

Patient-Physician Communication as Organizational Innovation in the Managed Care Setting

Wendy Levinson, MD; Tom D'Aunno, PhD; Rita Gorawara-Bhat, PhD;
Terry Stein, MD; Sandra Reifsteck, MS; Barry Egner, MD; and Rodney Dueck, MD

Despite changes in the healthcare system, the relationship between patients and physicians remains fundamental to high-quality care. Managed care rules and restrictions, such as constraints on choice of providers, review processes, and decreasing length of visits, are creating potential conflicts between patients and their physicians. To strengthen the patient-physician relationship, some managed care organizations are implementing communication skills training for physicians. This article provides case studies describing how 2 large managed care organizations successfully incorporated communication skills training into their environments. An organizational perspective is used to delineate the 3 stages—adoption, implementation, and institutionalization—that managed care organizations generally traverse in incorporating communication skills programs and making them an integral part of their organizational culture. Specific suggestions are provided for physician leaders and administrators who are considering similar programs in their settings.

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The interaction between physicians and patients is the essential core of the practice of medicine, and the quality of this interaction is critically important to patient outcomes.¹⁻⁵ This interaction, however, does not occur in isolation; instead, it is strongly influenced by the organizations in which physicians work. Managed care organizations have implemented delivery systems that have a profound influence on what actually transpires between physicians and patients.⁶⁻⁹ Constraints on patients' choice of providers, the use of guidelines and review processes, and decreasing time for routine visits create a fertile ground for conflict between patients and physicians.¹⁰⁻¹²

Managed care organizations recognize the critical importance of the physician-patient relationship to their economic success. Many organizations have examined the factors that influence a patient to enroll and continue membership in their health plan. Over time, they recognize that patients' per-

ception of the quality of their relationships with healthcare providers is a key factor in patient satisfaction with a health plan.¹³ If patients believe that their provider is caring and concerned, they are likely to stay with that provider for care. Conversely, if patients feel that their provider is not paying attention to their concerns or does not seem to care, they are more likely to switch providers or plans, to complain about care, or possibly even to initiate malpractice suits.³ Hence, as the healthcare market has become intensely competitive, healthcare organizations are eager to maintain and strengthen the quality of relationships between physicians and patients.

To achieve this ambitious goal, some of these organizations have made physician-patient communication one of the highest organizational priorities and have invested significant resources to develop and implement programs to enhance physicians' communication skills. Other physician leaders are considering whether and how to invest in these efforts. Why has communication skills training become a high priority for managed care organizations? What innovations are healthcare organizations implementing? What can be learned from examples of successful practices?

This article describes 2 case studies of organizations that have had a major commitment to communication skills training for more than 10 years:

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From the University of Toronto, Department of Medicine, Toronto, Ontario (WL); School of Social Services Administration (TD) and General Internal Medicine (RG-B), The University of Chicago, Chicago, IL; Permanente Medical Group, Oakland, CA (TS); Carle Clinic Association, Urbana, IL (SR); Legacy Hospital, Portland, OR (BE); and Park Nicollet Clinic/Health Systems Minnesota (RD).

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Address correspondence to: Wendy Levinson, MD, The University of Toronto, Suite 3-808, 190 Elizabeth Street, Toronto, Ontario, Canada M5G 2C4. E-mail: wendy.levinson@utoronto.ca.

Kaiser Permanente Northern California (KP), a staff-model HMO, and Park Nicollet Clinic/Health Systems (PNC) in Minneapolis, MN, a mixed-model HMO. We describe these programs using a framework of organizational theory that articulates how organizations typically use 3 phases—adoption, implementation, and institutionalization—to introduce innovations.^{14,15} Although scientific evidence of the effectiveness of these programs is limited, physician leaders may learn about effective methods and potential barriers in developing and implementing such programs.

... PATIENT-PHYSICIAN COMMUNICATION
PROGRAMS AS ORGANIZATIONAL
INNOVATIONS ...

Programs to enhance physician-patient communication represent an example of innovation in an organization.¹⁶ Extensive research literature¹⁷⁻²³ suggests that several factors can promote or inhibit innovation or changes in how organizations work. In short, this literature indicates that organizational innovation typically occurs in 3 stages: adoption, implementation, and institutionalization. In the first stage, managers or other organization members decide to introduce a new policy, program, or practice. Such changes often occur owing to concerns about performance and threats from the external environment that stem frequently from increased competition or new government regulation.²⁴⁻²⁶ The second stage, implementation, is most effective when the new policy or practice fits well within the organization's culture (shared values, beliefs, and norms) and there is a supportive organizational climate for the new program.^{18,27,28} For example, are there appropriate incentives for using the new approaches? Are obstacles to their use reduced? In the institutionalization stage, a new practice becomes routine, widely accepted, and even taken for granted as the way to do work.²⁹⁻³¹ The institutionalization of an innovation depends on the extent to which other organizations (especially leaders in the field) adopt similar practices, how much initial "champions" of the change can convince others of its importance, and how well competing demands for resources are met.

... THE 3 STAGES ...

Adoption

Internal and External Factors Leading to Adoption. Managers and staff members need some

motivation to consider making changes in organizational routines. For healthcare organizations, such motivations often stem from external changes in the environment. Among these external changes are increased competition for patients and the need to maintain or improve patient satisfaction; increased pressure for cost containment and efficiency that comes with managed care; heightened concern about the quality of care due to an emphasis on cost containment; and increased consumer sophistication. In addition to these are internal factors, such as clinician "burnout," that also have become strong motivators for making changes. In combination, these factors have produced performance concerns for many healthcare providers across the nation and thus have fueled the search for innovations that can improve organizational performance. The adoption of physician-patient communication programs by healthcare providers seems to fit this general trend (Table 1).

In addition to motivation, organizations must also have some capacity to adopt new practices and programs.³² This capacity includes some slack financial resources and management time. In other words, managers may want to adopt new programs and practices but may find that they lack the resources to do so. In some cases, they simply wait too long to address performance problems and find that they are facing crises that paralyze them, making innovation difficult or impossible.³³

The Example of the PNC. The core values of the PNC include a commitment to quality of care, service for patients, wise use of resources, continual learning, and creation of a supportive work environment. In this effort, more than 15 years ago the organization started collecting extensive information from patients about their perceptions of the quality of their interactions with physicians. At the end of the first year of employment of a physician, and periodically thereafter, the organization mailed a 20-item questionnaire to 100 randomly selected patients per physician. The results were compared with those of similar physicians by specialty, and scores and written comments were given as feedback to physicians. Individual physicians identified as having poor communication skills compared with colleagues were given one-on-one coaching by colleagues recognized as having excellent skills, although these mentors had no formal training. The outcomes of these measures were not systematically collected, but follow-up surveys showed improvement in the communication skills of many physicians who had been lacking such skills previ-

ously. A general belief evolved over time that communication skills were important and that they could be learned.

As market forces intensified, there was an “intuitive feeling that better physician skills in communication would lead to better care, greater patient loyalty, fewer complaints, and greater job satisfaction for physicians” (Rodney Dueck, MD, oral communication, May 1, 2002). In 1994, the medical director, who was firmly committed to these beliefs, initiated a national search for a resource to help them develop and teach communication skills with-

in the organization. Furthermore, the PNC became committed to improving skills for all physicians rather than focusing on the “poor performers.” The PNC hired the American Academy on Physician and Patient and developed an internal “design team” to lead the efforts. The American Academy on Physician and Patient, a national organization of communication skills experts and trainers, developed and delivered a series of 13 one-day courses at the PNC, each attended by 25 to 50 physicians who were relieved of clinical duties for those days. In addition, the design team members received training as coaches and continued to discuss strategies for implementation in the organization, hence becoming a leadership group for this effort.

From March 1995 to October 1998, more than 350 physicians and other clinical professionals (eg, physical therapists, optometrists, and podiatrists) attended the program, which always included the medical director or the CEO, who introduced the purpose of the program and the American Academy on Physician and Patient faculty. It is crucial that an acknowledged leader publicly supports the efforts during the adoption and implementation phases, and this practice also helps the change become institutionalized in the organizational culture.

The design team and the organization are broadly invested in these communication skills efforts as a long-term strategic priority to improve patient experiences and ultimately to contribute to the growth of the practice. The data to support the effectiveness of the project are minimal, but physician focus groups have revealed strong support for the program’s continuation. In these focus groups, individual physicians have related experiences of major changes in their professional life, including alleviated symptoms of burnout, made possible by participation in the program. Such anecdotal support, along with the long history of attention to patient satisfaction and the commitment of the medical director (now a different person than the original individual), have contributed to the ongoing commitment of resources.

The PNC example illustrates not only the adoption but also the institutionalization of communication skills training over a long period of time (see the “Institutionalization” section). The belief that the physician-patient relationship was critical to the highest quality of care became part of the organizational culture over time; the enhanced competition and a strongly committed medical director in the mid-1990s promoted a higher level of commitment and resulted in resources to support the effort. No

Table 1. Reasons to Adopt Communication Skills Innovations

| Reason | Description |
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| Patient satisfaction feedback | Frequently used. Some organizations incorporate individual physician feedback into compensation. |
| Handling patient complaints | Patients and physicians separately come to the encounter with a defensive stance and a suspicious mood. |
| Communication image of organization | Patient groups value communication skills. Often popular press reports positively on these efforts. |
| Malpractice risk reduction | The cost of malpractice is high. Malpractice insurers will often support communication training. |
| Physician job satisfaction, retention | The cost of training a physician in the organizational culture is high. Hence, retention of a high-quality workforce can justify communication programs. |
| Decrease physician frustration and anger at “managed care system” | Stems from lack of clarity of role of provider to follow Hippocratic oath or distributive justice. |
| Discrepancy between patient expectations and physician judgment of treatment | Exacerbated by managed care policies, eg, review procedures. |
| Changing patterns of physician practice | Reduced opportunities for communication. |

definitive data were needed to support the importance or the continuation of the program.

In contrast to the experience of the PNC, other organizations have initiated communications training to address patient complaints or provider burnout. For example, at KP, the initial motivator more than 10 years ago was clinician frustration. In fact, the literature shows that communication difficulties with patients are troubling and can lead to physician burnout.³⁴ In 1990, a survey of practicing KP clinicians had a high response rate (78%) and demonstrated strong interest in learning strategies for dealing with “difficult patients.” Hence, leaders lent their support to patient-physician communication programs.

Implementation

Many organizations make a decision to change programs and practices only to fail when it comes to implementing them.^{18,35-37} In general, managers do not assess the extent to which a particular innovation fits with their organizational culture and climate. Physician-patient communication programs are most likely to be effective if they are congruent with physicians’ values and beliefs about what makes patient care effective.¹⁵ Managers and physician leaders must truly believe, even without good evidence, that communication training is a high priority.

Furthermore, the organizational climate must support the change by appropriate incentives and reduction of obstacles.¹⁸ Incentives to use a new practice technique include intrinsic or professional rewards (the new approach promises to produce better outcomes for patients) and monetary rewards and recognition (staff members are rewarded in performance evaluations or bonuses for using the new approach). Obstacles to the use of new communication techniques include the time and effort required in learning them and the extent of additional work (eg, documentation) that they require.

The Example of KP. Kaiser Permanente has implemented one of the most extensive communication skills training programs in the country. The mission of the program states: “Excellence in clinician-patient communication (CPC) becomes a shared expectation throughout the group and is perceived as a critical aspect of clinical practice.”

The overall program was initiated by a KP internist, who continues to provide leadership. The program originally began with the introduction of a 1-day interactive continuing medical education (CME) workshop for groups of 35 to 75 clinicians.

The workshop was entitled “Thriving in a Busy Practice” and focused on helping the physician handle difficult patient visits. The program was designed to be practical, drawing on difficult situations in the participants’ own daily experiences. It encouraged interaction with colleagues, and it was held at a luxurious retreat center away from the work environment. Overall, approximately 1500 physicians have attended the program so far, and a published report³⁸ demonstrates that physicians self-rate their skills as improved and perceive less frustration in dealing with “difficult patients.” Over time, the program, which was the centerpiece of a broader initiative, has received very strong recommendations and word-of-mouth appeal for physicians. In fact, there is always a long waiting list to participate.

Additional aspects of the KP efforts have evolved over time and include multiple venues for learning communication skills. There is now a “second-generation” program that focuses on further developing interviewing skills, improving nonverbal communication, and dealing with conflict. This program, “Thriving 2,” has been attended by more than 600 physicians, including all newly hired clinicians. Similarly, a third program focuses on communication about health behavior change. A 5-day intensive course has been developed and implemented in conjunction with the Bayer Institute for Health Care Communication (a national consulting organization) to improve the skills of clinicians with identified problems in communication. This program requires a major commitment of resources but has been considered important because it helps avoid potential adverse consequences of communication problems, such as malpractice suits, and is at the same time effective in supporting colleagues. Physicians who have received the intensive training have shown significant improvements in their patient satisfaction ratings (Terry Stein, MD, oral communication, May 1, 2002).

In addition, the organization has named and trained “communication consultants” at all 30 of their sites.^{39,40} These are mostly physicians selected to act as facilitators, teachers, and coaches at their respective clinical locations. They receive ongoing support and training at quarterly peer group meetings and periodic faculty development programs, which builds their abilities to teach communication skills. These communication consultants help integrate communication skills into the daily routines of the clinical sites, thereby increasing the likelihood that the programs will become part of the accepted organizational culture and be institutionalized.

The KP experience illustrates several key elements that lead to successful implementation into the culture of the organization, including organizational factors such as a credible physician champion, widespread physician leadership support, sufficient commitment of resources, and a long-term program. In addition, the actual communication programs are based on sound educational principles and are designed to help busy physicians feel more competent and less frustrated in their daily work. In fact, the name of the course, “Thriving in a Busy Practice,” was carefully selected to articulate how communication skills help physicians. The program had multiple communication workshop offerings and encouraged participants to continue to build skills over time. **Table 2** lists organizational factors and program elements necessary for similar successful implementation of communication skills training.

Barriers to Implementation. Organizations attempting to implement such programs commonly encounter barriers (**Table 3**). In addition to the obvious barriers of lack of widespread leadership support and financial commitment, there are some subtle

obstacles to implementing communication skills training. Effective physician-patient communication requires the physician to be aware of the patient’s emotional state and to demonstrate empathy.^{41,42} For example, if a patient is distressed or overwhelmed by events in his or her life, the physician should recognize the distress and show concern. In a similar and parallel fashion, many physicians are themselves feeling distressed and overwhelmed in healthcare organizations that are increasing the demands for productivity and changing old and standard ways of practice. Administrative leaders who are trying to implement communication skills programs might be most effective if they themselves modeled the behaviors that they are trying to teach physicians to use with patients. Hence, leaders should recognize and understand the emotions of practicing physicians and should demonstrate concern and respect. Unfortunately, in practice, the same administrators who are trying to encourage positive communication between physicians and their patients may inadvertently weaken a program by underestimating the concerns of the physicians who are “on the front line” in these times of turmoil and change. Consequently, the message of the programs is undermined rather than modeled by the leadership.

A second barrier that may be unique in the implementation of this particular innovation relates to the time required to effectively communicate with patients. In many healthcare organizations, there are increasing demands on physicians to see more patients in a set period of time. Simultaneously, these organizations are encouraging physicians to attend more carefully to effective communication, which may require physicians to spend more time in some visits. Most physicians believe that using these communication skills will lengthen their visits with patients, and, hence, they feel caught between competing demands from the organization—see more patients in less time and communicate more. In fact, it is not clear whether effective communication skills increase efficiency or require more time, but, in general, physician perception is that positive communication behaviors take time that they cannot afford.^{43,44} Communication trainers need to acknowledge the enormous time pressures physicians face and suggest strategies that may

Table 2. Key Issues for Successful Implementation of Communication Skills Training

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| <p>Organizational Factors</p> <ul style="list-style-type: none"> • Physician champion of the cause for communication skills training • Physician leadership commitment • Program innovation requires a major commitment of resources, such as program funds and physician time • Administrative leaders should model behaviors that they are trying to teach physicians to use with patients • The patient-physician program must fit with the organization’s culture • Organizational climate must be supportive of changes in policies and practices that accompany organizational innovation, eg, add system support such as an advice nurse(s) to help relieve the routine burden on the physician’s time • Incentives (ie, salary, time off) for participation <p>Program Elements</p> <ul style="list-style-type: none"> • Designed with physician input • Includes physician teachers for credibility • Interactive process allowing practice of skills • Opportunities for feedback to participants—from peers, staff, and patients • Programs are continued over time • Multiple program types, eg, 1/2-day, 1-day, and 1-week workshops • Skills targeted must help physicians do their work more efficiently and not be viewed as <i>added</i> work |
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be timesaving by preventing conflicts between physicians and patients.

Institutionalization

Observation of organizations over time is necessary to understand which innovations are enduring. We have drawn on the experiences of KP and the PNC because these organizations implemented their programs more than a decade ago and have had an opportunity to institutionalize them. Aspects of each organization’s programs illustrate key issues in successful institutionalization.

Institutionalization means that a new program or practice will remain in use beyond its initial implementation.⁴⁵ In other words, institutionalization calls for the integrating of communication skills training and practices into organizational systems such that the programs become independent of the individual “champions.” The extent to which a new program or practice becomes institutionalized is likely to depend on several factors.^{22,46} To begin with, one important consideration is how many organization members actually use the new program or practice. Innovations that are limited in scope or scale are relatively easy to jettison, and they may simply erode over time as the few supporters retire or move on.^{34,35} In contrast, it is difficult to replace large-scale programs in which considerable investment has already been made; such programs gain their own momentum as commitment to them builds, especially among organization leaders who have made public, visible statements to support them. For example, the scope of the program at KP has been very broad, and communication skills training has been incorporated into many different organizational initiatives. Physician leaders within the organization participate in intensive communication skills training as part of their orientation to leadership positions. The program has permeated a variety of traditional CME programs so that previously didactic CME programs now incorporate communication skills relevant to the topic.

Another factor that can affect institutionalization of a program is the extent to which competitor organizations use that specific new program or practice. The more that other organizations use a particular innovation, the more “taken for granted” it becomes and, as a result, the less likely it is that the innovation will be challenged.^{29,30,31,45} Furthermore, when powerful professional associations and regulatory bodies endorse a program or practice, it is more likely to be institutionalized, even if there is little empirical support for it.³⁰ Professional associations such as

the American Board of Internal Medicine⁴⁷ and the American College of Physicians have focused attention on the teaching of communication skills to both residents and practicing physicians, but there is still not widespread endorsement of the importance of these efforts in most healthcare organizations.

A third key factor in institutionalization is the adequacy of organizational resources. Even highly institutionalized programs and practices may be called into question when the resources needed to support them become scarce.^{24,48} In the domain of communication skills training, most of the cost incurred by the organization is the physician time required for participation in such programs. Although there are costs attributable to the presentation of communication courses, these are relatively small compared with the lost revenues from physicians leaving their clinical practice to attend workshops. Typically, communication skills training requires opportunities for participants to receive feedback on their performance and reinforcement of learning in additional CME programs. Hence, the educational program is more costly than some traditional didactic CME programs. We do not have accurate information about the true costs of these programs to the organizations.

A fourth factor that supports institutionalization is demonstrating the success of a program. Producing such evidence is often costly in itself, and

Table 3. Common Barriers to Successful Implementation of Communication Skills Training

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| <p>Organizational Barriers</p> <ul style="list-style-type: none"> • Unrealistic expectations of outcome from a small number of workshops • Organizational focus on productivity and efficiency of delivery rather than on effectiveness of care; rewards exclusively for productivity • Organizational systems may not encourage patients to take an active role in their care • Organizational cultures structured to reward productivity and not communication with and total healing of patients • Human resources not allocated for promoting physician-patient interaction • Physicians lack the time required to effectively communicate with patients <p>Program Barriers</p> <ul style="list-style-type: none"> • Lack of a clear relevance of course content to physician practice tasks • Physicians feel burdened to attend program if not relieved from clinical responsibilities |
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many organizations fail to make adequate investments in program evaluation. Demonstrating the success of a program is particularly a problem in the field of communication, since the evaluation of such programs is methodologically difficult and expensive. In addition, it is not clear what outcomes should be measured; although patient satisfaction might be the outcome most important to the organization, it may not be realistic to demonstrate a measurable effect of this outcome, especially in a short time frame.

Each organization may have different requirements for continuing their commitment to improving patient-physician communication. Some organizations may believe that communication skills programs are important for nurturing the well-being of practicing physicians because they give them skills to make their jobs easier. For these organizations, studies that demonstrate improvements in physicians' self-ratings of skills and satisfaction with practice may be important for sustaining the program. Burnt-out physicians and physician turnover can be costly to an organization. In other settings, the imperative to improve patient satisfaction or decrease complaints may be more important. One

randomized control trial of a 10-hour communication skills program was conducted by one of us (W.L.) using "Thriving in a Busy Practice" as the intervention. This trial used a tool called the Art-of-Medicine, an 8-item satisfaction measure that KP was using to give feedback to physicians. This trial did not show measurable improvement in patient satisfaction, but clinicians reported increased confidence in their communication skills.⁴⁹

At the PNC, a senior physician manager noted that "whether or not we had the data, there has been an intuitive feeling (in the organization) that better physician-patient relationships lead to better care, greater patient loyalty, fewer law suits, fewer wasted resources, and greater job satisfaction" (Rodney Dueck, MD, oral communication, May 1, 2002). This intuitive feeling has been sufficient to sustain expansion of the program despite the lack of hard data.

... FUTURE RESEARCH NEEDS ...

Readers of this article will undoubtedly wish we could present evidence that communication skills training can improve outcomes such as patient satisfaction, physician well-being, and measures of both patient and organizational health. There is a small body of literature demonstrating that well-designed educational interventions can improve physicians' communication skills. For example, randomized control trials show improvements in physicians' ability to break bad news or to communicate in a patient-centered fashion.⁴⁹⁻⁵² Overall, however, there is a relative paucity of data about the effectiveness of these educational interventions. Furthermore, we are aware of no studies assessing the effect of programs like we have described on the organization as a whole. Rigorous studies are needed to evaluate the outcomes that matter most to organizations investing in these efforts.

Furthermore, accurate information about the cost of implementing and institutionalizing these programs would allow organizations to weigh choices about resource allocation.

Table 4. How to Incorporate Physician-Patient Communication Into the Organizational Structure

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| <p>Adoption</p> <ul style="list-style-type: none"> • What is the motivation for change? • Who has a stake in preventing change? Do I have buy-in from key leaders? • Do I have adequate resources for the program? • What are the specific desired outcomes? Are they measurable? How so? • How does this program fit in with (or how is it threatened by) other initiatives and values within the organization (eg, staff customer service programs?) <p>Implementation</p> <ul style="list-style-type: none"> • Will the program train all physicians? Only volunteer physicians? Those with identified communication problems? Support staff? • What are the likely barriers that will challenge implementation? Should I convene a focus group of target individuals to incorporate their ideas and goals? <p>Institutionalization</p> <ul style="list-style-type: none"> • How will I maintain the skills of those trained? Second-generation courses? Case conferences to problem solve difficulties of using the tools? • Who will continue the training after the outside consultants leave? • How do I incorporate the training into organizational systems so that they sustain themselves and become less dependent on individual champions? How will I use initial outcomes to modify the ongoing program? |
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Studies addressing the cost-benefit of such programs are needed.

... CONCLUSIONS ...

Organizational and technological innovations in the healthcare field have facilitated the growth and development of medical care by leaps and bounds; nonetheless, the patient-physician relationship has remained at the core of medical practice. Healthcare organizations in today's competitive market recognize the critical importance of this relationship to patient outcomes, patient satisfaction, and provider well-being. Table 4 presents a list of questions that physician leaders and administrators should consider to adopt, implement, and sustain communications skills programs effectively. Ultimately, these efforts should improve the quality of care for patients and support the well-being of providers and organizations.

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