Commentary

A comparison of decision-making by physicians and administrators in healthcare settings

David S Matheson and Niranjan Kissoon

Department of Pediatrics, University of British Columbia, Children's Hospital Rm K4-105, 4480 Oak Street, Vancouver, British Columbia, Canada V6H 3V4

Corresponding author: Niranjan Kissoon, nkissoon@cw.bc.ca

Published: 5 September 2006
This article is online at http://ccforum.com/content/10/5/163

Critical Care 2006, **10:**163 (doi:10.1186/cc5028)

Abstract

Physicians and administrators are committed to the same goal of providing quality care at affordable costs. Their perceptions of each other and their resulting behaviors, however, may lead to conflict. We offer some insight into these perceptions and behaviors, and provide a framework to improve communication and to reduce misunderstanding.

Introduction

The chief of critical care walks into the Chief Executive Officer's office to discuss the proposal to purchase a new electronic order entry system for medications. The Chief Executive Officer is asking for justification to purchase this unit. The chief does not feel any justification is needed beyond 'it is simply good for patient care'. The administrator wants a business plan outlining the need for this system, its fixed and variable costs, and its projected savings. The meeting ends with both participants frustrated.

'Physicians are naïve, they don't realize that we cannot provide what we cannot afford', states the administrator. 'Administrators don't care about patients, they only care about their bottom line', states the physician. These are the typical perceptions of each other.

While it may seem that physicians and healthcare administrators are pursuing different goals, both are committed to one goal: value for patients [1]. Value, however, is a product of quality (good outcomes) and cost (efficiency). Conflict arises because each group perceives that they are responsible for meeting mutually exclusive objectives. For example, the critical care physician may think they are responsible for ensuring good patient outcomes only, while the administrator may think they are responsible for system efficiency and costs only. Cognizant of these disparate perceptions of each other, in the present article we offer some insight into these behaviors and offer some suggestions to bridge the chasm. We also outline how the principles of organizational justice can improve communication and reduce misunderstanding.

Behaviors and decision-making

In *Systems of Survival*, Jacobs [2] presents a framework that divides the behavior paramount in all types of jobs into one of two groups – 'traders' and 'guardians'. According to Jacobs, the moral behaviors characteristic of the trader (Table 1) are typical of individuals in business and commerce, and are also found in physicians and scientists. Unlike traders, guardians – including healthcare administrators – typically ensure that policies and procedures are followed and that there is a perception of fairness in the system (Table 2).

Decision-making in healthcare settings is intimately tied to these behaviors and relationships. A respect for hierarchy and an acceptance of deceit for the sake of the task (Table 2) is the anathema of 'collaboration, competitiveness and dissent for the sake of the task' (Table 1). Systems that depend on both of these behavioral types to operate successfully are clearly ripe for conflict. This may be especially true in the Canadian healthcare system, where the principles of equity and universality reinforce Jacob's roles and moral frameworks. The irony is that not only are both moral constructs required in hospital and academic institutions, but that each group also wants the best for patients, equity in resource allocation (truer among administrators), opportunities for innovation and creativity (truer among physicians), and recognition and rewards for their expertise and efficiency (both administrators and physicians).

These 'moral behaviors' support a model of relationships between individuals that, at the simplest level, can be described as either 'superior-inferior' (guardian) or 'independent-equal' (trader) relationships. Superior-inferior relationships are common in administrative organizations – such as is found in hospitals – where structural authority is integral and there is a need to control and manage systems, outputs and decisions. Independent-equal relationships are common in environments – also found in hospitals –that respect independent action, open discussion and innovation, and where advice is sought and considered but external direction may not be accepted readily.

Table 1

Moral behaviors of 'traders'	
Shun force	Be efficient
Come to voluntary agreements	Promote comfort and convenience
Be honest	Dissent for the sake of the task
Collaborate easily with strangers and aliens	Invest for productive purposes
Compete	Be industrious
Respect contracts	Be thrifty
Use initiative and enterprise	Be optimistic
Be open to inventiveness and novelty	

Table 2

Moral behaviors of 'guardians'	
Shun trading	Make rich use of leisure
Exert prowess	Be ostentatious
Be obedient and disciplined	Dispense largesse
Adhere to tradition	Be exclusive
Respect hierarchy	Show fortitude
Be loyal	Be fatalistic
Take vengeance	Treasure honor
Deceive for sake of the task	

Influence of behavior on relationships

Physicians are taught (through educational ward rounds) that dissent is approved of, will not be taken as a personal criticism and will even be rewarded. This reinforces the independent-equal construct for physicians. Dissent by a physician in an administrative setting, however, is frequently taken personally.

In contrast, an administrator's position within an organizational matrix reinforces the superior-inferior construct. Faced with a decision, an administrator might seek input from a number of parties, including physicians, and then reach a conclusion that meets an organizational need that physicians do not understand as logical and will therefore often discount as unimportant. Physicians (traders) typically see the administrators' decisions as ignoring their input.

Organizational justice

Some decisions are the responsibility of administrators while other decisions belong to physicians; few would argue this point. Equally clear is the fact that decisions taken by one group will affect the other. Decisions by both physicians and administrators therefore need to be transparent and understandable with appropriate collaboration and input.

For decisions to be perceived as fair or just, rules must be followed that those who make decisions and those affected by these decisions recognize as reasonable and fair. Uncertainty about how decisions were reached undermines these decisions and builds an environment of distrust. Even a popular decision can increase frustration, if the process for reaching it is not supported. The principles of organizational justice (procedural justice, distributive justice and interactive justice) ensure transparency in decision-making [3].

Procedural justice describes what criteria will be used, who will be accountable, who will have input and when the decision will be made. Procedural justice includes the opportunity to have input guided by six criteria (the Levanthal criteria), requiring that procedures be applied consistently across people and time, procedures be free of bias, procedures ensure accurate information is used, procedures have some mechanism to correct flawed or inaccurate decision, procedures conform to prevailing standards of ethics and morality, and procedures ensure the opinions of various groups are taken into account [4].

Distributive justice describes how resources are shared, divided or reallocated.

Interactive justice describes the interaction between the decision-makers and the stakeholders. It implies listening to ideas and expressed concerns with respect, and treating staff with dignity. Interactive justice requires the decision-maker to explain himself/herself why one option was chosen over another option.

A decision that follows the Levanthal criteria can be understood and is more probably supported even if the outcome was not favorable.

Organizational justice and perceptions of fairness

There is evidence that procedural justice and interactive justice are more important than distributive justice in contributing to the employees' perception of the fairness of the organization [5]. This may be particularly relevant in situations where budget constraints are severe.

In a model of instructors and students, the use of the principles of organizational justice revealed that instructors in institutions with higher principles of organizational justice had higher organizational commitment and that their students reported higher levels of instructor effort and of fairness [6]. If these results can be generalized in healthcare, the quality of care may be improved by enhancing the perception of fairness among staff members. Organizational justice principles can be taught [7] and organizational justice is

beginning to be discussed in healthcare, but there is little analysis of the current status of its principles or the impact of implementing them [8].

In the example given, the principles of justice are relevant and applicable. Appreciation and clear articulation of the role of both the critical care physician and the administrator in providing value for patients is a first step. A commitment to a procedural framework of resource allocation, timelines for decision-making and clear, respectful communication at every stage of the process are likely to dispel the perceptions outlined.

In summary, physicians and administrators are committed to the same goal. Adhering to the principles of organizational justice would enable us to reduce conflicts while striving to provide value for patients.

Competing interests

The authors declare that they have no competing interests

References

1. Hardwick DF: **'Directoring' and managing in a professional system.** *Modern Pathol* 1998, **11:**585-592.
2. Jane Jacobs: *Systems of Survival: A Dialogue on the Moral Foundations of Commerce and Politics.* New York: Random House; 1992.
3. Greenberg J, Cropanzano R (Eds): *Advances in Organizational Justice*. New York: Stanford Business Books; 2001.
4. Leventhal GS, Karuza J, Fry WR: **Beyond fairness: a theory of allocation preferences**. In *Justice and Social Interaction*. Edited by Mikula G. New York: Springer-Verlag; 167-218.
5. Beugre CD, Baron RA: **Perceptions of systemic justice: the effects of distributive, procedural and interactional justice.** *J Appl Social Psychol* 2001, **31:**324-339.
6. Masterson SS: **A trickle down model of organizational justice: relating employees and customers' perception of and reactions to fairness.** *J Appl Psychol* 2001, **86:**594-604.
7. Cole ND, Latham GP: **Effects of training in procedural justice on perceptions of disciplinary fairness by unionized employees and disciplinary subject matter experts.** *J Appl Psychol* 1997, **82:**699-705.
8. Persaud DD, Narine L: **Organizational justice principles and large scale change: the case of program management.** *Can Healthcare Manage* 2001, **101:**71-80.