide meetings and ask them to stand by your side when questions and problems arise. Moreover, successful change will require support from finance, HR, nursing, pharmacy, housekeeping and the support staff in each clinical area. A major reason change efforts of this magnitude fail is that leaders underestimate the number of people needed for success. Before you announce anything publicly, you will need to have engaged with many people and parties, individually and in small groups, listen to their thoughts and gain their confidence. Until then, you can't move forward.

Governance. Individual doctors in their own office answer to no one. Larger organizations (and even smaller, integrated medical groups) need a structure to make decisions, allocate resources and measure performance. Without this, the vision for the future is likely to remain just that—a vision. Governance has three parts, and all are important:

1. ***Formal structure***. Often there is a board and medical staff committee that must affirm the direction and key parts of the plan. Frequently, leaders see this as the biggest hurdle, since these groups have clearly defined accountability and power. But leaders soon realize that the getting approval and support through the formal structure is the easiest part of the change process.

2. ***Informal structure***. This group includes leaders who have massive influence, even without a high-ranking title. Every organization has "influencers" like these. They're the people doctors look to first before they'll consider supporting the change process. Leaders might falsely assume that gaining board/committee approval to move forward automatically means that physicians will follow. Ultimately, doctors believe they have the right to do what they think is best, no matter what they're told. When it comes to change initiatives, they usually look to their peers and the clinical experts, not the administration to tell them what to do. For these reasons, garnering the support of the informal leaders before moving forward is crucial.
3. ***Incentive structure***. Finally, most organizations use financial incentives to motivate behavior. Leaders tend to view these visible "carrots and sticks" as most effective, but rarely is that the case. Financial incentives for performance can be powerful motivators. But, in healthcare, they rarely lead to the outcomes desired. Doctors are skilled. They got into medical school by acing tests. Financial incentives lead to change, but most often, not the ones leaders desired. Unintended consequences almost always are the result. For example, what happens if you pay people more to consult on weekends? Suddenly, doctors will begin recruiting requests for inpatient consultation from colleagues for patients for whom the additional opinion will add no value, but will be a waste of time and money. There are no shortcuts when implementing effective change in clinical practice. The purpose of the A–G model is to remind leaders of all the steps needed for success. Skip a step and the initiative will fail. Fail to provide a compelling aspirational vision and physicians won't hear the context, or care about the behaviors and data. Fail to engage as a leader and have a strong faculty, and the most powerful financial incentives will prove futile.

18.7 Measuring the Success of the Seven-Day Hospital at Kaiser Permanente

When The Permanente Medical Group undertook the move from a five- to seven-day model, it measured success based on the improvements in clinical outcomes and reductions in hospital utilization for the Medicare members it served. One reason for this choice was the availability of benchmarks across the country against which to measure performance. The second motivation was that patients in this 65+ age group are frequently utilizers of hospital services, so the impact of the change would be most significant.

In conjunction with this effort, the medical group decided to also raise quality and lower costs by maximizing preventive services and aggressively managing chronic diseases. Although determining the success of this approach involved a detailed and comprehensive analysis of clinical outcomes and costs, the easiest way to understand the resulting changes in hospital utilization is to examine the number of inpatient

days per year per 1000 Medicare patients. To do that, you take the total number of hospital days for everyone covered through Medicare, divide by the total number of enrollees and multiply by 1000. That number is approximately 1400 days across the United States. Since the patients who enroll in Kaiser Permanente get all of their care through the medical group and multiple Kaiser Permanente hospitals, total inpatient utilization for the organization's hundreds of thousands of Medicare members could be directly measured and compared to external benchmarks.

Within five years of implementing the seven-day hospital and the various programs to make The Permanente Medical Group the nation's leader in quality outcomes, utilization in Kaiser Permanente was down to 700 days per 1000 Medicare members per year, half the national average. Of this 50% reduction, half could be attributed to the quality improvements, and half came from the shift to a seven-day hospital. Neither outcome would have happened without applying the full A–G model. And the clinical results included 40% fewer heart attacks, strokes and cancer, a decrease in mortality from these diseases by 30–50% (compared to national numbers) and a major cost reduction. Thanks to these changes, the organization could make further investments in medical care, fund capital improvements and lower prices for patients and purchasers.

18.8 The Next Generation of Healthcare Leaders

The healthcare-delivery organizations that lead in quality outcomes, patient convenience and affordability have already adopted and embraced each of the elements of the "Four Pillars." So why then is it so hard to institute similar changes everywhere?

The answer is that every change process involves "winners and losers." As a result, motivating everyone to move forward (in the same direction) proves difficult. The next generation of healthcare leaders can use A–G model to help inspire and implement effective change. And they need to remember the importance of three vital organs: the heart, brain and spine.

18.8.1 The Heart

Leaders must demonstrate and evoke passion and show compassion. Meeting regulatory requirements for quality and making care more affordable for populations of patients don't generate the same passion in doctors as saving a life in the operating room or performing a complex operative procedure. And yet these approaches to preventing disease in the first place or avoiding further complications in patients with chronic diseases have a far greater impact on mortality and life expectancy than heroic interventions.

Outcome data demonstrates that by controlling blood pressure effectively for patients, the incidence of stroke will drop by 40% for the entire total population

served, compared to a similar number of people whose blood pressure remains high. But the deaths avoided will happen at some ill-defined time in the future and without knowing exactly whose life was saved. In contrast, pull the clot causing the stroke out of a major blood vessel to the brain, and the physician knows precisely whose life was saved. In addition, that doctor earns the family's gratitude forever.

The best leaders understand this challenge and overcome it by engaging the heart of doctors, nurses and staff. If you are trying to get people to wash their hands to prevent hospital-acquired infections (a growing threat in hospitals across the country), you can't just show an instructional video and expect to see change. People may forget statistics, but they will remember forever being in the same room with a man as he tells the story of his wife's death from an infection she developed inside your hospital. And their spines will stiffen when they're reminded of a difficult truth: No doctors think they're capable of transmitting the bacteria that kills a patient. But when they fail to wash their hands, that's exactly what they're capable of doing.

In my 18 years as CEO of The Permanente Medical Group, one of the most powerful experiences I can remember came during what I thought was a standard departmental meeting. At the time, all Kaiser Permanente medical centers were implementing a comprehensive EHR that added work to the reception and office staff. These individuals were already busy with their primary jobs, such as registering people or recording their weight and blood pressure measurements. Now they had to also check the medical record to see whether patients were due for breast cancer screening (mammography) or colon cancer assessment (stool sample kit).

Wanting to hear how the department was doing, I took a seat in the back row. The department chief began the meeting by pointing to a staff member sitting in the front row. He explained that this woman had identified a patient who was overdue for a mammogram and, in addition, went above and beyond in helping her get screened the same day. Even though the patient came into have her eyes evaluated, the staff member's actions led to an early detection of breast cancer, which was treated before the malignancy had spread.

The staff member, in front of her entire department and with her husband and children in attendance, received the organization's first-ever "I Saved A Life" award. Outside of the birth of her children, this was the happiest moment of her life. The next day, all of the medical-office departments were abuzz, each staff member hoping for similar recognition. The overall result of this program and others like it vaulted the screening rates for breast cancer among the patients treated by The Permanente Medical Group to the top of the nation, according to the National Committee for Quality Improvement.

18.8.2 The Head

As pointed out in the A–G model explanation, clinicians are scientific and demand data. A powerful example of how data can be used to improve clinical outcomes is in the effective treatment of sepsis. Early and aggressive treatment of this potentially

lethal, system-wide infection could save as many as 70,000 American lives each year. However, effective sepsis treatment is very intrusive. And, despite saving numerous lives, the treatment can, on occasion, lead to the death of a few individuals who otherwise might have lived.

For doctors, not all deaths are the same. When someone dies from something a specific physician did, the doctor perceives that death as far more tragic than when multiple other patients die with no one to blame. For this reason, physicians have resisted early, aggressive intervention.

Dr. Diane Craig, a hospital-based physician at Kaiser Permanente, decided to address this problem. She studied the literature and met with leading national experts. Then she met with the emergency department physicians and presented the data on the number of lives that could be saved. She identified the specific steps needed whenever someone might be at risk and the time frame for doing so each time. She created "sepsis" teams to be summoned when a patient at risk was identified, similar to what is done for patients following a cardiac arrest. And she embedded the protocol into the health system's electronic medical record to ensure it was followed every time. The result was a dramatic reduction in hospital-wide mortality from sepsis—down below half of the national average.

18.8.3 The Spine

Changing clinical practice requires courage. The consequences of making a mistake are immense for physicians including nights of loss sleep and potential malpractice suits. Compared to risking being blamed, an unnecessary or redundant test feels inconsequential. Telling parents their child doesn't need an antibiotic is far more difficult than writing a prescription. Next generation leaders need to use the A–G model to make change happen and harness the power of the group to bring the most reticent along. Unfortunately, these approaches don't always lead to change. When stagnation happens, leaders have to step up and "do the right thing." And that takes spine.

An example of great courage came from Dr. Sharon Levine, one of the Associate Executive Directors at TPMG. She led our pharmacy efforts and accomplished remarkable work with the various "Chiefs of Quality and Therapeutics," especially in the areas of reducing inappropriate antibiotic use and prescribing more cost-effective generic medications for patients when appropriate. An area of concern for her was the pernicious impact that drug companies had on physician prescribing behaviors. From a strategic perspective, if we wanted our patients to trust the decisions of physicians, we had to insulate them from any nefarious financial incentives drug companies utilized to incent prescribing of unnecessarily expensive drugs when an equally or better low-priced alternative existed.

Even today, a decade after confirming the negative impact of drug-company dollars on medical practice, many physicians fail to accept that free lunches and lavish dinners have any effect on their drug ordering. And when confronted with the data

that shows how much more often they deviate from the prescribing habits of their colleagues, they're certain the explanation is that their patients are different. Any implication that their prescribing habits are influenced by financial payment are rejected.

Sharron proposed, and our board accepted, a complete prohibition on taking anything from a drug company, including a mug or a pen, recognizing the slippery slope that can result when exceptions are made. She told me she was going forward, even though in her mind it was a potentially career-ending journey. A decade later, her policy remains the gold-standard against conflicts-of-interest. After its implementation, only two out of the 6000 physicians in the medical group at the time left the organization and she remained a highly respected and trusted leader until her retirement.

Leaders must be smart, able to analyze problems and skilled at communication. Without these abilities they rarely are chosen for leadership roles. But individuals wanting to be highly effective next-generation healthcare leaders will need to do more than that. They will be required to be skilled at creating a powerful vision for the future, aligning people around it and motivating them to move forward. They will apply the A–G model to making change happen and, through their efforts, move their organization closer to the four pillars. Each will understand the importance of the heart and mind and possess the spine needed to drive change when the right thing needs to be done.

Administration is the ability to make the things happen that people expect—from paying employees on time to following rules and regulations that govern the industry. In contrast, leadership is the ability to make things happen that otherwise would not.

Leadership in healthcare is difficult but, when done well, it's incredibly rewarding. Developing a strategy and an implementation plan that saves lives and makes medical care more affordable is a unique privilege. It's incredibly satisfying to watch an idea begin with people saying, "It can't happen," and then "It could happen," and, eventually, "It had to happen." Finally, "I'm glad it happened."

In healthcare, the best leaders don't act for personal gain, but on behalf of the patients to whom they are accountable and the doctors, nurses and staff they lead. In the end, if leaders don't experience pushback, they're not doing anything important. The measure of their leadership ability is whether they can overcome the resistance and make people grateful they did. When that outcome happens, the hours spent and dedication required prove well worth it.

18.9 Homework: Applying the A–G Model to Other Healthcare Challenges

Several years ago, I came across a sign hanging on the wall of a public health building that read "Quality. Service. Cost." in big, bold letters. And below that, in small print, "Pick any two." This all-too-common assumption reflected the mentality

of twentieth-century healthcare, with its intrinsic belief that higher quality and better service could not be achieved without greater financial investments. As the example of the seven-day hospital demonstrates, this is simply not true.

Make no mistake, some businesses can be successful catering to customers with expensive taste. Examples include Lexus, Apple and Ritz Carlton. Even in healthcare, some brand-name hospitals have been able to command higher fees for the privilege of being cared for in their prestigious institutions. But in healthcare, leaders should strive to offer the highest quality in the most convenient ways at an affordable price for every patient. That is medicine's mission. As such, the next generation of healthcare leaders will need to address all three: "Quality. Service. Cost."

Doing so will be challenging, but there are far more opportunities than people assume. Here are four examples. Success in each will require powerful leadership, bold thinking and bravery. As a next-generation leader, ask yourself how you would apply the A–G model to achieve the following:

1. ***Limit the number of physicians and hospitals doing procedures in each community to raise quality, increase patient confidence and lower costs***. The clearest predictors of superior outcomes and performance in medicine are volume and specialization. The most important question a patient can ask a surgeon is this: "How many of these operations did you do last year?" Getting this information can be difficult, but organizations like the Leapfrog Group are making that data available, as are some state-wide databases. To improve clinical outcomes, we need fewer specialists with great experience and expertise. We will also need to close low-volume surgery programs and refer more patients to high-volume facilities. It will be a great test of even the best leader to convince doctors and local communities to accept these realities.
2. ***Focus on prevention***. It's no secret that it's far better to prevent a heart attack, stroke or cancer is better than to treat it. Unfortunately, that is not what the culture of medicine values or the achieves today. For example, hypertension (elevated blood pressure) is the most common etiology of stroke and contributes to heart attacks and kidney failure, and yet across the U.S. it is controlled only 55% of the time. When you compare those numbers to the best medical groups, which can achieve success rates of 90%, the call for action is clear. A major part of the solution is to include specialists in measuring blood pressure and coordinating with the patient's personal physician on modifying treatment. Getting everyone to focus on this major area of opportunity proves difficult, since reimbursement for doing so is minimal in comparison to doing more procedures.
3. ***Implement effective technology***. Much of today's medical technology is expensive and no better than the traditional, manual alternatives. Multimillion-dollar robots and proton-beam accelerators have been shown to add little value in terms of clinical outcomes for most patients. At the same time, there is technology that can reduce cost, improve access and raise quality through earlier intervention. A powerful example involves video visits (often called "telemedicine"), which allow patients to get a consultation and participate in follow-up visits conveniently without having to miss work or school. Fewer than 10% of doctors offer

these today, and less than 1% of medical care is provided this way. The reasons are complex, but mostly involve the doctor's concerns, not the patient's. In fact, data demonstrates that patients are even more satisfied with these virtual visits, than in-person ones. In many countries, including the United States, these visits are not reimbursed by insurers, so physicians are loath to offer them. And even when they are paid, it can be more convenient and lucrative for doctors to ask the patient to come to their offices. Finally, many physicians are not "tech-savvy" and resist anything that is device- or application-dependent. In the future, as much as 30% of what is done in doctors' offices could be accomplished effectively virtually. Making that happen is a major opportunity for the next generation of healthcare leaders.

4. ***Eliminate valueless interventions***. Much of what physicians do today adds little value, according to research published in peer-reviewed medical journals. This is true for orthopedics relative to knee arthroscopy and for angioplasty and stenting in patients with stable heart problems. The same failure to improve patient outcomes goes for complex back surgery in individuals with pain as their only symptom and even ordering an MRI to evaluate most cases of back pain in the first place is unnecessary. The same phenomenon of futile care can be seen in prescription of brand-name drugs, when identical generics exist and the over-use of antibiotics for viral infections for which they are completely ineffective and risk complications from taking them. And even treatment of some cancers, particularly prostate for patients with low risk of spread, has been shown to diminish the quality of life and fails on average to prolong it. Of course, that's not how income-generating physicians and hospitals perceive the situation. Often, they respond with intuitive, not scientific, justifications. They'll use phrase like "in my experience," or "you never can tell," or "I remember a patient who…" Even when the outcomes are better for patients and society overall, those changes that bring down individual incomes are trickiest to implement.

Leadership is a privilege. As these examples demonstrate, doing it well is difficult and time-consuming. Developing a strategy and a clear vision for the future is the first step. Helping the people of an organization overcome their fears and move forward to make change happen on behalf of patients is the goal. The A–G model offers specific steps that helps leaders be successful in achieving their vision. Like all skills, effective application takes practice and time. But as you will discover, nowhere is being a leader more rewarding than in healthcare.

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