## 

## Volume 42, November 2010

## Clinical Issues

##### Providing value: the key to job security

**By David A. Novis, MD, FCAP**

As might occur at a national meeting of any group of doctors, the informal conversations that take place among pathologists in conference hallways and hotel bars often gravitate to the two occupational disasters they fear most: misdiagnosing lesions and losing their jobs. The pathology literature is packed with advice on the former but does not offer much on the latter. That is not surprising. Who wants to share his failures with colleagues?  
  
When relations between hospital administrators and pathologists begin to strain, pathologists assume that it is about money: the hospital wants to ratchet down its contract fee in order to improve the bottom line. In fact, it is almost never about money; it is about value.  
  
**In search of value**  
Hospital administrators do not like problems with doctors. Skirmishes with the one or two physicians have a way of embroiling the entire medical staff into political, time-consuming, emotionally draining, and counterproductive wars. It would be a naïve administrator who would jeopardize the operation of a well-functioning service contract and alienate a complacent medical staff just to trim a fraction of a percentage point off the hospital operating margin. But give a CEO cause to doubt the value of those services? That contract becomes a blip on his fiduciary radar.  
  
In any business, customers must be able to articulate the value that service providers bring to them. Clinicians must be able to cite the merits of their pathology departments beyond recounting anecdotes concerning national experts who confirmed diagnoses made by local pathologists. Administrators must have a handle on precisely what their laboratory medical directors do to run the laboratory.   
  
**Making the correct diagnosis is not enough**   
Clinicians regard accurate and timely pathology diagnoses as baseline performance — nothing less than the service they expect from mechanics who repair their cars or waiters who serve them their meals. If doctors are dissatisfied with pathology services, it is not with the analytic phase — the level of diagnostic acumen — but, rather, with the pre- and post-analytic phases of service.   
  
Most pathologists are usually unaware of physician dissatisfaction. They wait for doctors to complain. The problem is nobody likes to complain. Doctors do not like face-to-face confrontations with other physicians. Disgruntled clinicians verbalize their grievances in operating rooms, doctor’s lounges, and administrator’s offices — everywhere but in pathology laboratories. Most medical-staff dissatisfaction is resolvable but only if clinicians believe the pathologists are earnest in making things right. Nothing moves dissatisfaction to anger more quickly than the feeling that no one is listening.1   
  
For instance, pathologists may be proud of their latest, cutting-edge, CAP-based template pathology reports. But those reports may anger physicians who are unable to convince pathologists that they prefer those old, antiquated but colorful narratives. Physicians who are unhappy with laboratory turnaround times may become irate by being stonewalled with arguments that laboratory performance exceeds national benchmarks, especially when those benchmarks were established in institutions other than the one in which they practice.2  
  
By the time pathologists become aware of complaints, or at least aware of the degree to which they have ignited passions, it may be too late to recover. The administrator may have already begun to look at solutions, some of which exclude them.   
  
**Problems in the laboratory**  
Pathologists’ relationships with medical technologists and laboratory managers are equally fragile. Some laboratory medical directors believe that the standards of the Clinical Laboratory Improvement Amendment (CLIA) bestow upon them some form of entitlement. They might believe they have a license to hire and fire employees summarily, purchase equipment with little or no justification, and see their orders executed without question. (Actually, CLIA is a directive not to laboratory medical directors but to the laboratory owners who hire them.) Hospital administrators already have on their payrolls laboratory managers and superiors to whom those managers report. It is unlikely that they welcome another layer of management. When overzealous pathologist oversight creates, rather than solves, problems, administrators may begin to rethink relationships.   
  
Problems with laboratory oversight can head in the opposite direction. Pathologists may regard their laboratory duties as interfering with their anatomic-pathology activities, especially if anatomic pathology provides their major source of revenue. They may abrogate the lion’s share of their CLIA responsibilities to laboratory managers and do little more than affix their signatures to laboratory documents. If the laboratory managers are competent, pathologists can fly under the radar of scrutiny for quite some time. If accreditation-inspection reports begin to accumulate citations or if doctors start complaining about laboratory services, these pathologists’ images begin to appear in the cross hairs of institutional reorganization. Administrators for whom the notion of having pathologists oversee laboratory operations was never theirs in the first place may start to wonder what the hospitals are getting for six-digit oversight checks they dole out.   
  
**Creating opportunities to fail**   
It is not that pathologists do not care. They just have not been trained in business-related skills that define the executive positions they are asked to occupy. Never in their training did they learn the basics of production, contract negotiation, or customer service. Pathology residents complain that they are poorly trained in laboratory management. Indeed, the individuals responsible for training young doctors may be veterans of the large urban academic centers they joined immediately after residency, but they deploy recruits to small community hospitals with which they have no experience. As well intentioned as they may be, these mentors may never have had to sign a paycheck, to be held accountable for falling revenues, to risk their personal finances to grow a business, or to fend off a national laboratory marketing blitz.   
  
The manner in which pathology services are engaged can also undermine pathologists’ relationships with hospitals. In most practices, pathologists provide services under exclusive contracts. Pathologists may view these monopolies favorably, but they can backfire. Monopolies are not known to raise the bars of innovation or customer service. They tend to de-incentivize accountability and encourage providers (rather than customers) to define the levels of service. Paraphrasing Henry Ford, some pathologists might say, “You may have a pathology report in any format you like as long as it is this one. You can have us assist you with needle aspirations at any time as long as it is not on Friday after 5:00 p.m.”3   
  
Pathologists may see no reason to develop, and may even dread, the notion of performance standards. The medical staff may not want to force the issue for fear of having peers scrutinize their performance. Pay-for-performance incentives are becoming incorporated in some “Part A” pathology contracts.4 Indeed, without performance metrics by which to gauge the level of service, pathologists may never know when they are drifting off course and headed towards an iceberg.   
  
Hospital administrators may bear some responsibility in this. Hospital CEOs do not embrace laboratory medical directors onto their executive staffs as they do, say, physician hospital medical directors. They provide no platform by which to make pathologists aware of, let alone contribute to, resolving the day-to-day tribulations of hospital operations. How is a laboratory medical director to know that her request for a new hematology analyzer came on the day the CEO had to deal with the news of a competing surgi-center, an impending nursing shortage, and a plummeting bond rating? Distanced from the “big hospital picture,” pathologists are left to focus only on the small laboratory details. They are squeezed into operational vacuums that keep them out of touch and bias their perceptions.  
  
**Controlling the damage**  
Waiting for that day when customers complain before taking action is waiting one day too long. Table 1 offers some suggestions as to what steps pathologists can take proactively to improve customer satisfaction. Not all suggestions are appropriate for every hospital. Among other things, they must be customized to institutional culture, hospital operations, expertise, and interests of pathology department members, and the level to which relations may have deteriorated.

|  |
| --- |
| http://www.mlo-online.com/features/2010_november/images/MLO1011_CLINICALISSUES_TABL.jpg |

**David Novis, MD, F(CAP)** , has practiced anatomic and clinical pathology for more than 30 years. He is a founding partner and director of Physicians Professional Management Corp., a former trustee of Wentworth Douglass Hospital, and the medical director of Oxford Diagnostic Laboratories in Marlborough, MA. Dr. Novis is president of Novis Consulting. In the course of offering expertise in pathology, management, compensation, contracting, and quality systems, he has interviewed pathologists, clinicians, and administrators in hospitals throughout the United States. He may be contacted at davidnovis.com or dnovis@comcast.net.

**References**

1. Gilly MC. Post-complaint processes: from organizational response to repurchase behavior. J Consum Aff. 1987;21:293-313.
2. Novis DA. The Quality of Customer Service in Anatomic Pathology. Diagnostic Histopathology. 2008;14:308-315.
3. Kass ME, et al. Adequacy of Pathology Resident Training for Employment: A Survey Report from the Future of Pathology Task Group. Arch Pathol Lab Med. 2007;131:545-555.
4. Raich M, president/CEO, Vachette Pathology. Personal communication, August 15, 2002.