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Assumptions

I recently tripped over my assumptions. We often assume that those we talk with share our assumptions, even though we know that is rarely the case. The reason I bring this up, of course, is that many of you do share my assumptions, even if you do not draw the same conclusion from those assumptions that I do. Let me enumerate some of them for your consideration and future discussion.

First, I assume that people will want medical care for the foreseeable future. Second, I assume the way we get paid to provide that care will change, probably in important ways, in the near future. Third, I assume that fee for service practice is on life support and its survival is problematic. Fourth, I assume that if fee for service survives, the reimbursement rate per unit of service will go down. Fifth, I assume that all hospitals must learn to break even on the Medicare book of business to survive, and that means most of them must wring at least 35% out of their current COST structure. Sixth, I assume that hospital administration cannot get a 35% reduction in real costs without real pain and without real changes in the way physicians practice medicine. Seventh, and last for this discussion, I assume that it is in the best interests of our community, including us, that we continue to have a vibrant, growing, high quality health care system.

These may not seem unreasonable assumptions to you, so why did I trip on them? Primarily, I forgot two things. First, the problems of today are easier to see and more certain than the problems of the future. This is why patients sometimes hesitate to take the risk of aggressive therapy for bad disease when they don't feel like they are dying just now. Of course, by the time they realize they are dying, it is too late to make the change. Organizations and the people who work in them have the same problem. For patients and organizations alike, there is an optimum time to take drastic action, but timing is important. The second thing I forgot is that people and organizations both have histories that influence what seems proper.

At the risk of being improper again, let me suggest that our hospital culture defines proper as a strict separation of the medical and management spheres of concern and a strong preference for operating "behind the screen," meaning that all public utterances are bland and uninformative. Yet at the MEC meeting this month we had what diplomats would call "frank and candid" discussions about how to deal with meeting a Joint Commission requirement. Management had considered this as in its responsibility, and set about to resolve the problem in its own way, perhaps without realizing the negative downstream impact on patient care. Now that we have had that "frank and candid" discussion, I suspect that the resolution of the problem will be different from the one first envisioned. A lot of time and energy might have been saved if we had a new culture that saw that the previous paradigm of separate spheres and secrecy as obsolete. What is needed now is transparency, cooperation, and lots more "frank and candid" discussion about our problems and what we need to do about fixing them. Or at least that is my conclusion. What do you think?

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