VITAL WorkLife & Cejka Search: Organizational Culture Survey

2012

As physicians move increasingly to an employed model, organizational culture becomes more of an issue, especially for those who previously worked in smaller medical groups and in solo practice. The attendant differences in areas as varied as accountability, autonomy, work environment and modes of communication can create gaps between expectations and reality. For healthcare organizations, the implications for retention and recruitment are compelling, as well as the downstream effects on behaviors, attitudes and the ability to accept and embrace change.

Survey Report and Addendum

November, 2012

Dear Colleague;

Last year, our ground-breaking study on physician stress and burnout revealed insight about an issue that we have found, in our respective practices, to have far-reaching consequences for patient safety, and also physician satisfaction, wellbeing and engagement. We learned a great deal about causes, effects—and what can be done by organizations to address stress and burnout on a practical level. Many organizations that we work with have taken the data and recommendations to heart in re-examining day to day operations and introducing new initiatives to combat this problem.

At a time when physician engagement is critical in effectively addressing the changes impacting healthcare, we looked at another important factor physicians tell us is central to their sense of engagement: organizational culture.

As physicians move increasingly to an employed model, organizational culture becomes more of an issue, especially for those who previously worked in smaller medical groups and in solo practice. The attendant differences in areas as varied as accountability, autonomy, work environment and modes of communication can create gaps between expectations and reality.

We have found that this can lead to dissatisfaction, frustration and cynicism. And, for those physicians who are still working in more autonomous medical group and solo practice settings, organizational culture still plays an important role as they evaluate their current situation versus what might lie ahead. For healthcare organizations, the implications for retention and recruitment are compelling, as well as the downstream effects on behaviors, attitudes and the ability to accept and embrace change.

If addressed at all, organizations tend to deal with culture in general terms, with little understanding of the specific cultural attributes that are meaningful to physicians. With that in mind, we conducted this survey to delve more deeply into these attributes to determine:

- How they impact physicians' satisfaction and to what degree;
- Their beliefs about their organizations' competence with respect to these cultural attributes;
- How satisfied physicians are with their organizations' approach to them;
- The physicians' own sense of cultural fit, and how it impacts their job satisfaction.

We also conducted a companion survey with healthcare administrators to determine what they perceive as important to their physicians—and how they feel their organizations meet physicians' expectations.

Our goal is to better understand what elements of organizational culture resonate with physicians, and then help the organizations we work with to develop solutions to close the gaps we uncovered between expectation and reality. By bringing physicians and healthcare organizations into greater alignment around organizational culture and its various attributes, we feel that physician engagement and overall satisfaction will increase.

Sincerely yours,

Mitchell Best
COO
VITAL WorkLife

Lori Schutte, MBA
President
Cejka Search

VITAL WorkLife, Inc.™ is a national behavioral health consulting organization providing support to people facing life's challenges, while also assisting organizations in improving workplace productivity.

We have deep experience in healthcare, especially assisting physicians and providers in dealing with the challenges facing their profession.

This approach of helping employees and their families, while also guiding organizations, builds healthy, sustainable behaviors. For over 30 years, we have offered industry leading Employee Assistance Programs, specialized support, training and consulting for a wide variety of industries.

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Introduction

VITAL WorkLife and Cejka Search work very closely with physicians and the healthcare organizations they work for. VITAL WorkLife addresses mental, behavioral and work/life-related issues that concern individual physicians and their families. In addition, its Intervention Services assist organizations in effectively addressing disruptive behavior and other performance issues in physicians within their organizations. Training and consulting around such topics as workplace conflict, change management, civility, stress and burnout, and others is offered for organizations, workgroups and individuals. Cejka Search works with physicians in meeting their career and work needs, and also works with healthcare organizations consulting on recruitment and retention of clinical providers and administrative executives.

Both companies are hearing increasingly from the physicians they work with how important organizational culture is to their overall satisfaction and sense of engagement with their organizations. When physicians feel a lack of cultural fit, it manifests itself in various ways, from feelings of anger, disengagement and cynicism to, ultimately, leaving their jobs. In cases where they feel they can't leave their jobs, for reasons ranging from family or location preference, economic issues or career stage, they stay—and become increasingly unhappy.

They are also rejecting employment opportunities with organizations that don't meet their expectations around organizational culture. The resulting turnover and prolonged vacancies are key cost drivers, estimated to run as high as $100,000 per month when all costs and lost revenue are considered.

These consequences of poor cultural fit are concerning at a time when physician engagement has never been more important in the changing landscape of healthcare.

The research done to date on organizational culture within healthcare has focused more on its relationship, in general terms, to patient safety and quality of care across healthcare organizations. This work has involved identifying different types of cultures and attributes, and tying them to different levels of performance against safety and quality metrics. These studies have been valuable in demonstrating how important culture can be and the impact it can have on teamwork, communication and conflict management. There are also a small number of studies linking job satisfaction with organizational culture.

However, little has been studied related to organizational culture that is specific to physicians. With this survey, we wanted to learn more about issues surrounding organizational culture and what was important to physicians—and where there were gaps that contributed to dissatisfaction with their jobs and organizations. We also wanted to quantify the impact of cultural fit or lack thereof.

We first did a review of the literature on organizational cultural survey instruments specific to healthcare organizations, and the attributes they measured. We narrowed these down to 14 cultural attributes which we felt were most relevant to physicians, based upon our joint experience. These fell

into 4 major areas: work environment, organization, leadership and management, and communication. The cultural attribute questions formed the basis of the survey.

In addition to the physician survey, we also did a companion survey with administrators to determine congruity of perception around these cultural attributes, as well as their opinions about cultural fit and its impact on physician satisfaction, retention and recruitment.

Questions asked in this survey focused on:

- What cultural attributes were most important for physicians (or, in the case of the administrator survey, which they felt were most important to their physicians)
- The degree to which they agreed or disagreed that their organizations exemplified those attributes (both surveys)
- How satisfied or dissatisfied they were with their organizations' focus on those attributes (physicians only)
- In absolute terms, which were the three most and least important cultural attributes to them (and for administrators, what they felt these would be for their physicians)
- Cultural fit for physicians—how well they felt they fit within their current organizations, how it impacted their satisfaction, and whether issues of cultural fit had prompted them to leave a practice or job, or to accept other opportunities
- Cultural fit for administrators—how well they felt their physicians, as a whole, fit within their organizational culture, if they'd received physician feedback on the topic, and whether cultural fit had influenced offers extended to qualified job candidates or been a factor in voluntary physician departures.

By doing this survey, VITAL WorkLife and Cejka Search sought to identify areas that healthcare organizations could address that would result in better relationships with their physicians. The results show several areas that are actionable by healthcare organizations in addressing organizational cultural issues to achieve greater satisfaction in their physician populations. In doing so, they can also promote greater physician engagement, and improved retention and recruitment.

Methodology

The survey questions were developed with all questions mandatory to ensure a comprehensive data set. Other than for demographic questions, 10-point Likert scales were used in all cases except where respondents were asked for their choices for the three most important and least important cultural attributes from a list of all that were presented. A non-mandatory open comment question was presented at the end.

The surveys (physician and administrator versions) were sent via e-mail in October, 2012. The physician survey was delivered to a national sample of 122,398 individual physicians from the Cejka Search physician database, across multiple practice areas. There were 26,808 unique opens, and 2,262 completed surveys, representing a 99% confidence level with a +/- 3% margin of error against an active physician population in the US of about 798,000. The e-mail was sent from the CEO of VITAL WorkLife with the subject line of "Your Opinions on Physician Workplace Culture." Physician respondents accessed an online survey instrument through a link in the email, which compiled results and screened for non-completes. An additional round of surveys was deployed one week later to the same group, excluding those who had initially responded in the first deployment. The survey was held open for a total of 17 days.

The administrator survey was delivered to a sample of 4,291 individual administrators from a combination of the Cejka Search and VITAL WorkLife administrator databases, across multiple titles ranging from manager level to CEO/president at organizations of multiple types and sizes. There were 707 unique opens, and 123 completed surveys. The email was sent from the CEO of VITAL WorkLife with the subject line of "Your Opinions on Physician Workplace Culture." Administrator respondents accessed an online survey instrument through a link in the email, which compiled results and screened for non-completes. An additional round of surveys was deployed one week later to the same group, excluding those who had initially responded in the first deployment, and a final round was sent one week later. The survey was held open for a total of 19 days.

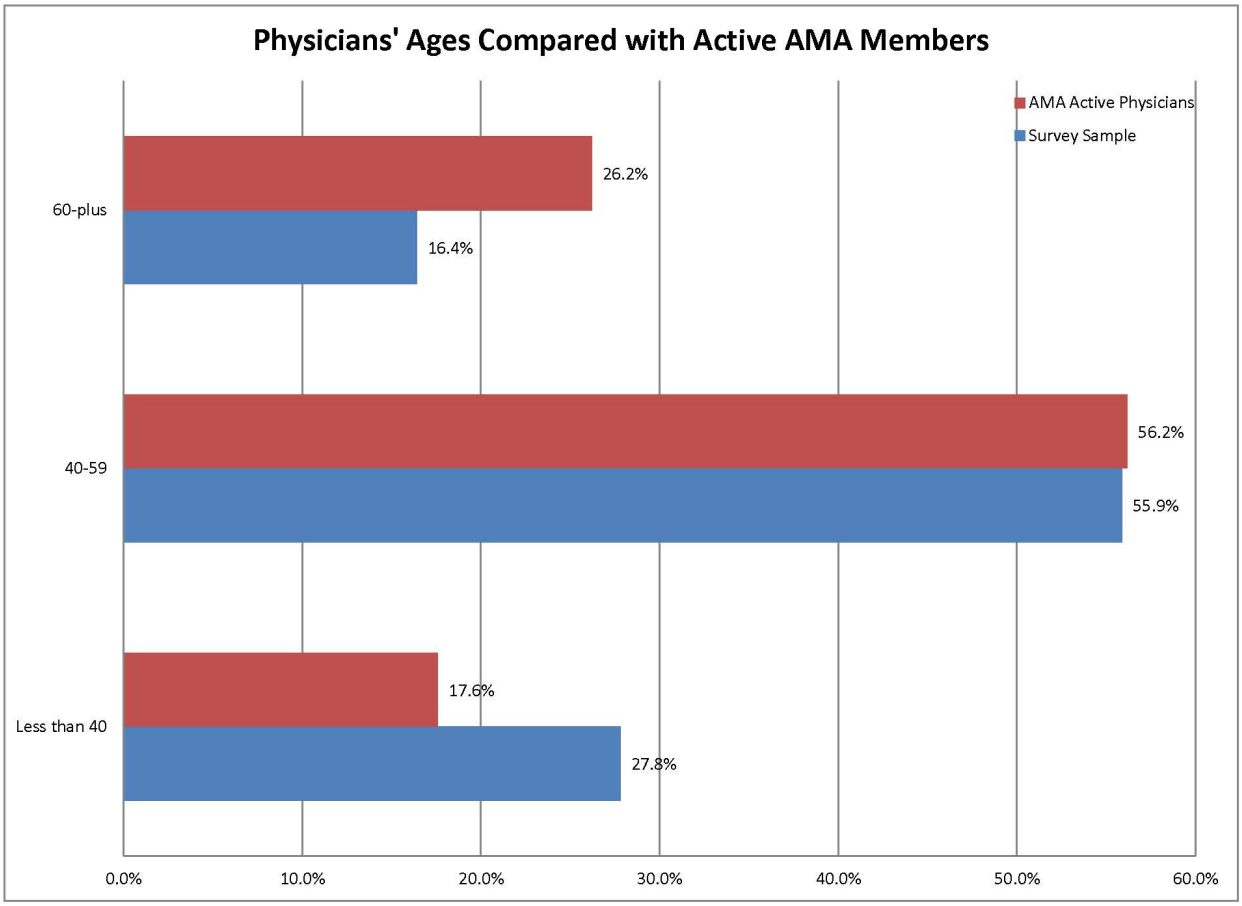
The data was collected in an Excel database that allowed for multivariate analysis across most survey fields. Demographic data was compared with the AMA 2010 Physician Masterfile to determine correspondence to a national active physician profile. T-tests were used on comparative gaps between scores to ascertain statistical significance to $P \leq .05$.

Survey Results—Physicians

Demographics

The survey respondent profile largely mirrored the national active physician profile as measured by the AMA 2010 Physician Masterfile[1] data.

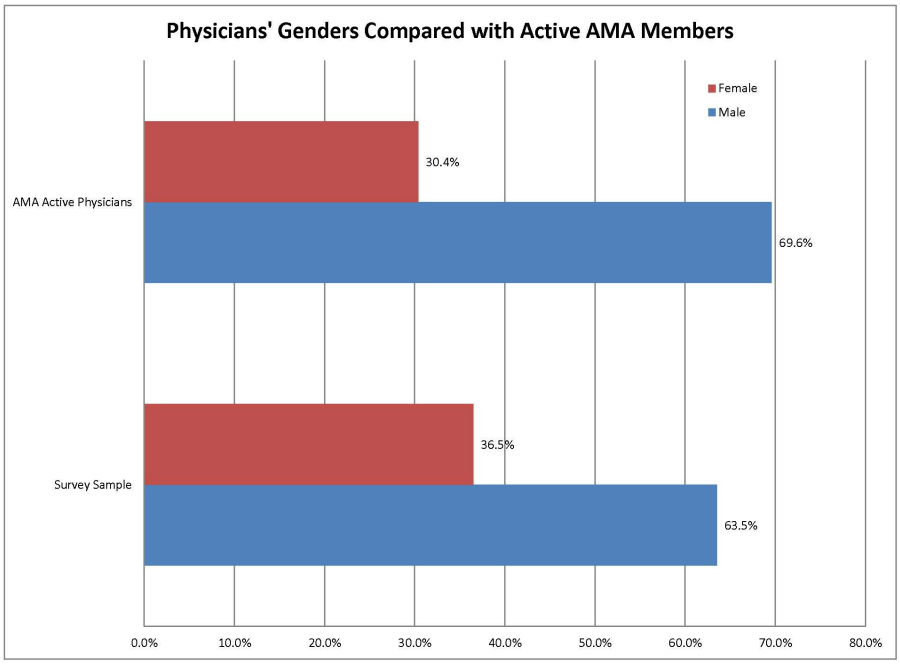
The age of the survey respondent sample skewed younger compared to the national active physician profile whose age was known. Although the middle range was within 1 percentage point of each other, the more significant differences were seen in the youngest and oldest cohorts. This was most likely attributable to overall sample bias, which due to its methodology would skew more toward physicians that are younger and more technologically engaged. The average age of the overall survey sample was 47.5 years.



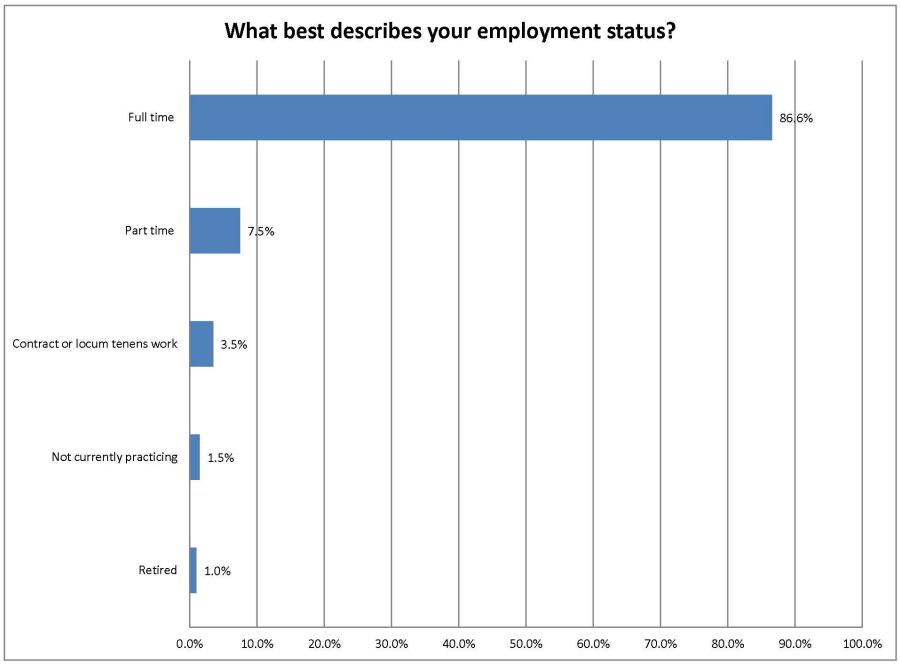
With regard to gender, the survey respondent sample was more skewed to females compared to the national active physician database for physicians. This was very possibly a function of the somewhat

[1] AAMC Center for Workforce Studies, 2011, "2011 State Physician Workforce Data Book, " retrieved November 1, 2012 from AAMC website: https://www.aamc.org/download/263512/data/statedata2011.pdf

younger age of the respondents compared to the national active physician population (see above), as gender trends have moved toward more female medical school graduates over the past several years.[2]

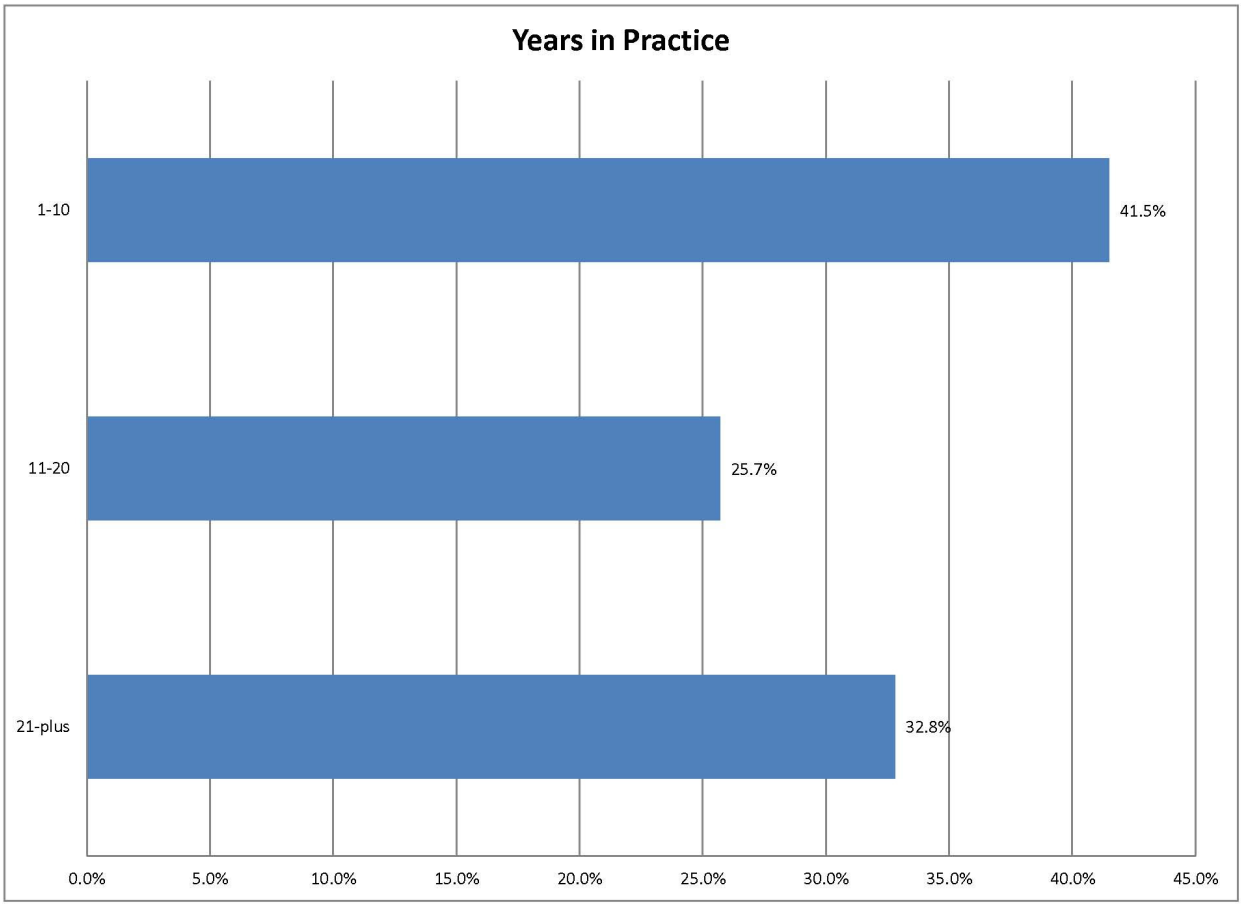


The vast majority—86.6% of survey respondents—were employed full time. The remaining respondents worked part time, did locum tenens or contract work, were not currently practicing or had retired.



[2] AAMC (ibid.), Kaiser Family Foundation statehealthfacts.org

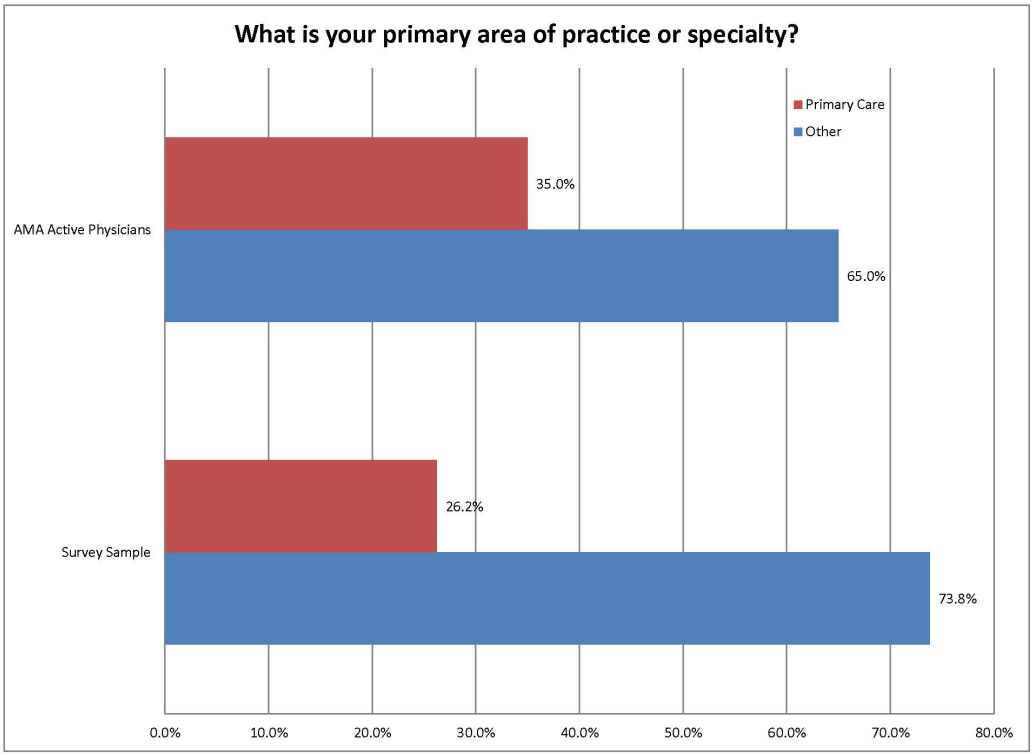
The average number of years in practice for the survey respondent sample was 15.7 years. This tracked generally with a) the average age of respondents and b) the skew toward non-primary care (see below) and the longer residencies and fellowships involved in various specialties and subspecialties. No comparable national data was available.



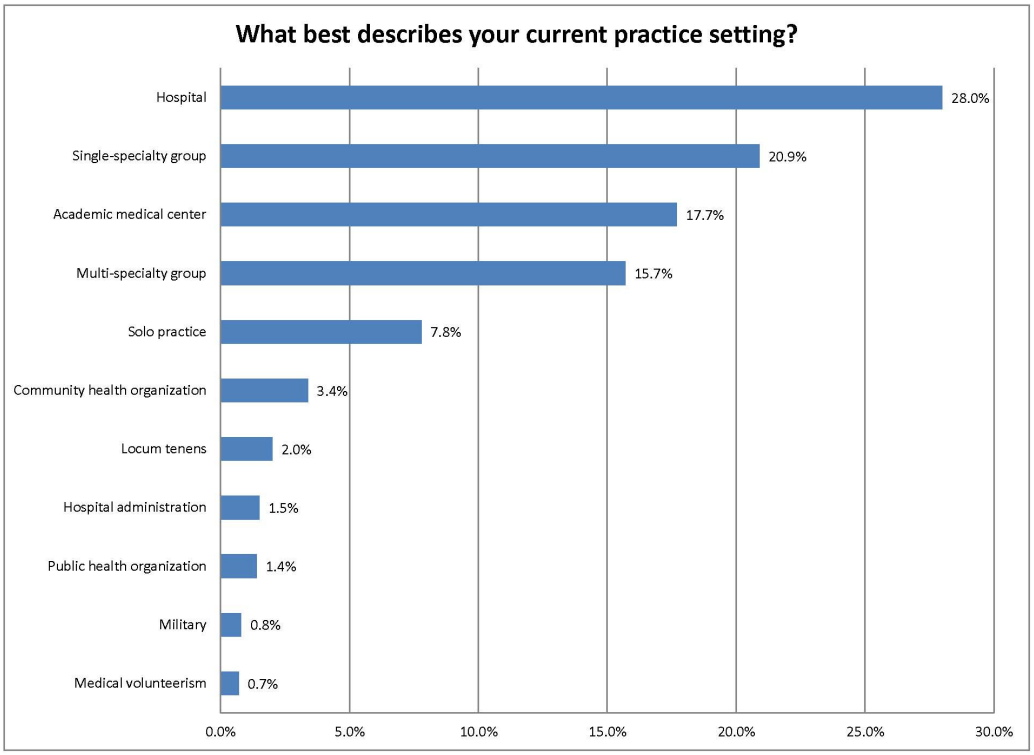
With regard to the primary practice area of the respondents, most were in non-primary care practice areas (primary care as defined by the AAMC Center for Workforce Studies).

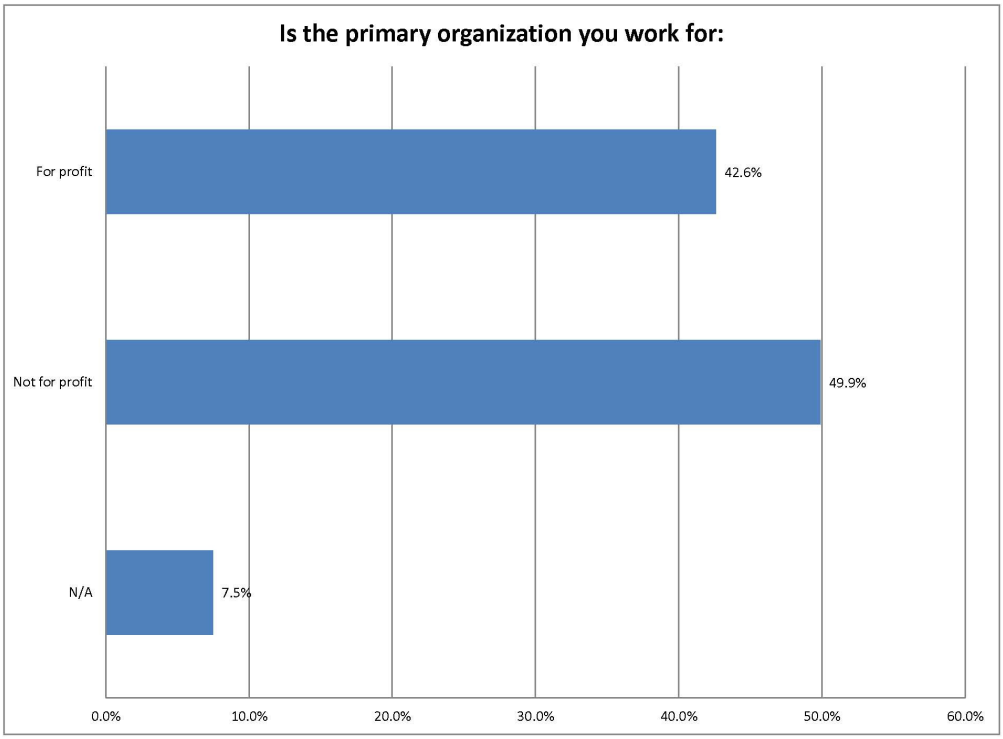
The survey respondent sample skewed more toward non-primary care practices than the national active population by 8.8 percentage points, possibly reflecting the somewhat younger skew of this survey sample (see above) and the trend away from primary care in more recent medical school graduates.[3] See Appendix C for the breakdown of specialties.

[3] GAO, 2009, "Graduate Medical Education: Trends in Training and Student Debt, retrieved November 1, 2012 from GAO website: https://www.aamc.org/advocacy/washhigh/highlights2009/157676/gao_publishes_report_on_medical_education_debt_and_specialty_ch.html

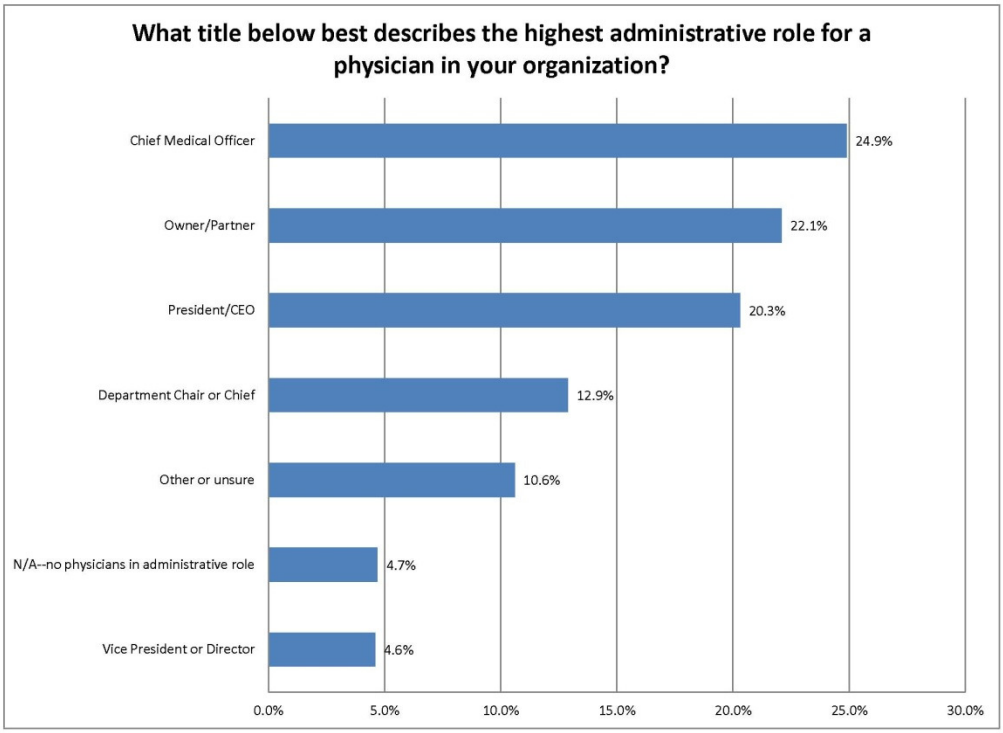


A plurality of sample survey respondents were employed by hospitals (28.0%), followed by those who were in a single-specialty practice (20.9%), academic medical center (17.7%) or multi-specialty practice (15.7%). A narrow majority worked in not for profit organizations (49.9%).





We also asked the highest administrative role for a physician in their organization. Chief Medical Officer led with 24.9%, followed by Owner/Partner (22.1%), President/CEO (20.3%), dropping down to Department Chair or Chief (10.9%). Only 4.7% indicated there were no physicians in an administrative role.



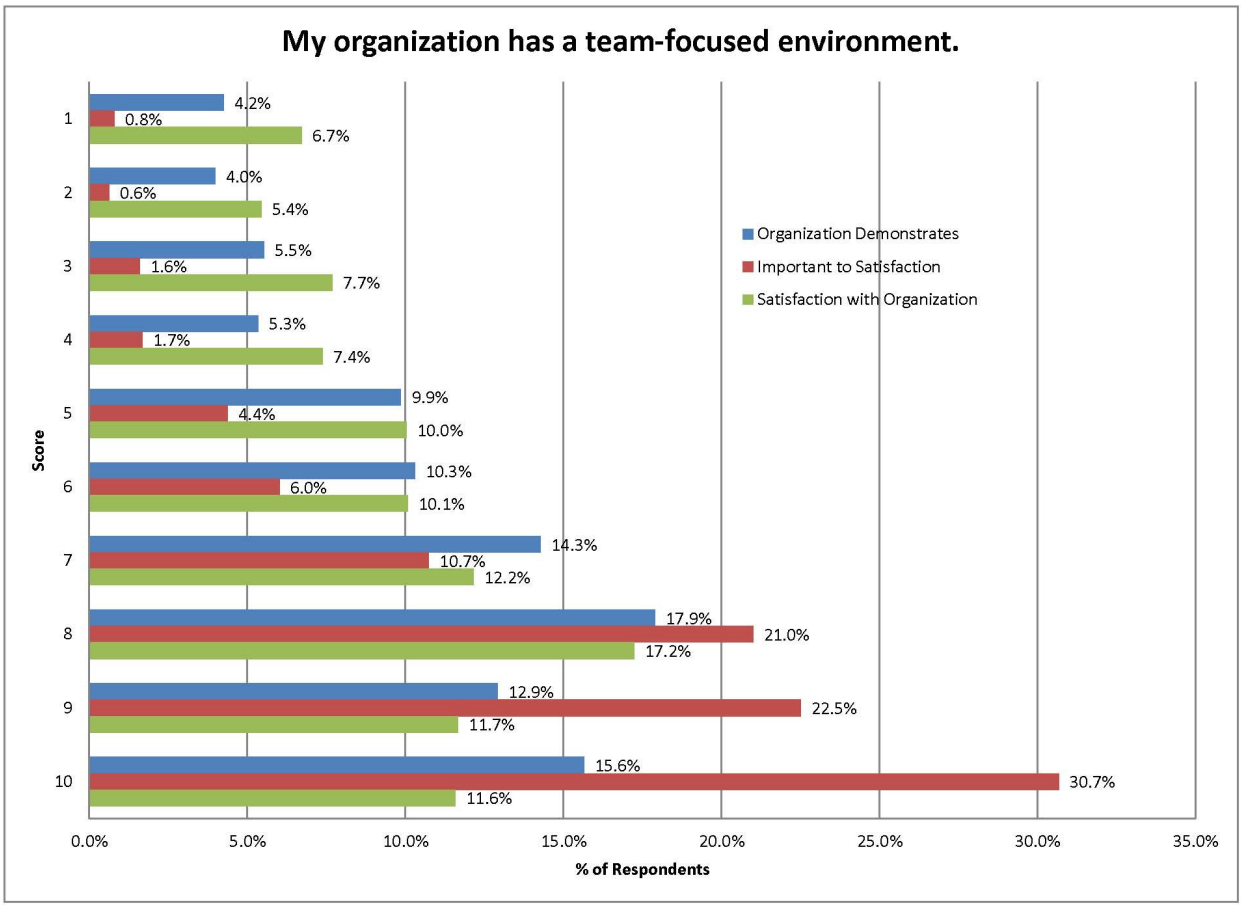
Results: Organizational Culture Attributes

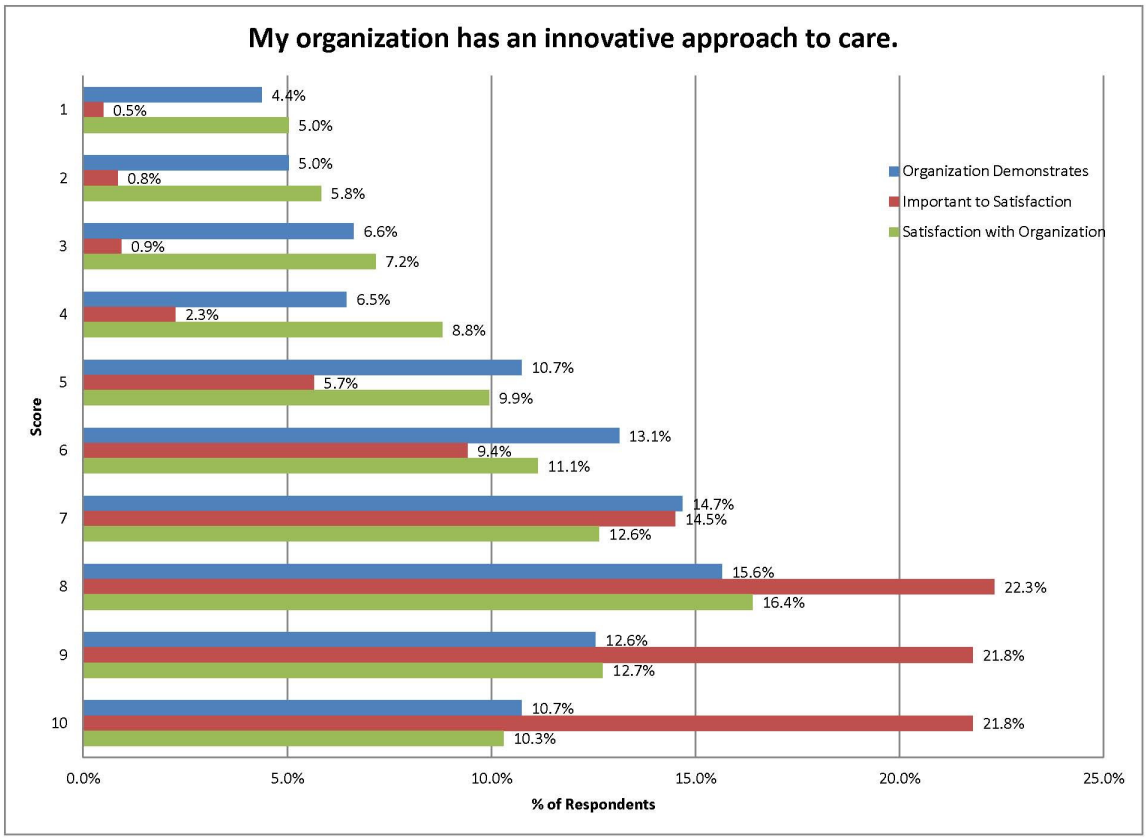
We asked for physicians to review 14 different cultural attributes. For each attribute, they were asked three questions, scored on a 10-point Likert scale:

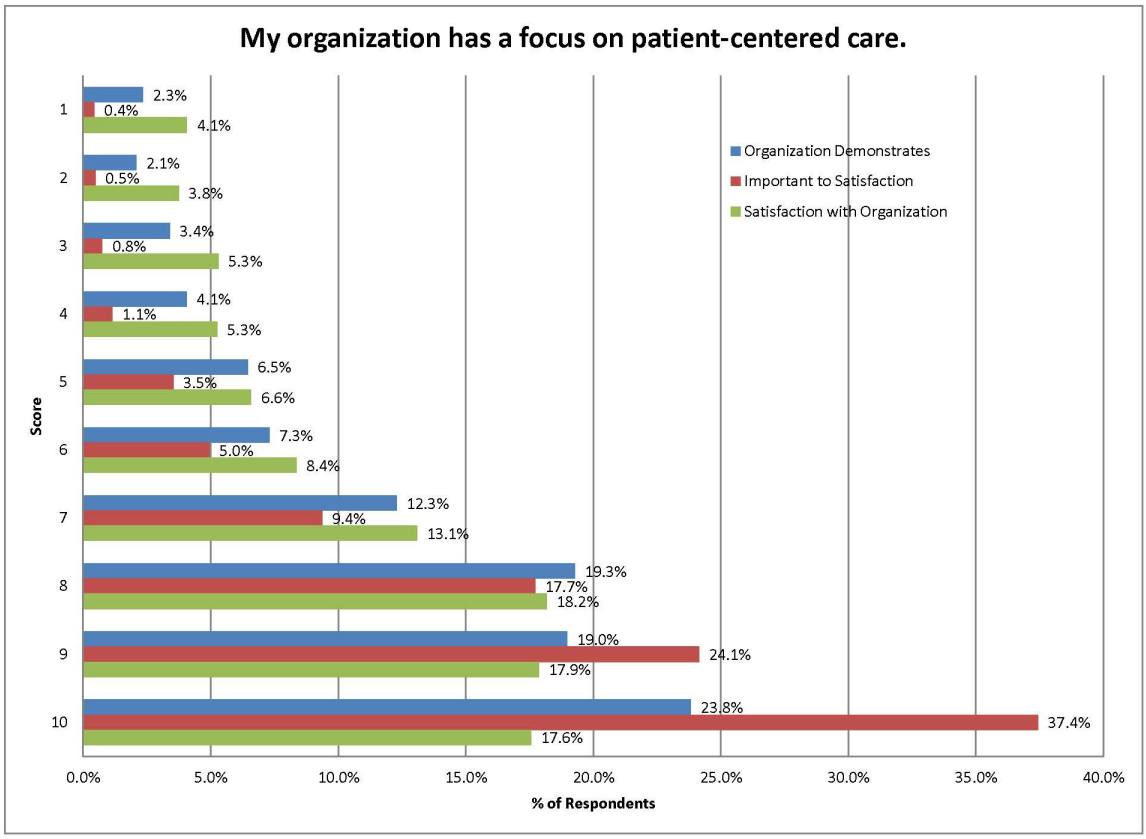
- To what degree they agreed or disagreed with a statement related to whether their organization demonstrated competence around the cultural attribute, e.g., "My organization has a team-focused environment." ("Organization Demonstrates" on charts)
- How important this attribute was to their overall satisfaction, on a "Not at all important" to an "Extremely important" scale. ("Important to Satisfaction" on charts)
- How satisfied they were with their organization's focus relative to this attribute, on a "Very dissatisfied" to a "Very Satisfied" scale. ("Satisfaction with Organization" on charts)

As noted earlier, these fell into 4 major areas: work environment, organization, leadership and management, and communication. The results for each attribute are detailed below.

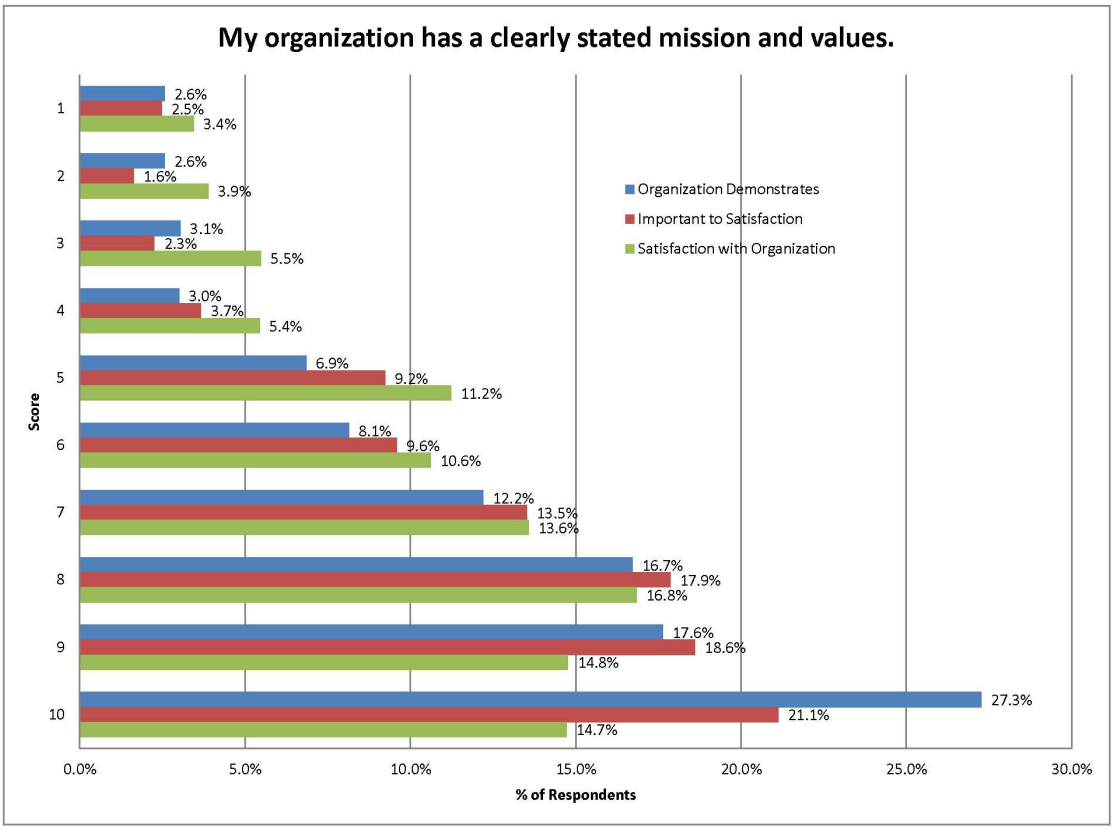
Work Environment:

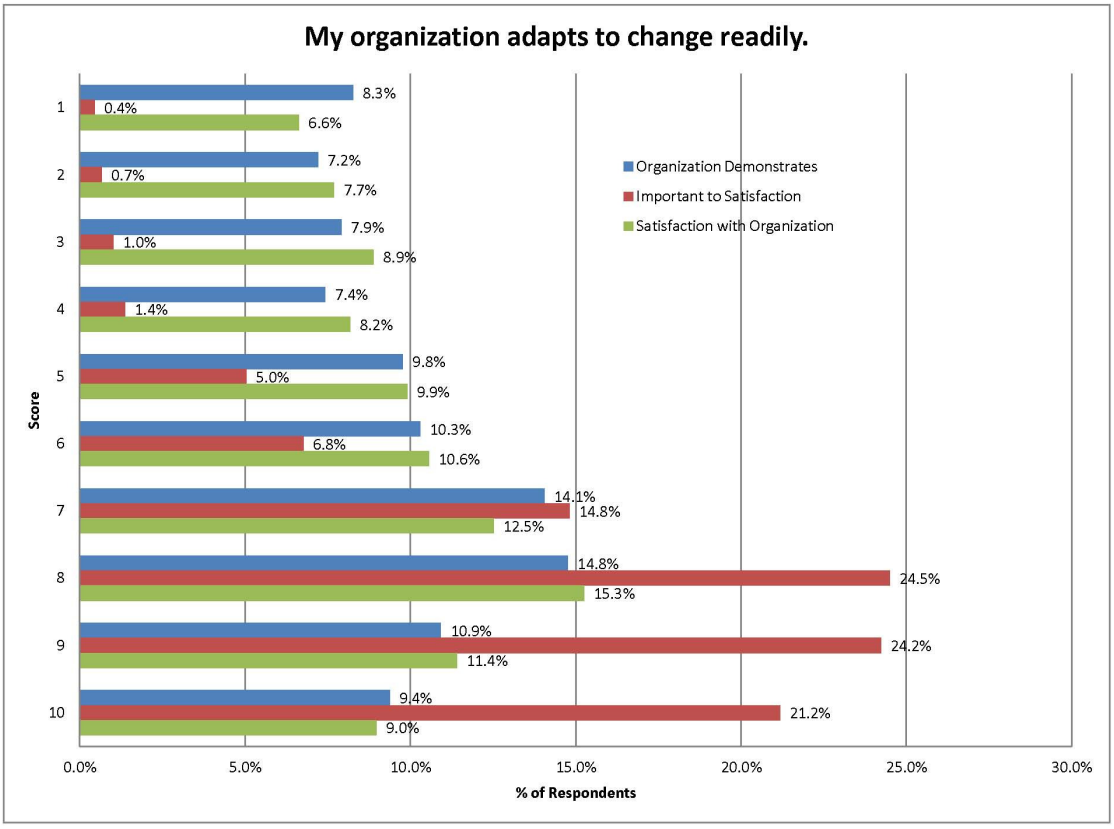


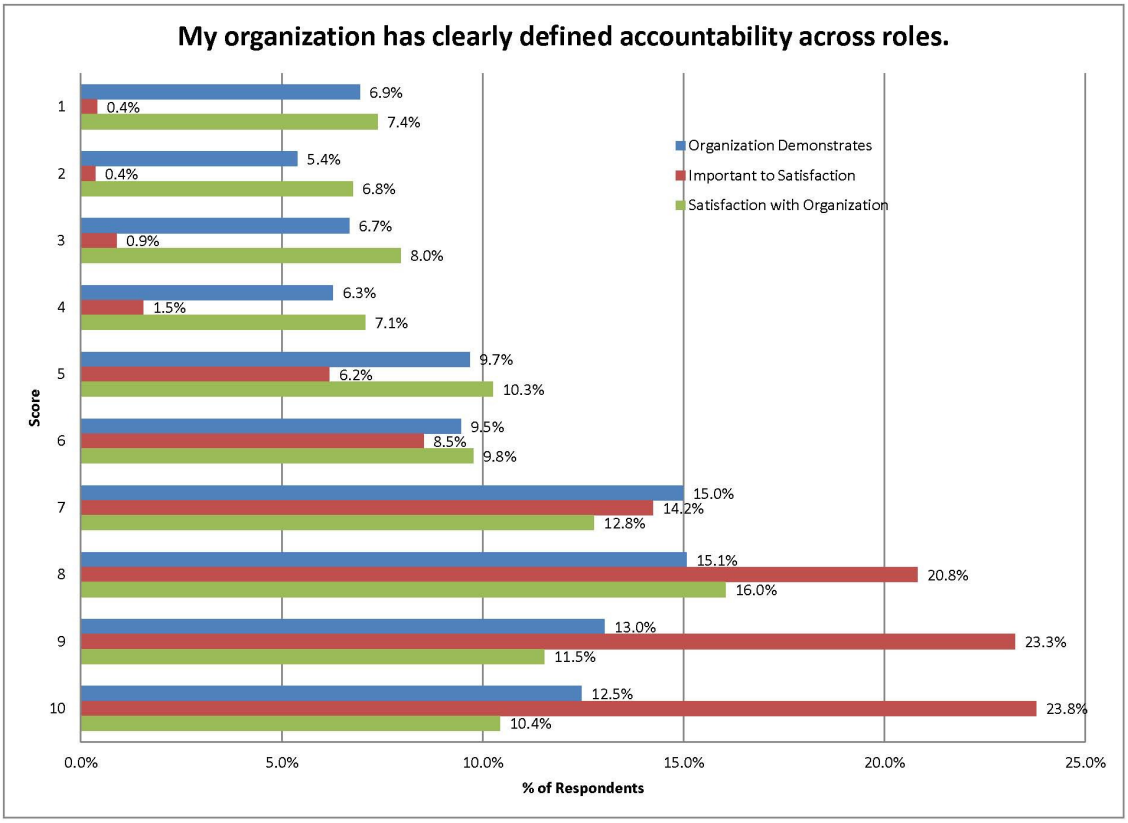




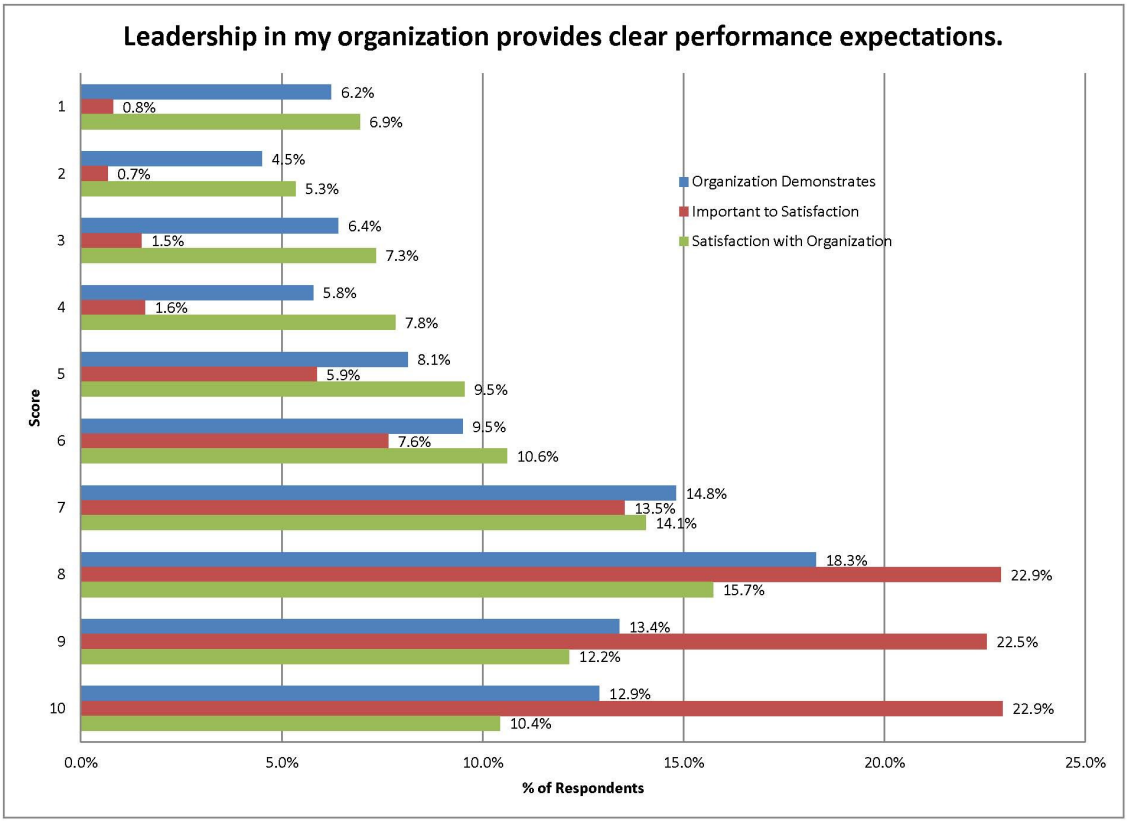
Organization:

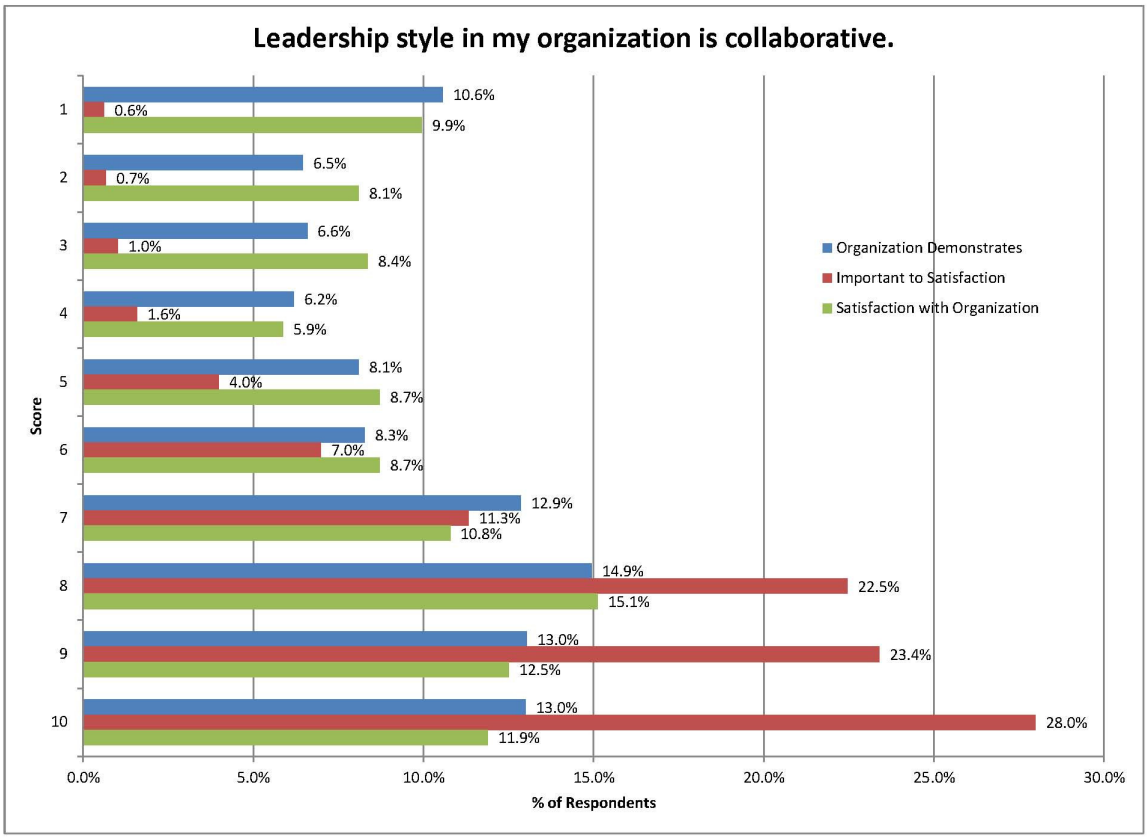


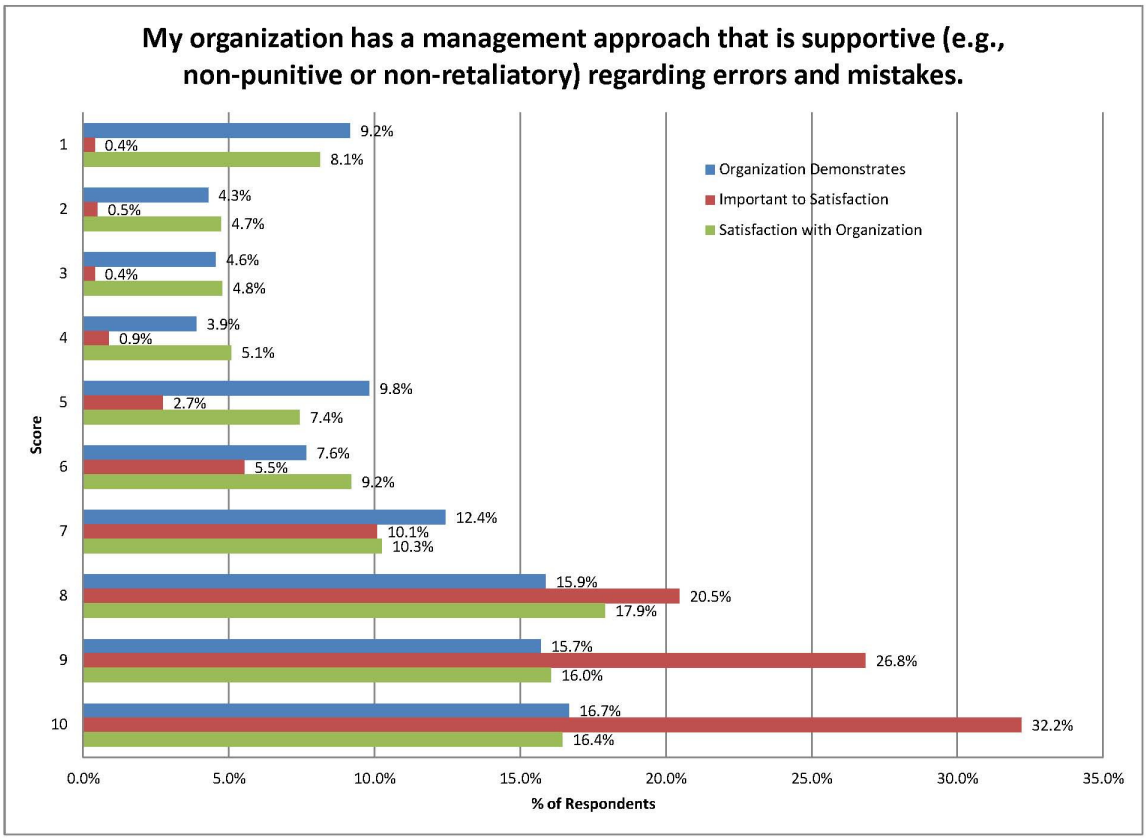


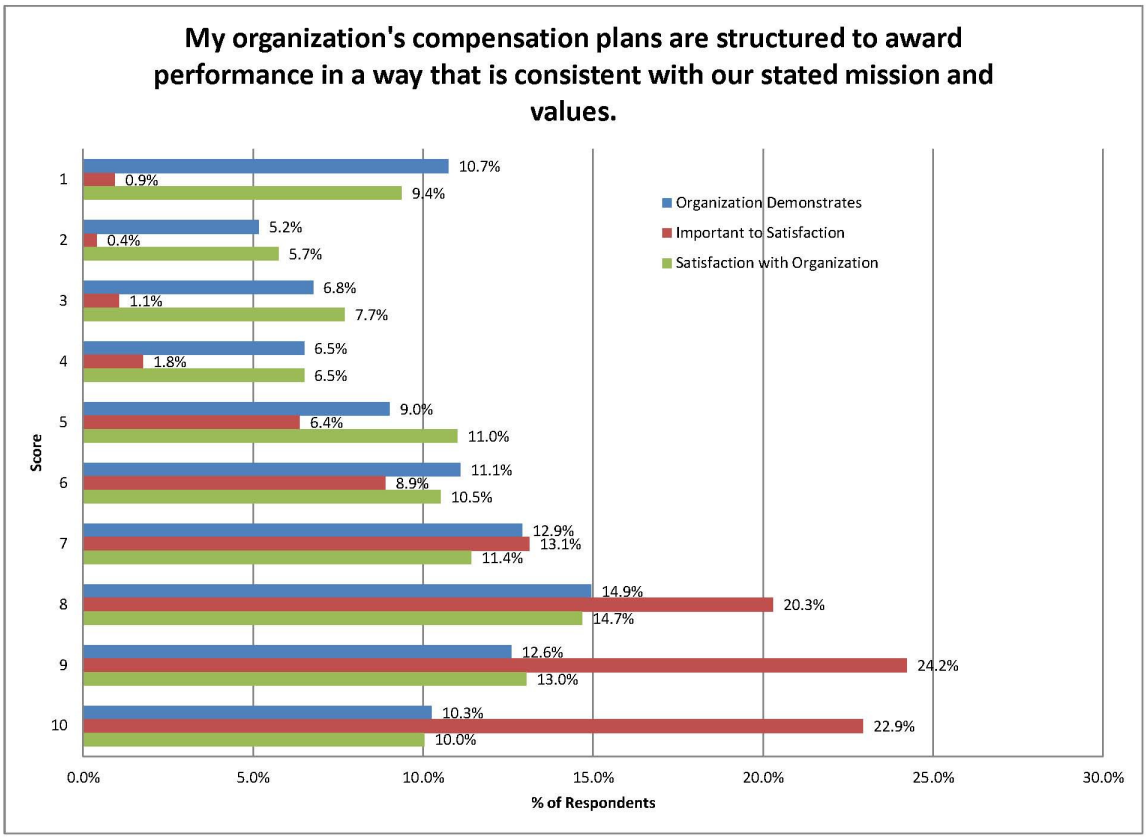


Leadership and Management:









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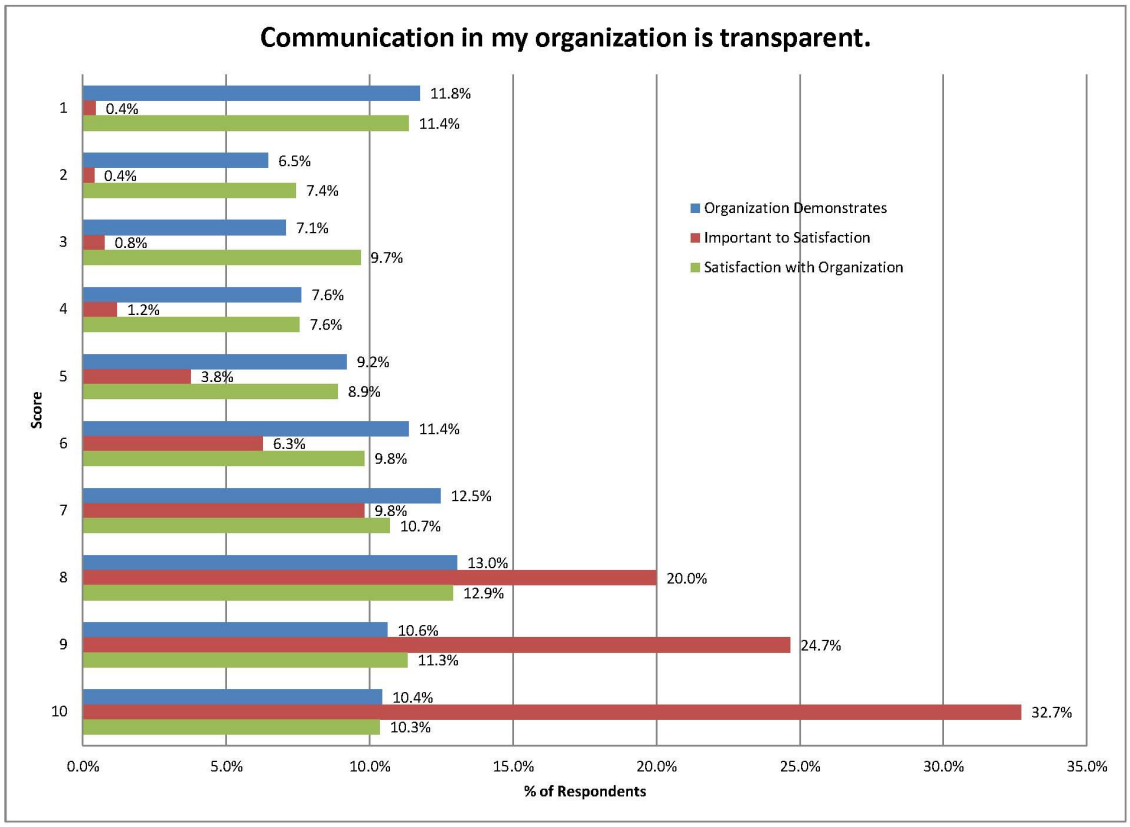
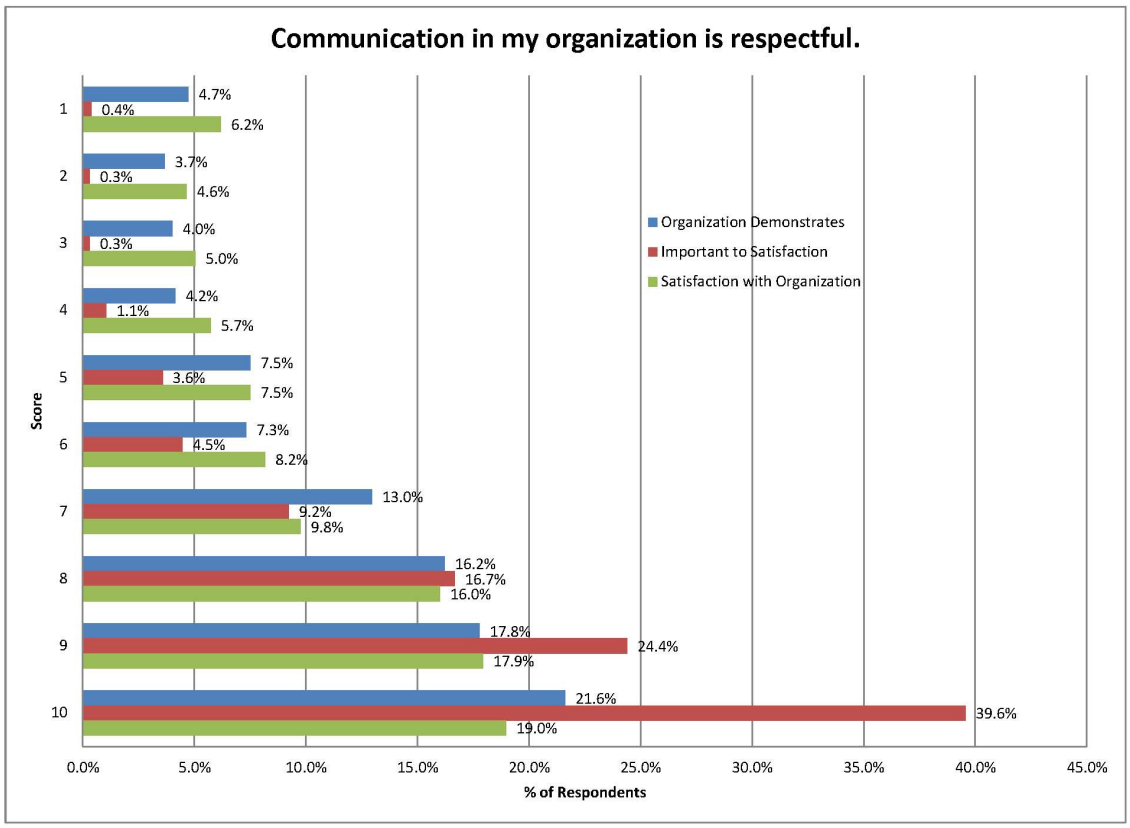
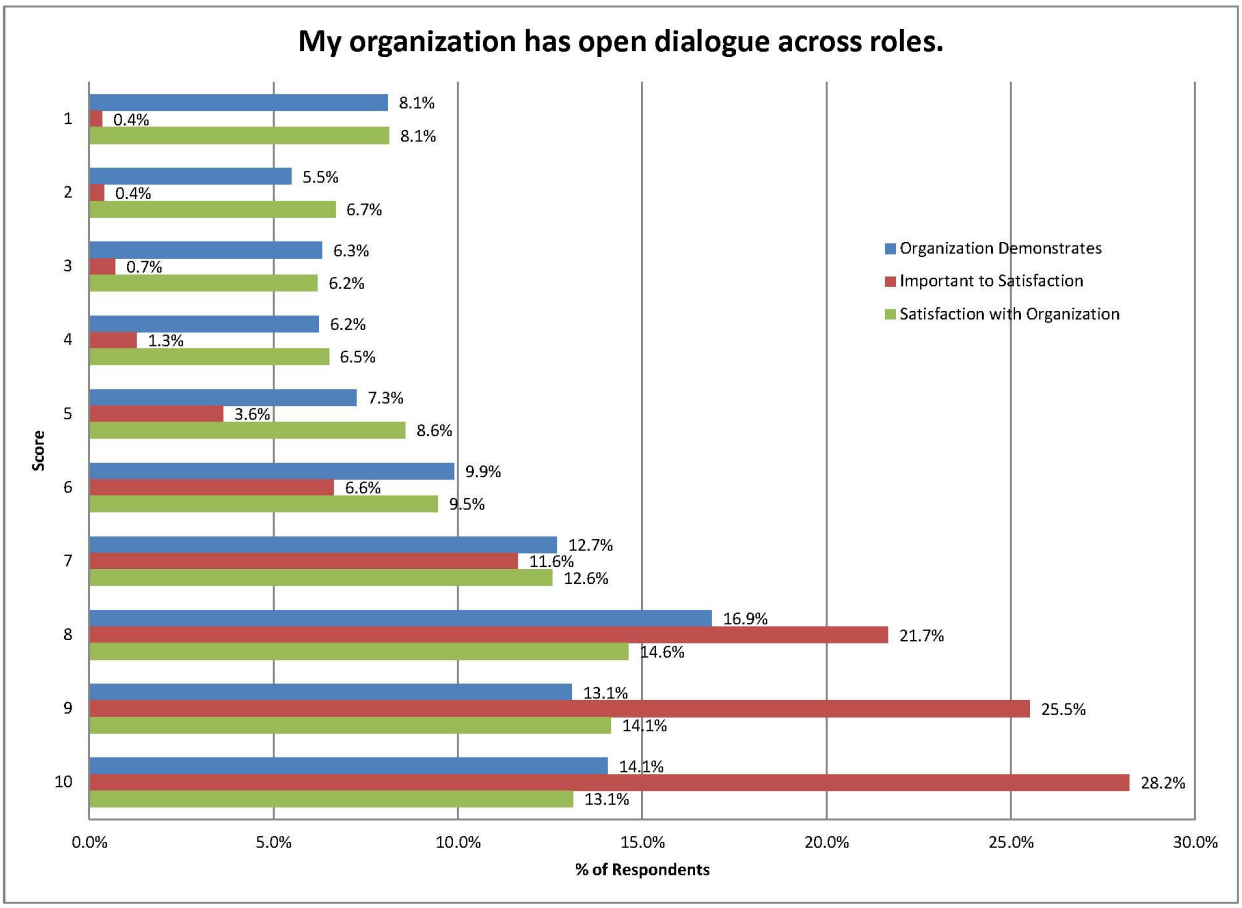






The chart below details the average scores for each cultural attribute, in rank order according to importance to physicians' satisfaction.

	Physicians' Average Score, 1-10 Scale:		
Cultural Attribute:	**Organization Demonstrates**	**Important to Satisfaction**	**Satisfaction w/ Organization**
Respectful Communication	7.2	8.6	6.9
Patient-Centered Care Focus	7.6	8.5	7.0
Supportive Management Regarding Errors and Mistakes	6.6	8.5	6.7
Transparent Communication	5.8	8.4	5.7
Open Dialogue Across Roles	6.4	8.3	6.3
Team-Focused Environment	6.8	8.2	6.2
Collaborative Leadership Style	6.1	8.2	6.0
Clearly Defined Accountability Across Roles	6.4	8.1	6.1
Adapts to Change Readily	6.0	8.1	6.0
Clear Perfomance Expectations	6.6	8.0	6.2
Compensation Plan Alignment with Mission and Values	6.0	8.0	6.0
Innovative Approach to Care	6.4	7.9	6.3
Clear Mission and Values	7.6	7.5	6.8
Objective Performance Evaluations	6.1	7.4	6.0

Physicians generally felt that all of the cultural attributes were important, based upon average scores ranging from 7.4 to 8.6—well above the 3.0 to 7.0 point mid-range—when asked how important the attributes were to their overall satisfaction. The top cultural attributes were:

- Respectful communication (8.6 average score)
- Patient-centered care focus and supportive management approach to errors and mistakes (tied at 8.5 average score)
- Transparent communication (8.4 average score)

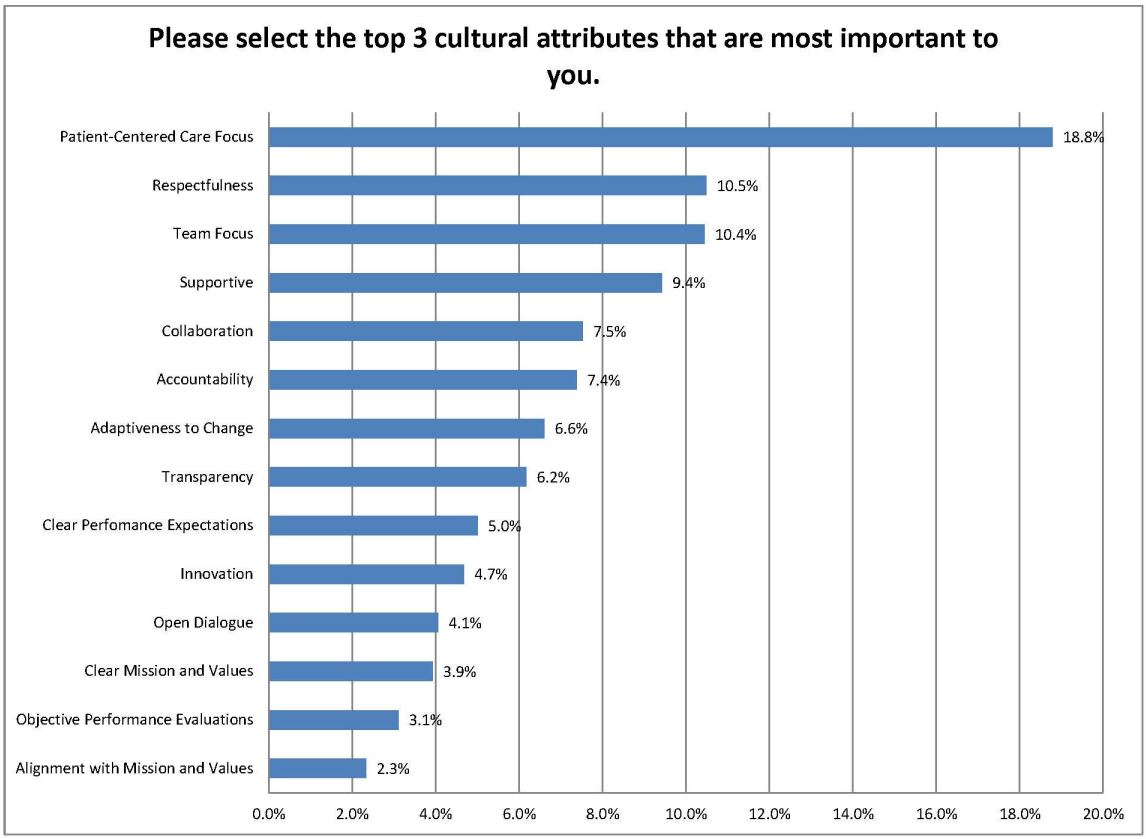
The least important were objective performance evaluations (7.4 average score), clear mission and values (7.5 average score) and innovative approach to care (7.9 average score). All other attributes scored at 8.0 or higher.

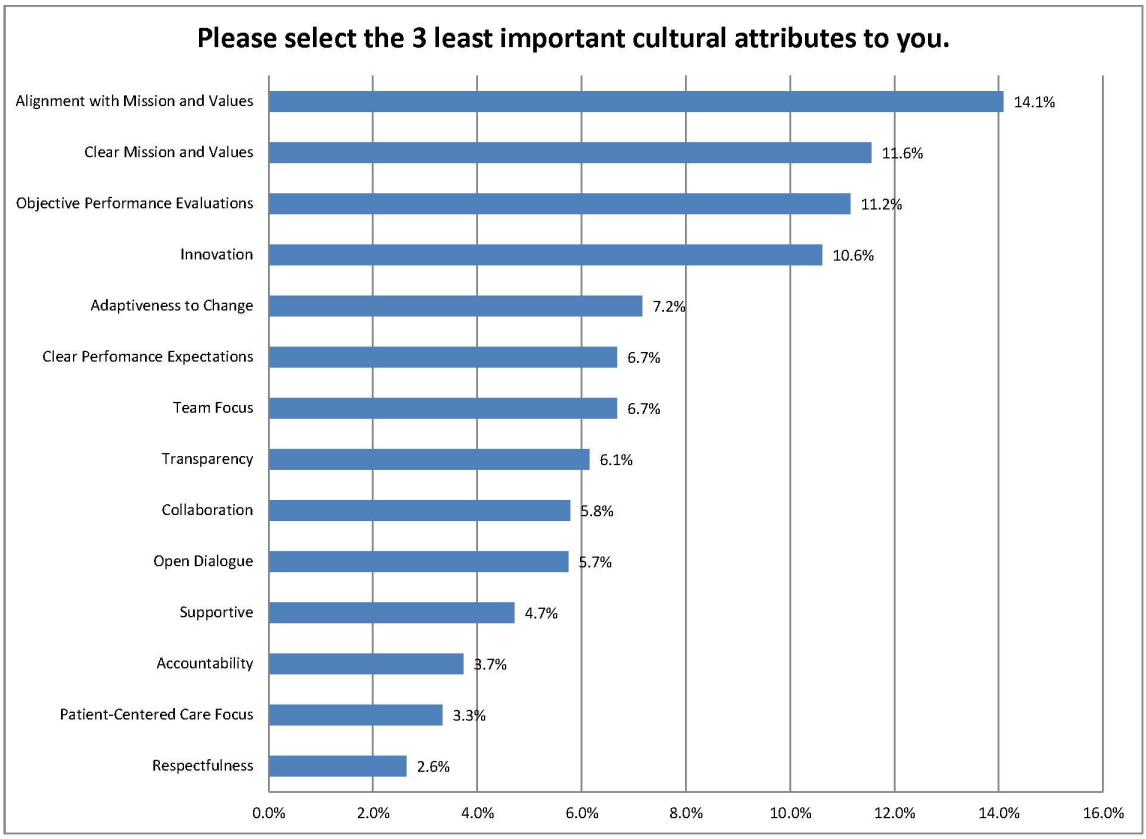
Physician respondents gave lower marks for how well they felt their organizations demonstrated competence around the cultural attributes, with average scores ranging from 5.8 to 7.6 and falling more in the mid-range. The highest scores were for patient-centered care focus and clear mission and values (tied at 7.6) and respectful communication (7.2). The lowest scores were for transparent communication (5.8), and adapts to change readily and compensation plan alignment with mission and values at 6.0 each.

Physicians scored even lower for their satisfaction with their organizations' focus on these cultural attributes, with average scores ranging from 5.7 to 7.0. Only one attribute—supportive management approach regarding errors and mistakes—scored higher than the competence question, by just .1 point; the rest were the same or lower. Gaps between perceived organization competence and satisfaction ranged from .1 to .8 points—the latter for clear mission and values, followed by a .6 point gap for patient-centered care focus and team-focused environment.

Ultimately, the area of biggest concern is the gap between the ideal—a 10 score—and their feelings of satisfaction with their organization. Ranging from 3.0 to 4.3 points, there is considerable room for improvement.

Respondents were then asked to indicate the top three cultural attributes that were most important to them, and similarly, the three least important attributes to them. These results are given below:





The top three most important cultural attributes were also the only three that registered in the double digits in terms of overall scores, with the top attribute clearly preferred:

- Patient-centered care focus (18.8%)
- Respectful communication (10.5%)
- Team-focused environment (10.4%)

While these tracked generally with the overall satisfaction scores for the individual cultural attributes, the team-centered focus ranked sixth in overall satisfaction compared to third in the top three. The attribute around a supportive management approach to errors and mistakes tied for second in overall satisfaction, but ranked fourth in absolute terms, overall.

The three least important cultural attributes were:

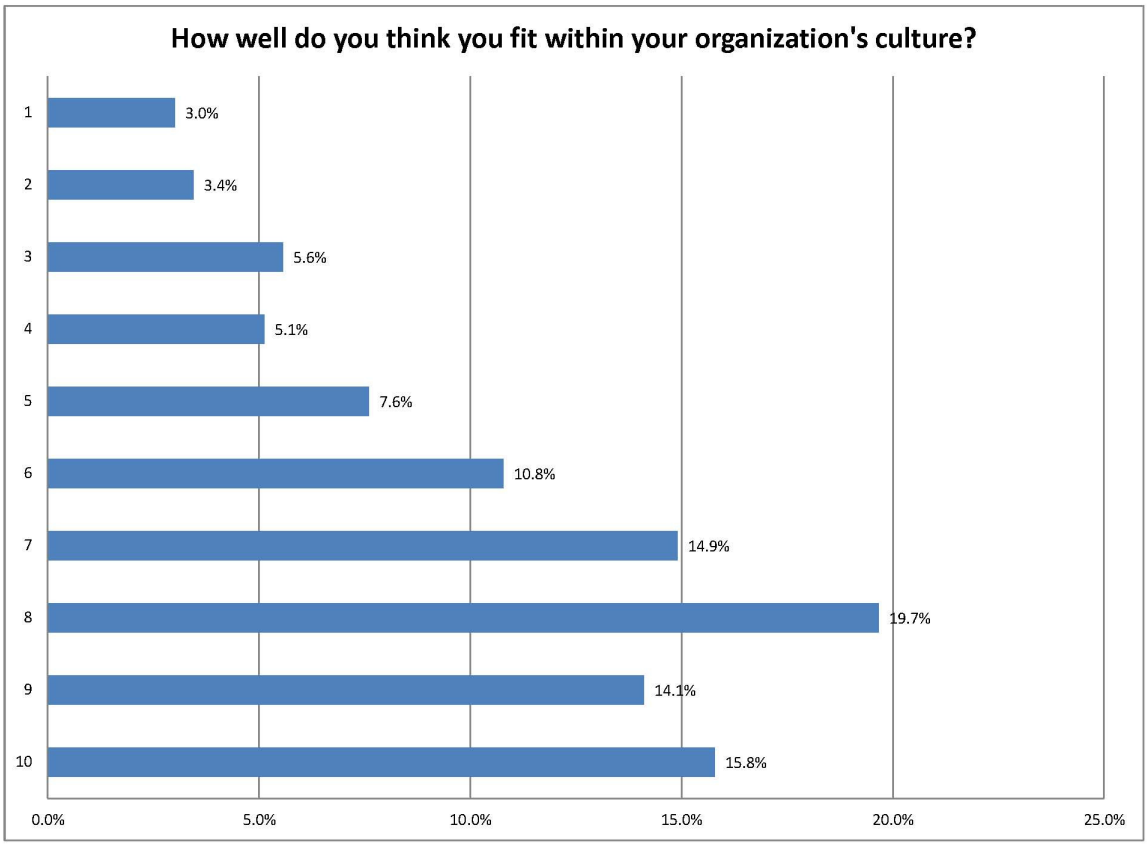
- Compensation plan alignment with mission and values (14.1%)
- Clear mission and values (11.6%)
- Objective performance evaluations (11.2%)

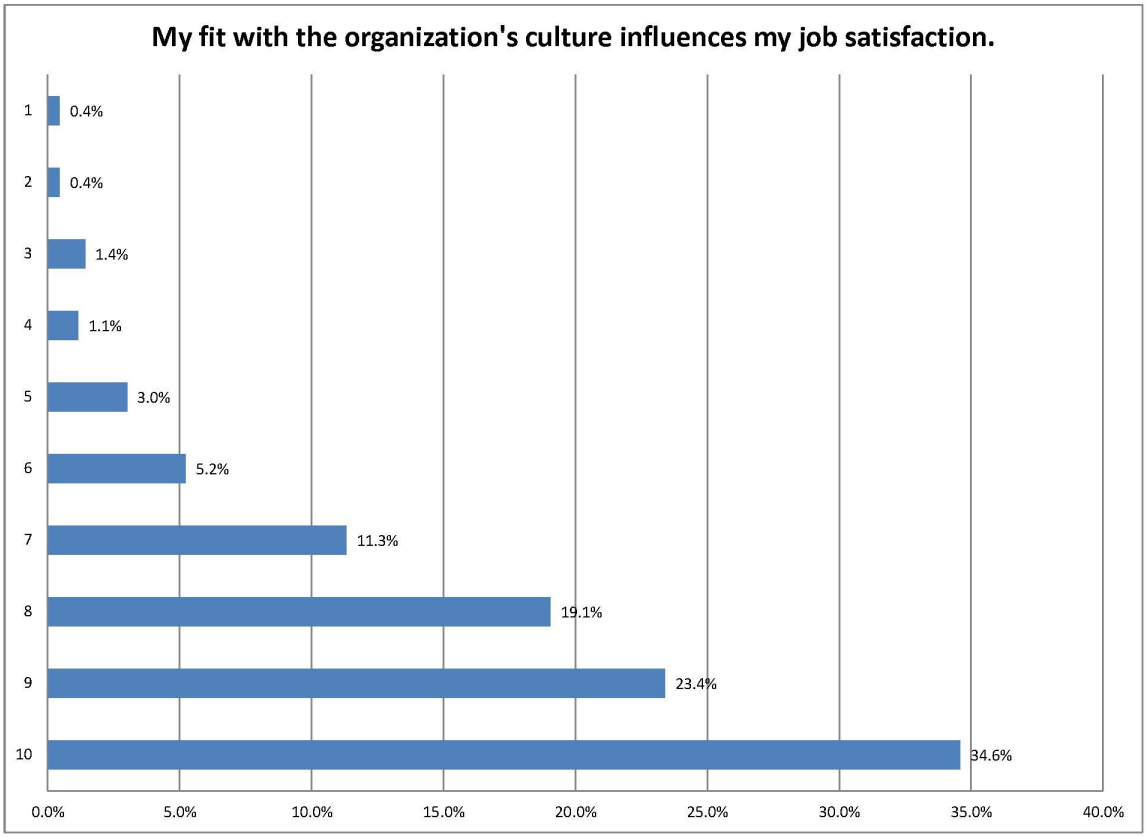
Again, these largely tracked with overall satisfaction scores. However, compensation plan alignment with mission and values ranked somewhat higher in the overall satisfaction scores, and innovative approach to care was third to the last.

Results: Cultural Fit

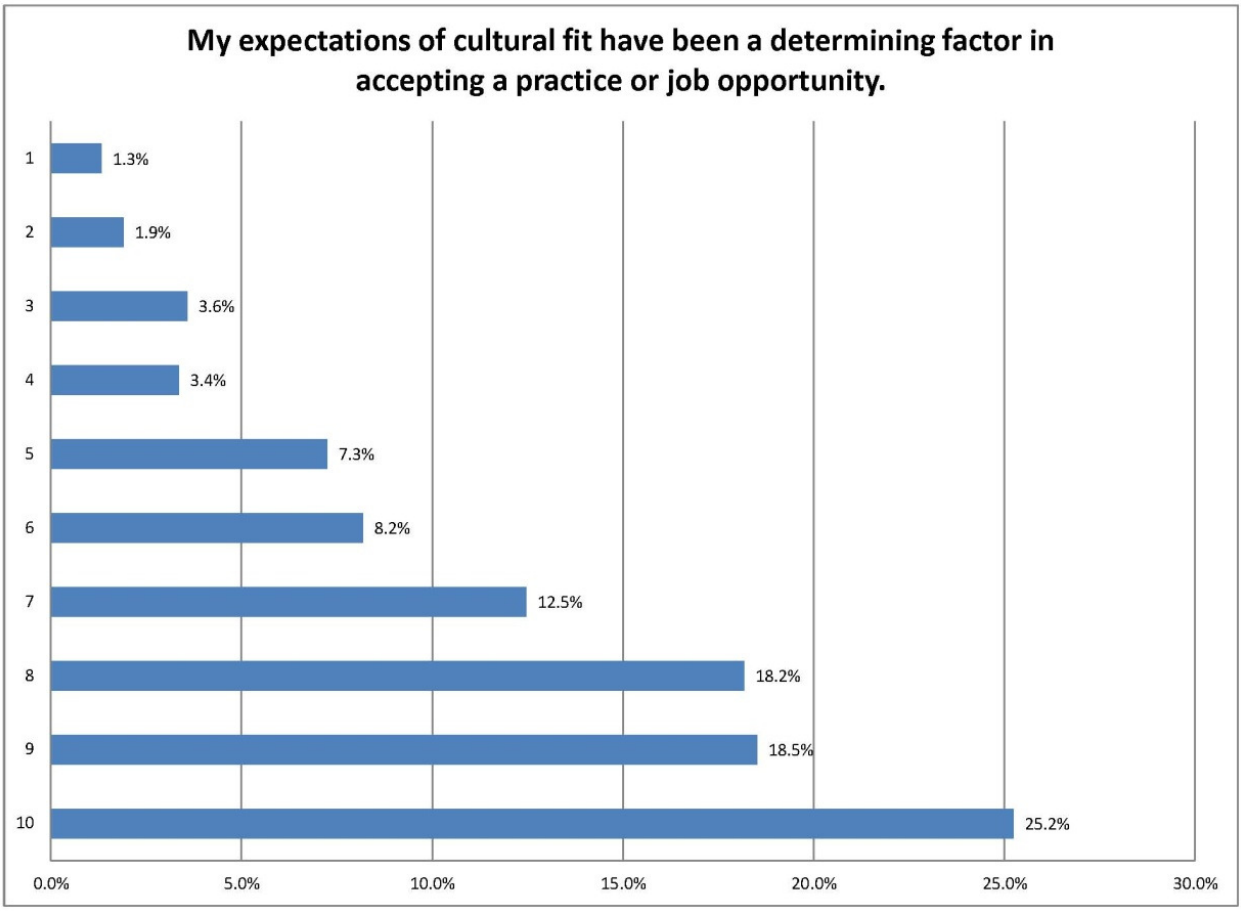
The final set of questions dealt with how well the respondents felt they fit within their current organizations, how it impacted their satisfaction, and whether issues of cultural fit had prompted them to leave a practice or job, or to accept other opportunities.

With regard to their own cultural fit, respondents scored 7.0 on average—at the high end of the mid-range. When asked about how cultural fit influenced their job satisfaction, the average score was a more robust 8.4, indicating that they clearly felt this was an important factor for them.

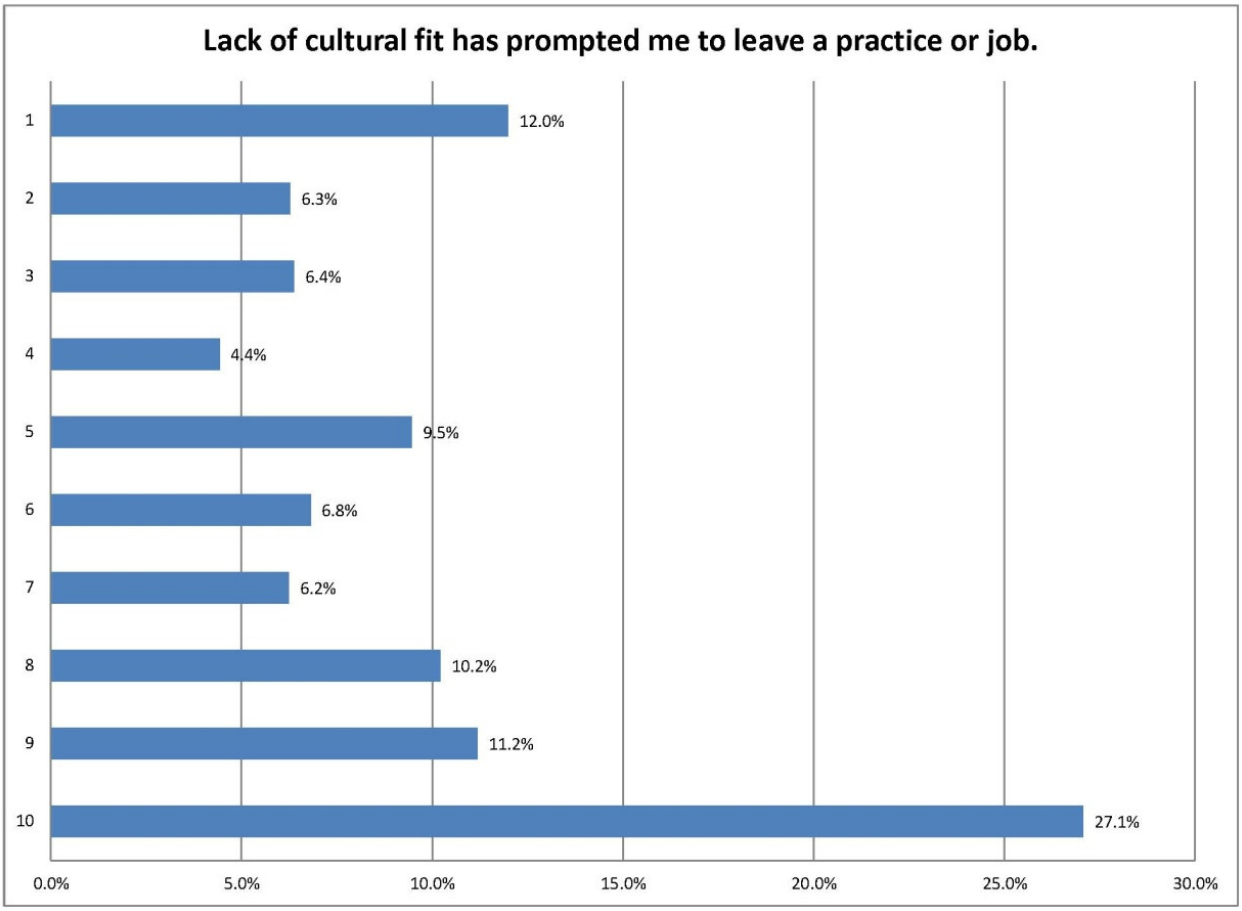




Ultimately, the influence of cultural fit on behavior is key. When asked if their expectations around cultural fit had been a determining factor in accepting a practice or job opportunity, the average score was 7.7, showing that cultural fit was a significant factor in evaluating prospective opportunities.



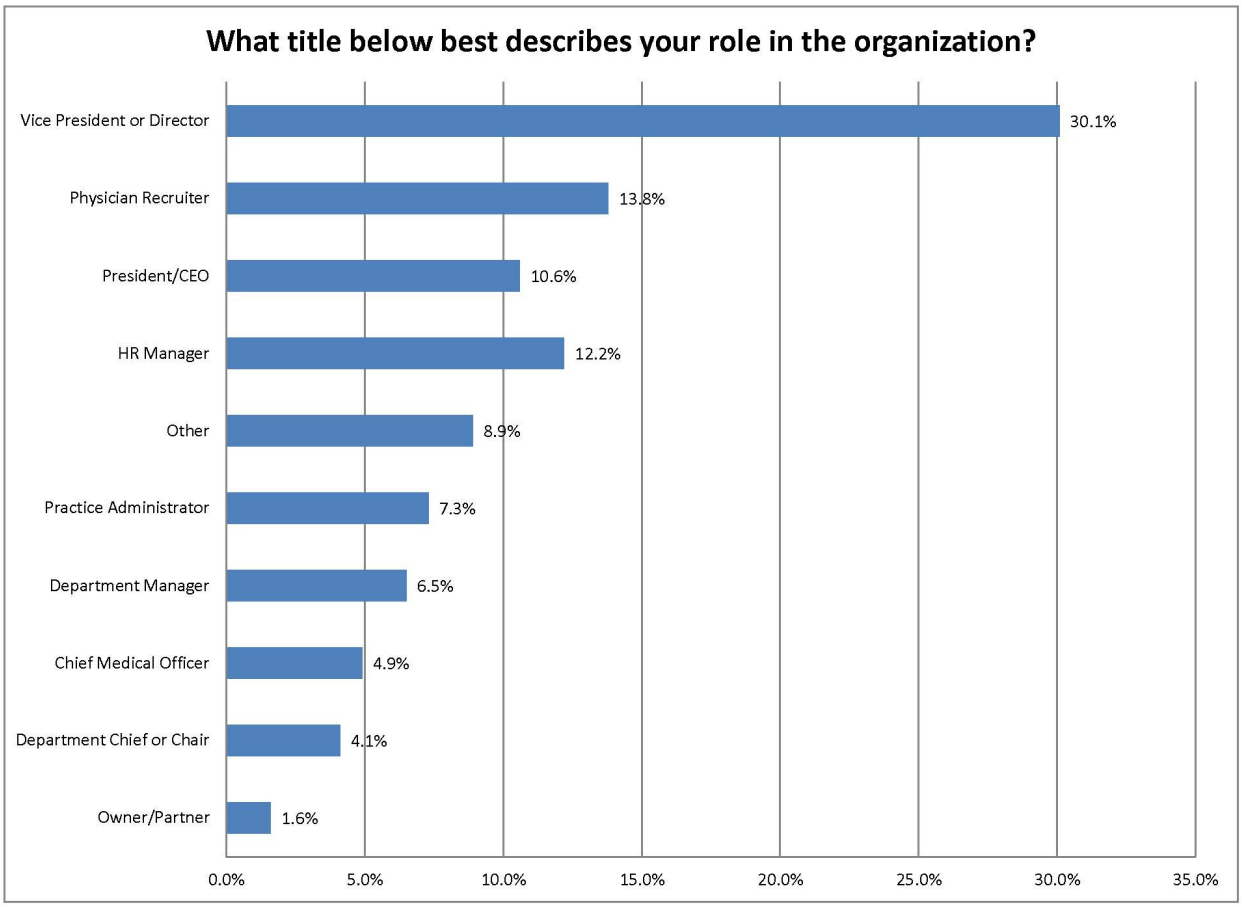
When asked if lack of cultural fit had prompted respondents to leave a practice or job, the score was 6.5. This number may be understated, given several of the comments in the open-ended questions (see Appendix A) indicating that some physicians wanted to leave, but stayed in their present job due to concerns around family and location preference, stage in their career, or economic concerns relating to the poor economy. Insofar as this result indicates that over 50% of respondents felt lack of cultural fit had a greater influence on their decision to leave than not, this is a significant finding.



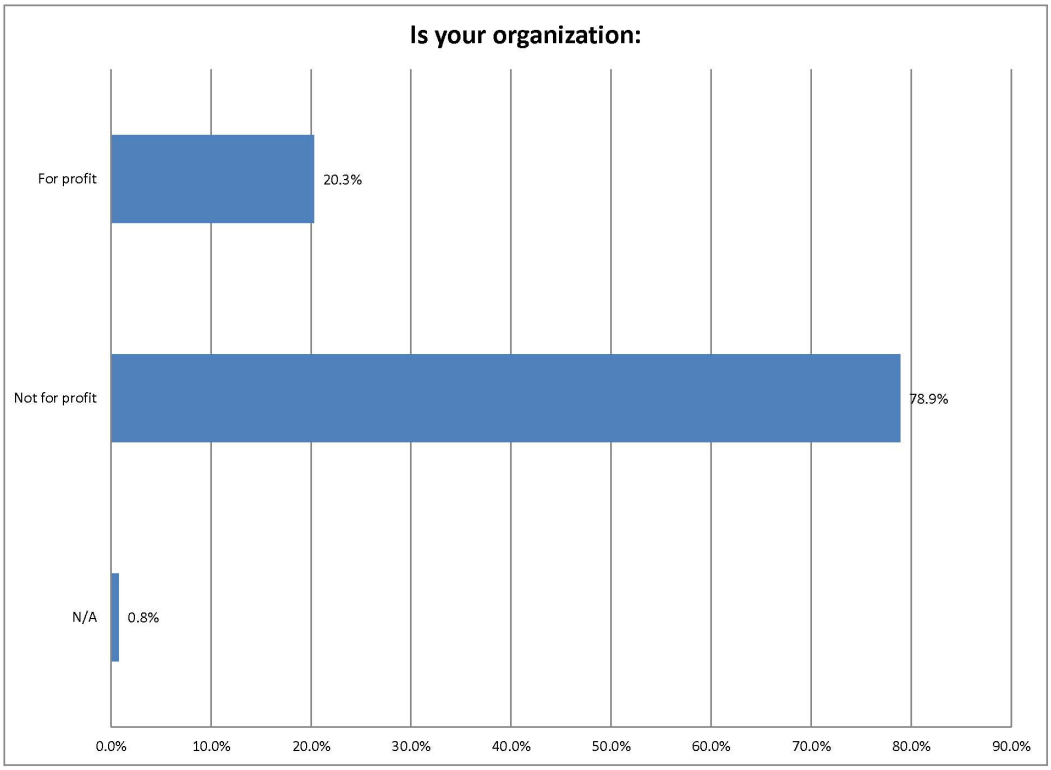
Survey Results—Administrators

Demographics

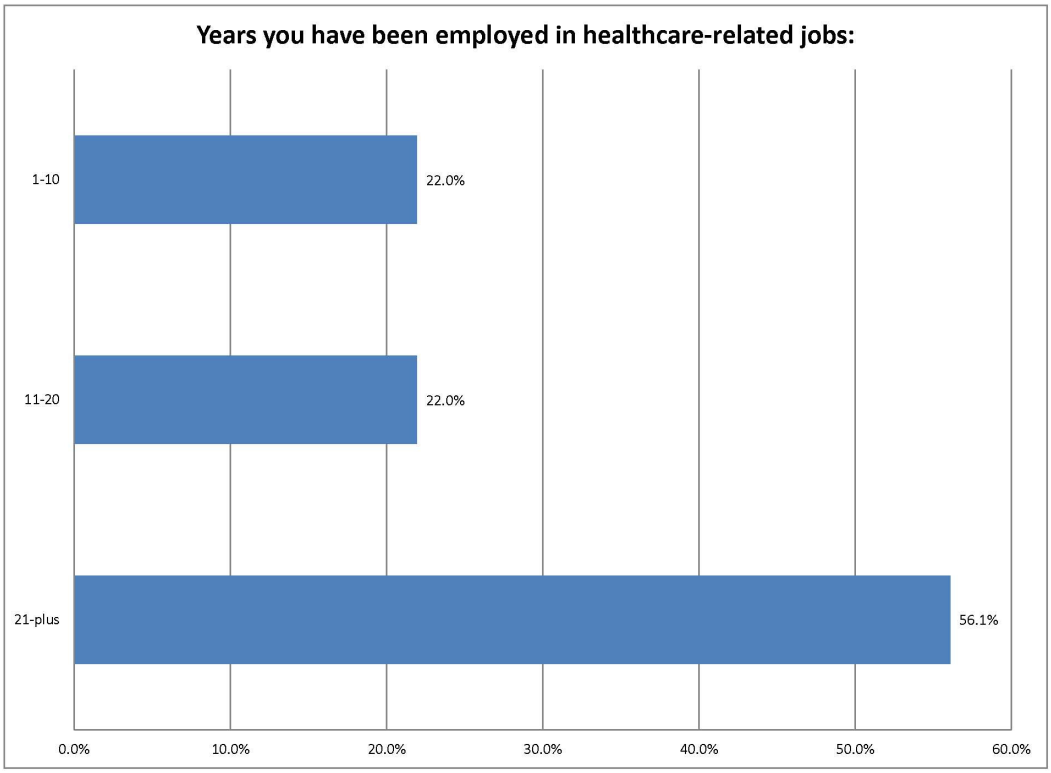
When asked for their role in their organizations, a plurality of respondents reported their title as Vice President or Director (30.1%), followed by Physician Recruiter (13.8%), HR Manager (12.2%) and President/CEO (10.6%).



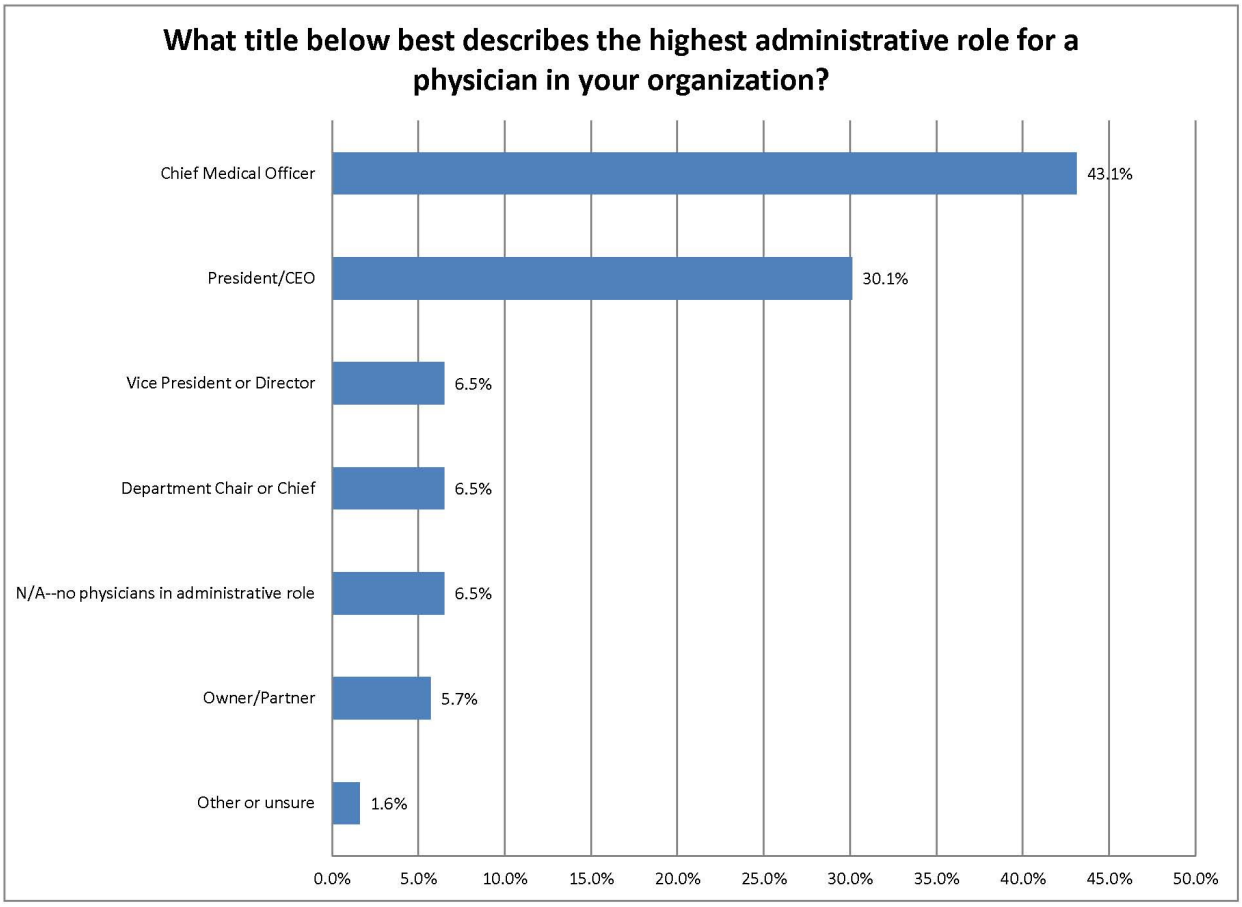
A plurality of the sample survey respondents were employed by hospitals (47.2%), followed by those who were with a health system (30.9%). There was a sharp drop to those who were in a multi-specialty practice (8.9%) or single-specialty practice (7.3%). A large majority worked in not for profit organizations (78.9%).



The average number of years in healthcare-related jobs for the survey respondent sample was 19.1 years.



We also asked the highest administrative role for a physician in their organization. Chief Medical Officer led with 43.1%, then President/CEO (30.1%). Only 6.5% indicated there were no physicians in an administrative role in their organization.



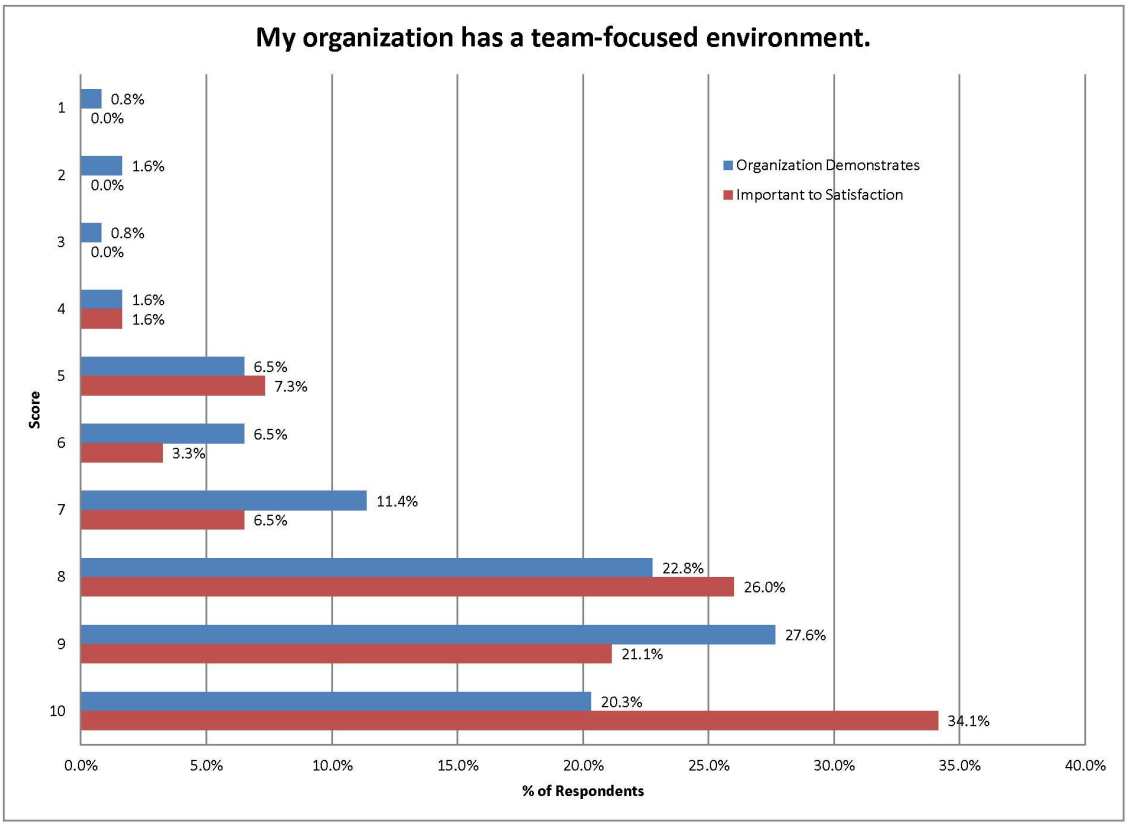
Results: Organizational Culture Attributes

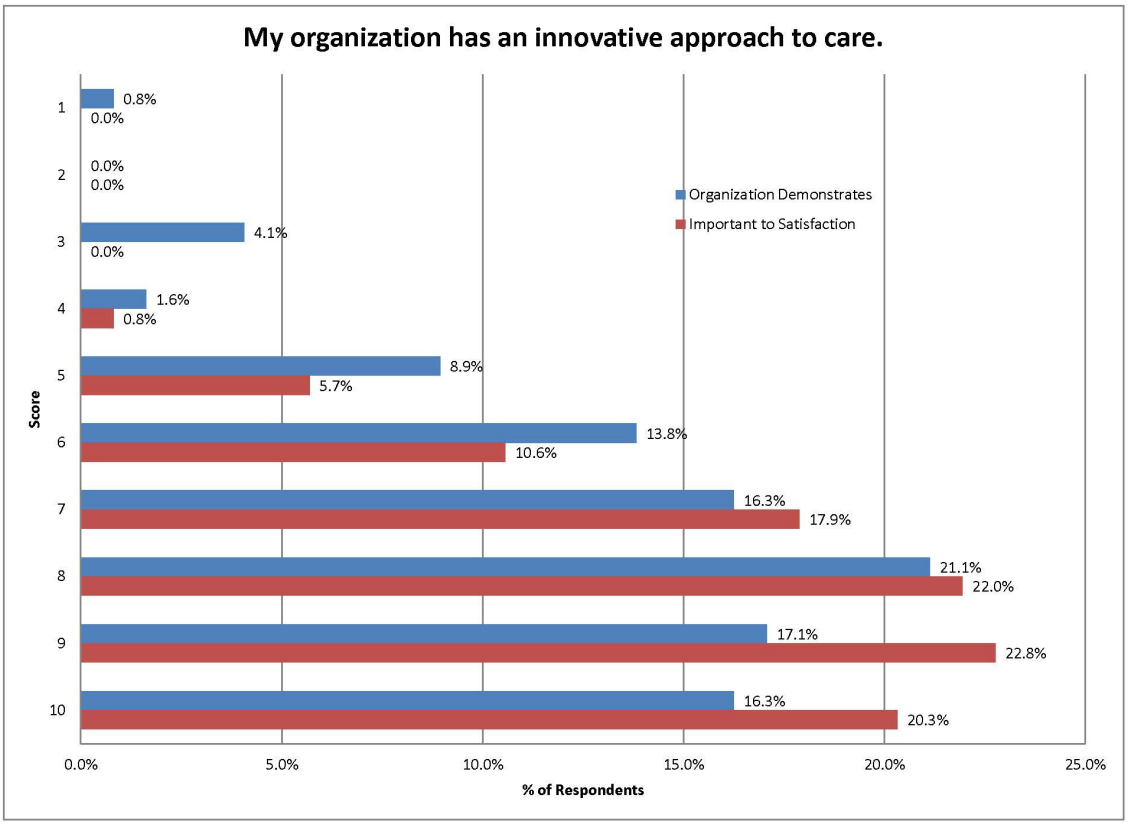
We asked for administrators to review the same 14 cultural attributes that were given to the physicians. For each attribute, they were asked two questions, scored on a 10-point Likert scale:

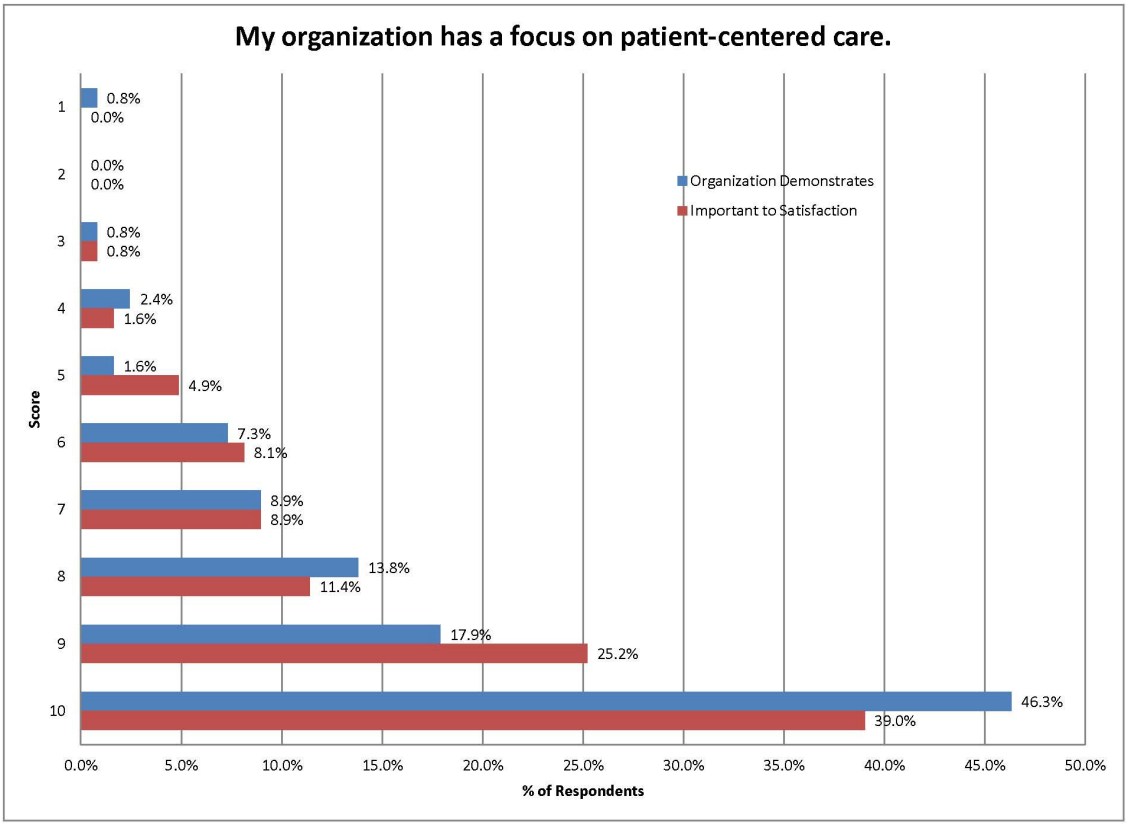
- To what degree they agreed or disagreed with a statement related to whether their organization demonstrated competence around the cultural attribute, e.g., "My organization has a team-focused environment." ("Organization Demonstrates" on charts)
- How important they felt this attribute was to their physicians' overall satisfaction, on a "Not at all important" to an "Extremely important" scale. ("Important to Satisfaction" on charts)

As with the physician survey, these fell into 4 major areas: work environment, organization, leadership and management, and communication. The results for each attribute are detailed below.

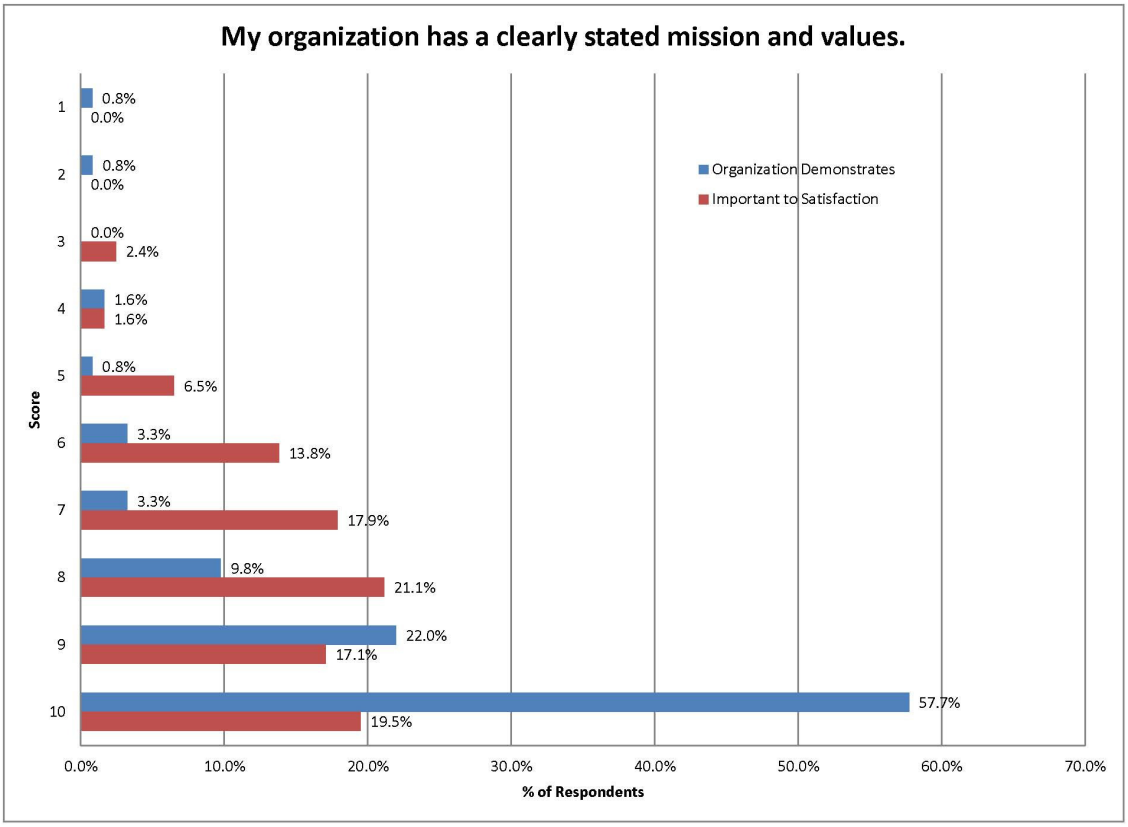
Work Environment:

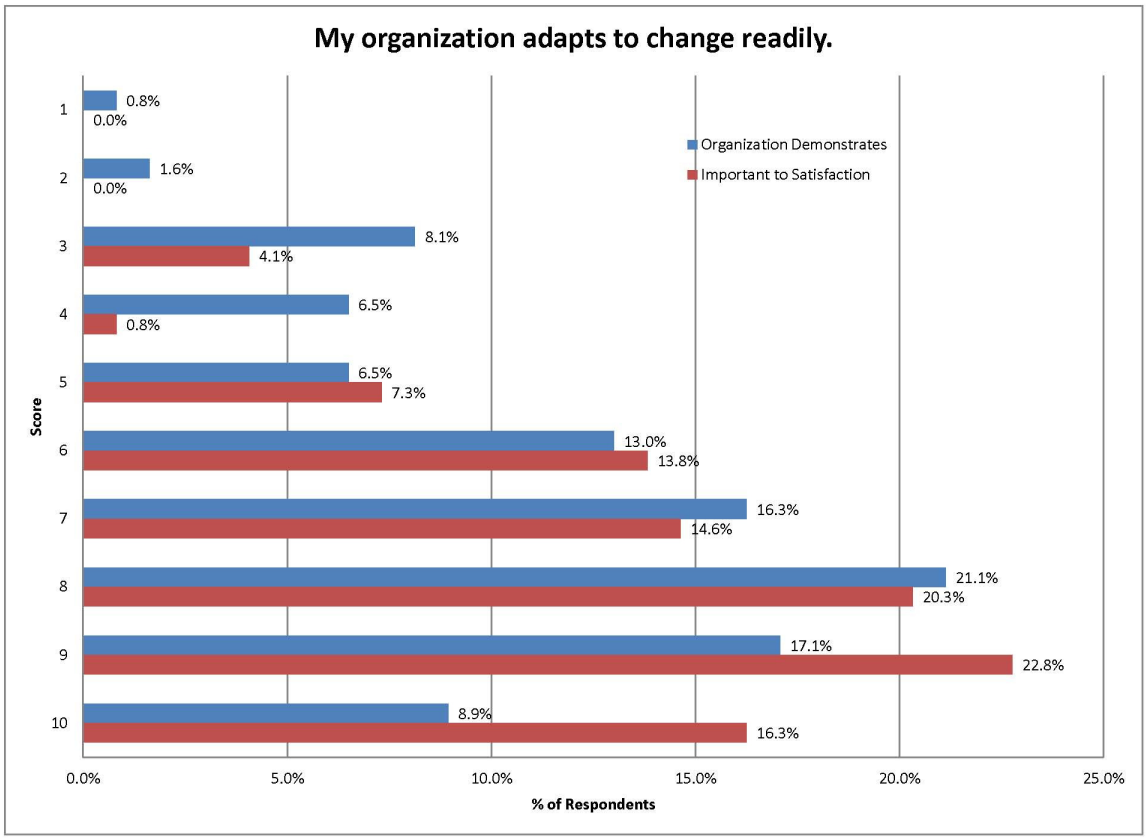


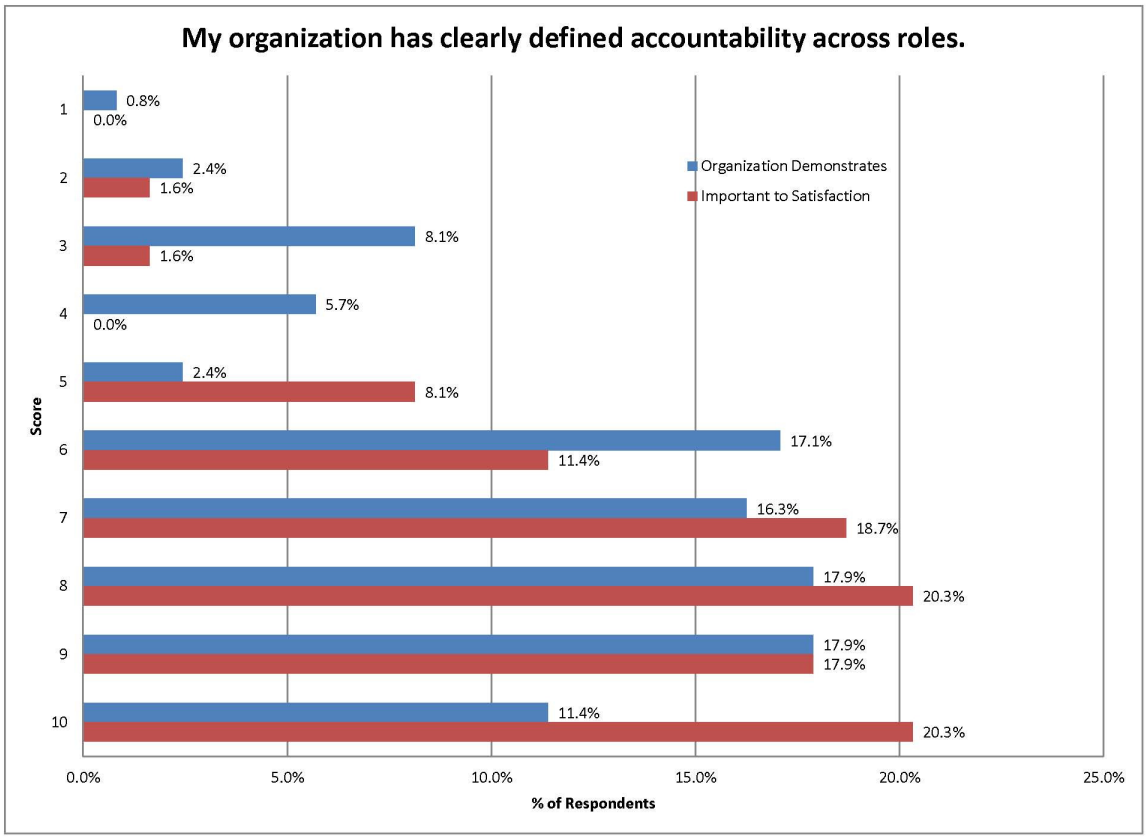




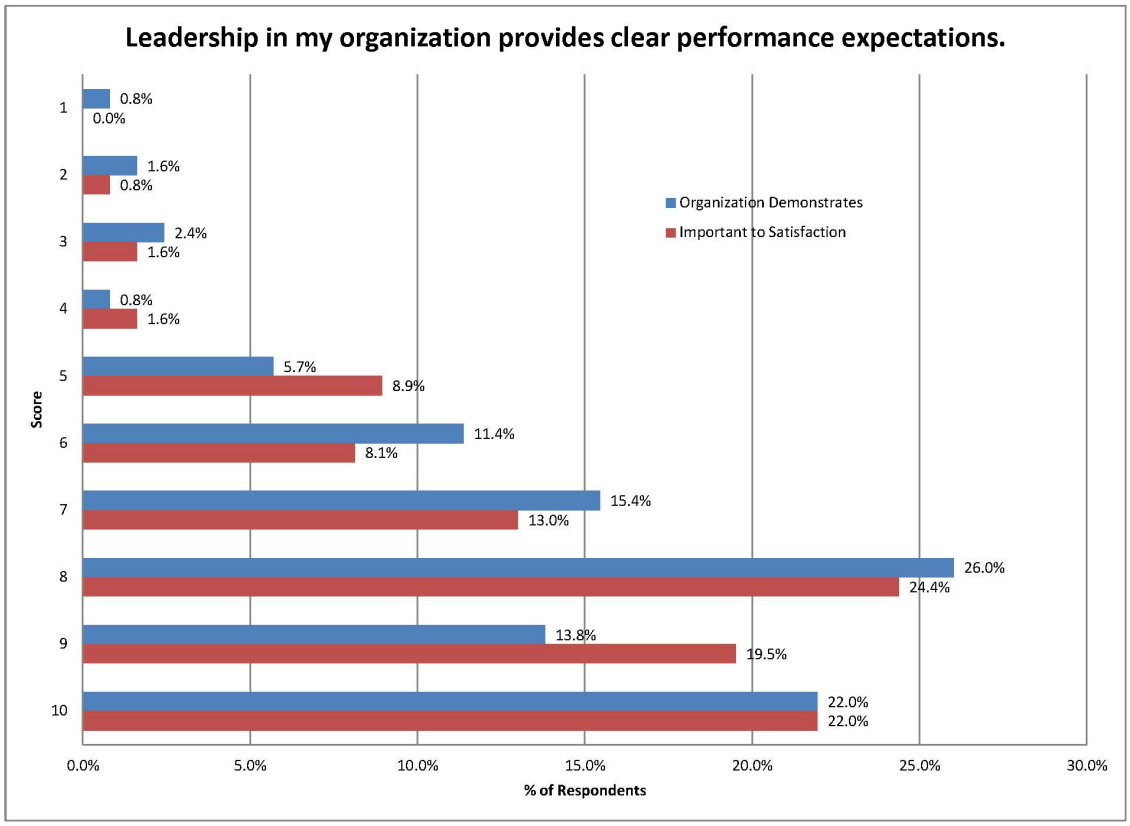
Organization:

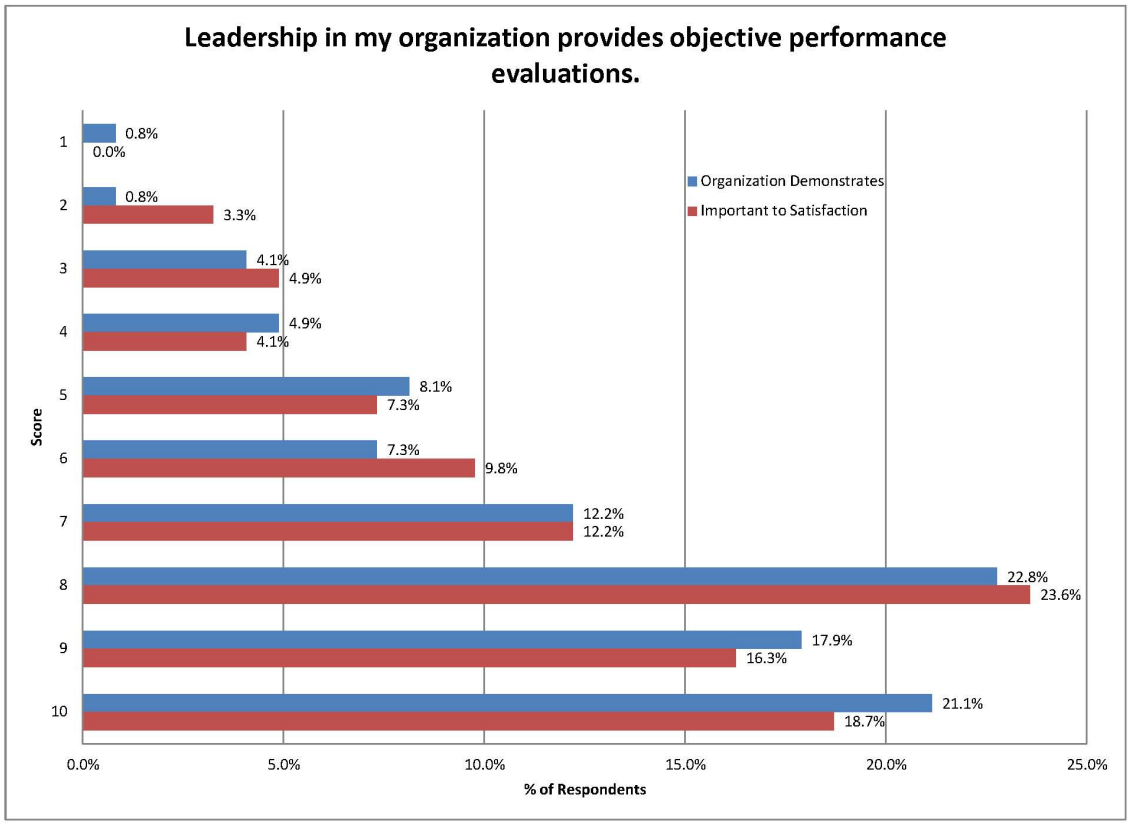


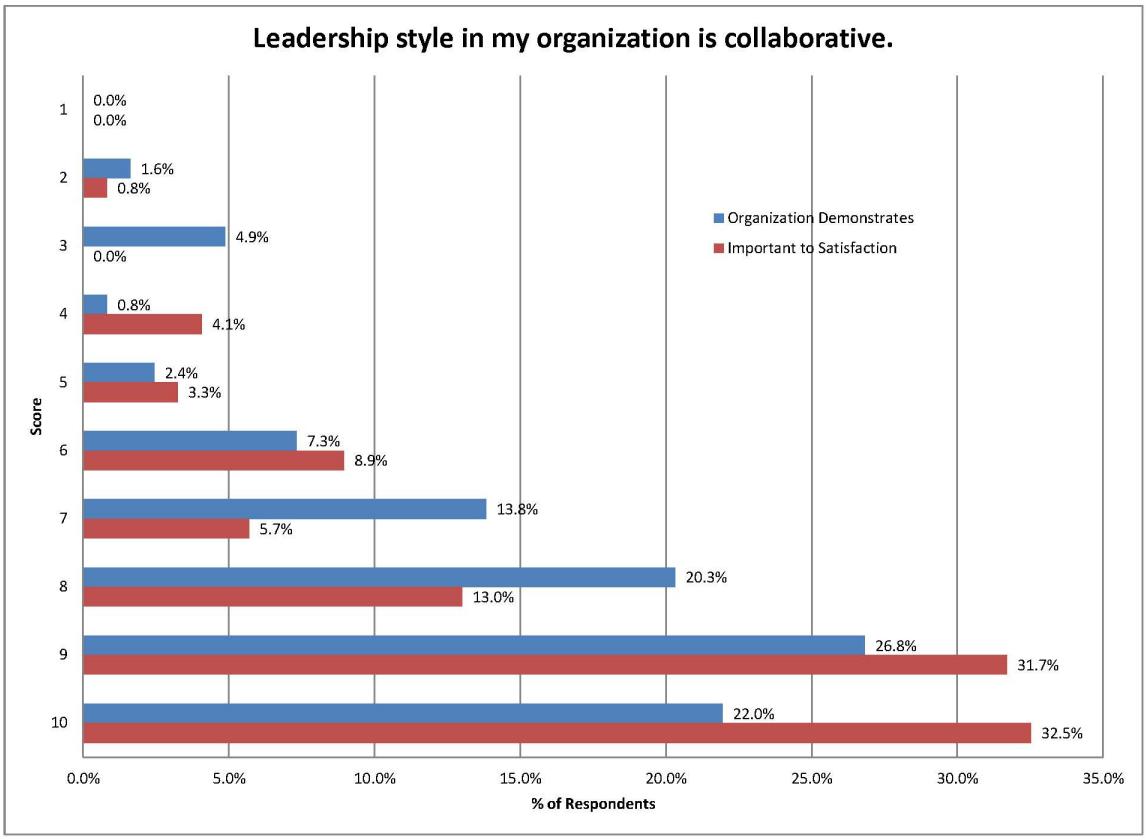


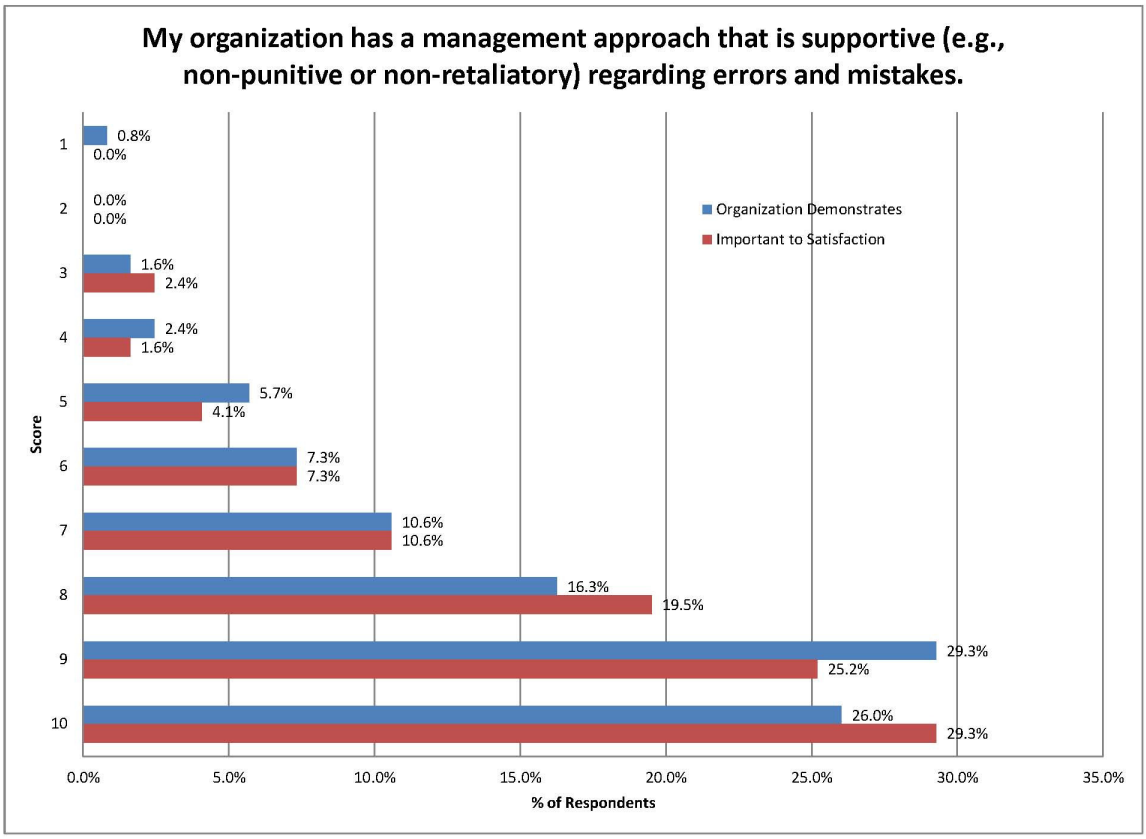


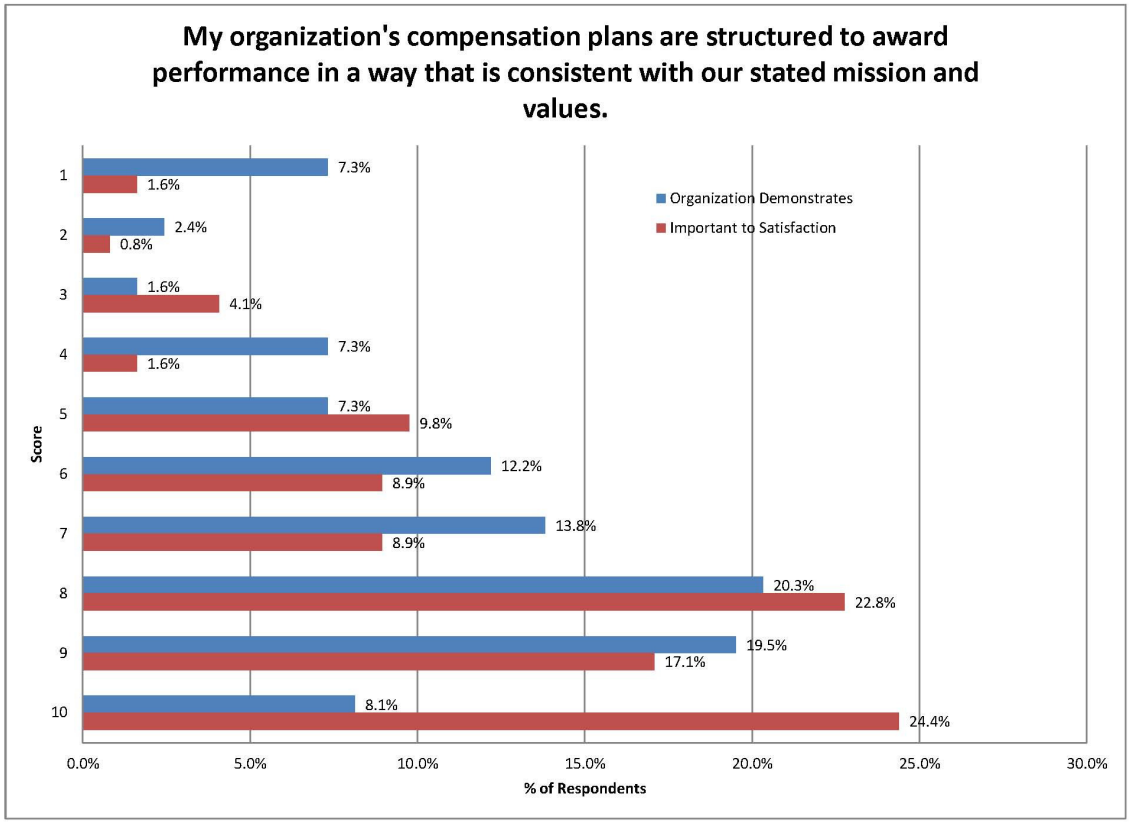
Leadership and Management:



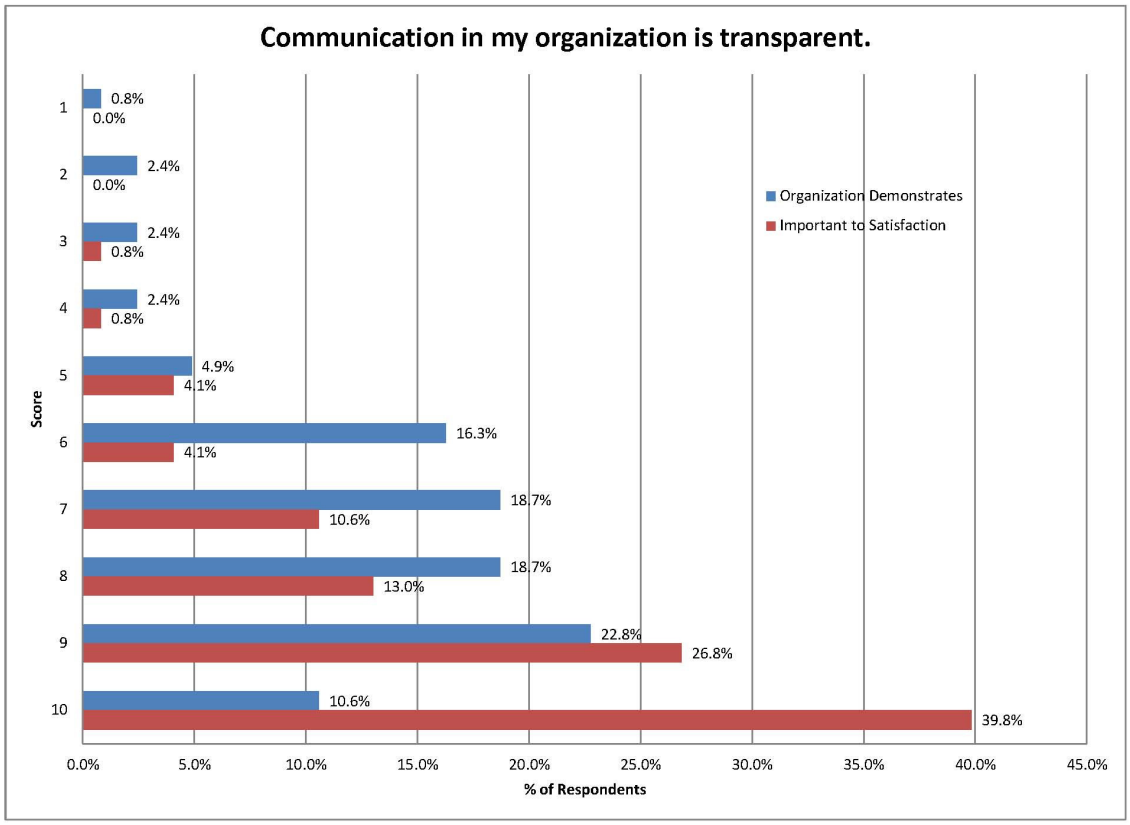


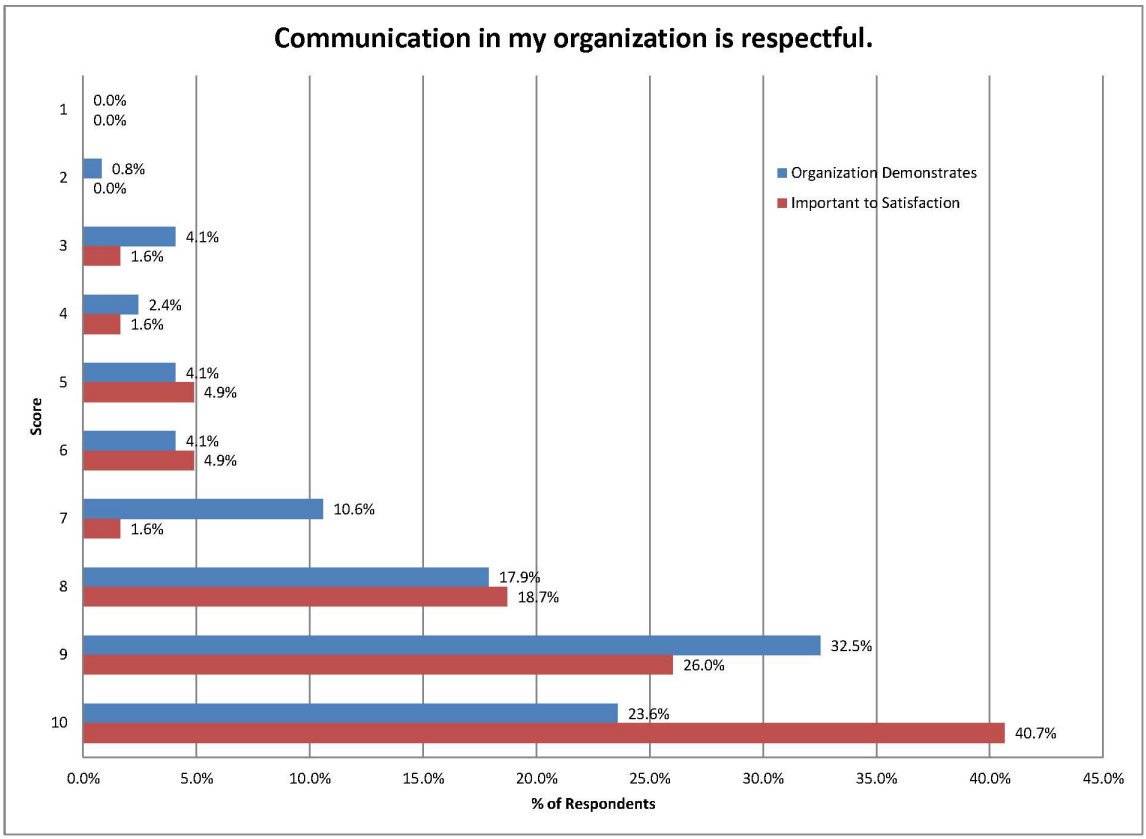


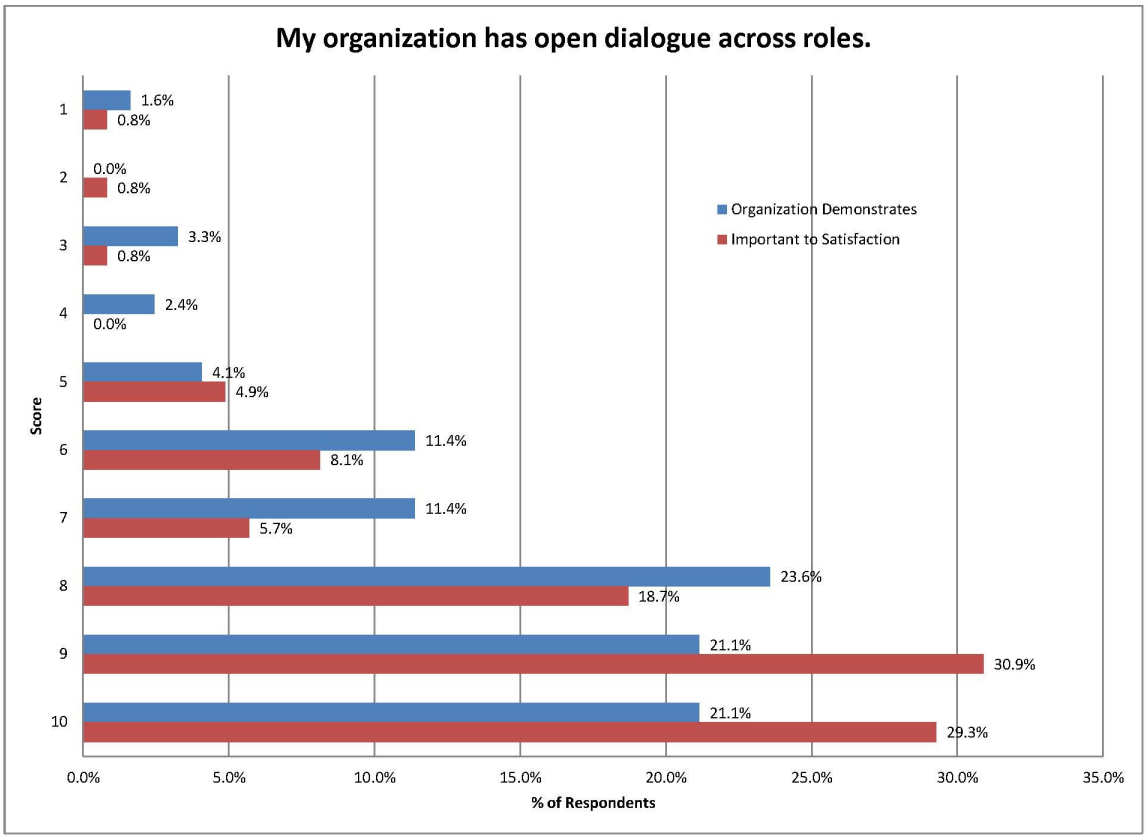




Communication:







The chart below details the average scores for each cultural attribute, in rank order according to their perceptions of importance to physicians' satisfaction.

	Administrators' Average Score:	
Cultural Attribute:	**Organization Demonstrates**	**Important to Satisfaction**
Respectful Communication	8.1	8.7
Transparent Communication	7.4	8.7
Patient-Centered Care Focus	8.6	8.5
Team-Focused Environment	8.0	8.5
Collaborative Leadership Style	8.0	8.4
Open Dialogue Across Roles	7.8	8.4
Supportive Management Regarding Errors and Mistakes	8.2	8.3
Innovative Approach to Care	7.5	8.0
Clear Perfomance Expectations	7.7	7.9
Clearly Defined Accountability Across Roles	7.0	7.7
Adapts to Change Readily	6.9	7.7
Clear Mission and Values	9.1	7.7
Compensation Plan Alignment with Mission and Values	6.7	7.7
Objective Performance Evaluations	7.6	7.4

Administrators were, for the most part, in tune with the contribution of the cultural attributes to physicians' overall satisfaction. Their average scores ranged from 7.4 to 8.7, almost identical to the range for physicians of 7.4 to 8.6. There were slight differences in the top-ranked attributes, however.

The top cultural attributes were:

	Score/Rank, Contributes to Overall Satisfaction:	
Cultural Attribute:	**Physicians**	**Administrators**
Respectful Communication	8.6 (1)	8.7 (1)
Patient-Centered Care Focus	8.5 (2)	8.5 (3)
Supportive Management Regarding Errors and Mistakes	8.5 (2)	8.3 (7)
Transparent Communication	8.4 (4)	8.7 (1)
Team-Focused Environment	8.2 (5)	8.5 (3)

The least important were objective performance evaluations (7.4 average score for both), clear mission and values (7.5 for physicians, 7.7 for administrators) and innovative approach to care (7.9 for physicians, 8.0 for administrators, although 7th from the bottom in rank).

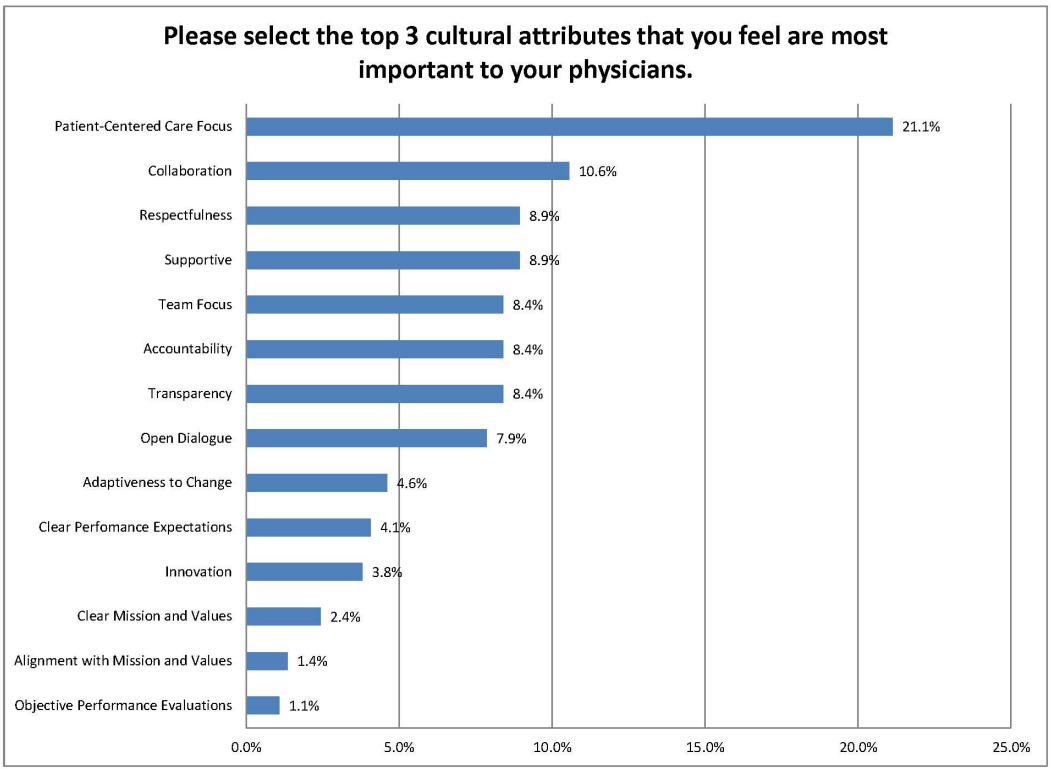
A different picture emerges with respect to the question about the degree to which organizations demonstrated competence with regard to the cultural attributes. As noted earlier, physician respondents were generally only moderately satisfied with how well they felt their organizations

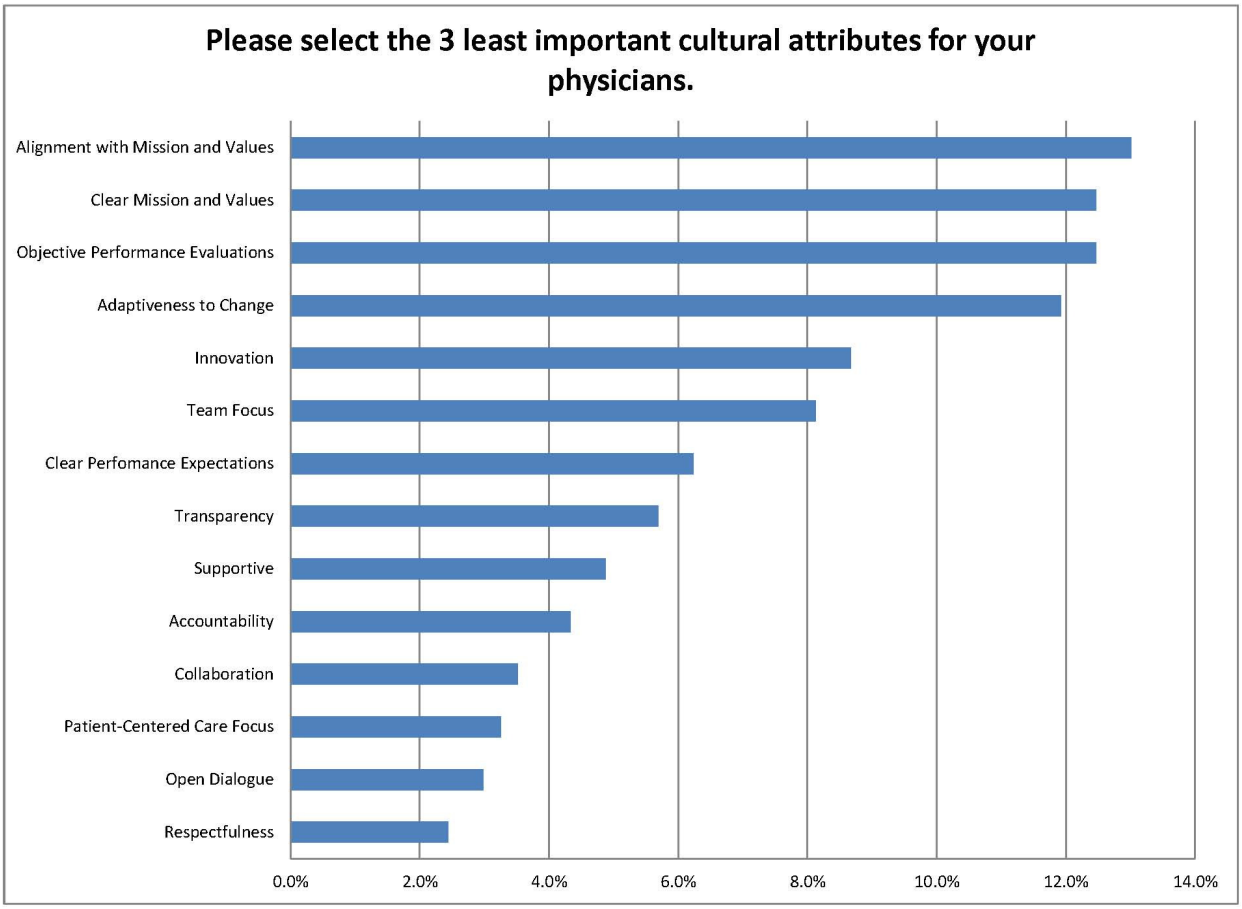
demonstrated competence around the cultural attributes, with average scores ranging from 5.8 to 7.6. Administrators were more positive in their assessment of their organizations' competence on cultural attributes, with scores ranging from 6.9 to 9.1. The top three cultural attributes for physicians were close in ranking to those of administrators (i.e., supportive management approach to errors and mistakes was third-ranked for administrators at an 8.2 score), but they were farther apart in scores:

	Score/Rank, Organization Demonstrates Competence:	
Cultural Attribute:	**Physicians**	**Administrators**
Patient-Centered Care Focus	7.6 (1)	8.6 (2)
Clear Mission and Values	7.6 (1)	9.1 (1)
Respectful Communication	7.2 (3)	8.1 (4)

The lowest scores were different, as well, although the rankings were, again, close. Ranking last for physicians was transparent communication (5.8 score/14 rank for physicians vs. 7.4 score/11 rank for administrators). Adapts to change readily and compensation plan alignment with mission and values scored 6.0 each and tied for second to the last place for physicians. Administrators scored and ranked them at 6.9/13 and 6.7/14, respectively.

As with the physicians, administrators were then asked to indicate the top three cultural attributes that they felt were most important to their physicians, as well as what they felt were the three least important attributes to them. These results are given below:





The top three cultural attributes in absolute terms differed between physicians and administrators:

	Rank, Top 3 Cultural Attributes:	
Cultural Attribute:	**Physicians**	**Administrators**
Patient-Centered Care Focus	1	1
Respectful Communication	2	3
Team-Focused Environment	3	5

The three least important cultural attributes were identical for both physicians and administrators, as well:

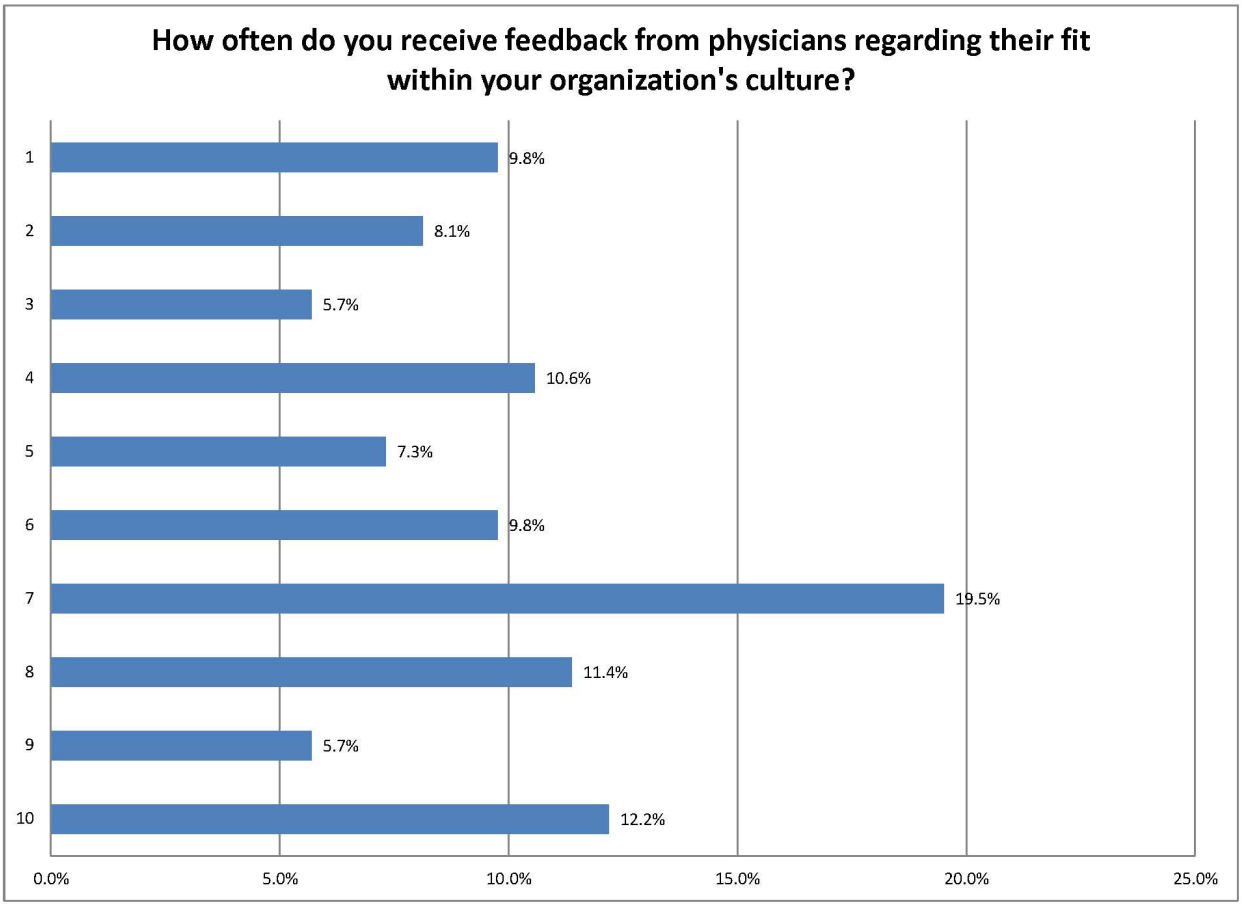
- Compensation plan alignment with mission and values
- Clear mission and values
- Objective performance evaluations

Results: Cultural Fit

The final set of questions somewhat paralleled those asked of physicians, dealing with cultural fit, but from the perspective of how well they felt the cultural fit was between their physicians and their

organizations, if they received feedback about it, and how it impacted retention and recruitment of physicians.

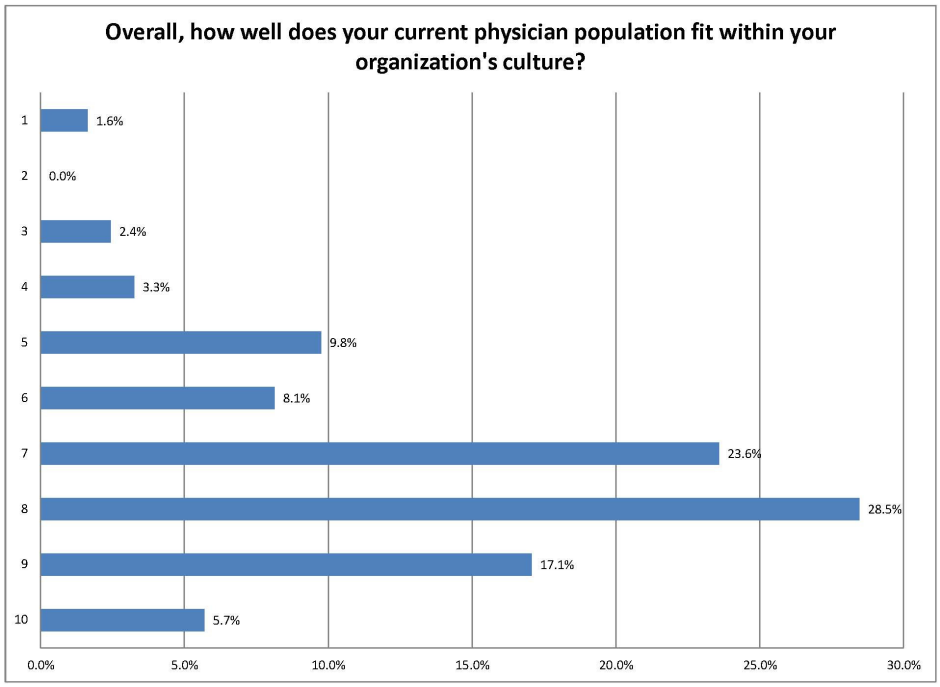
The first question in this series asked how often administrators received feedback regarding their fit within the organization's culture.



Despite indications from physicians' responses about their own organizational fit, and the importance of all of the cultural attributes to their satisfaction, the average score for this question was only 5.8. This is surprising, given that culture and cultural fit is important to physicians.

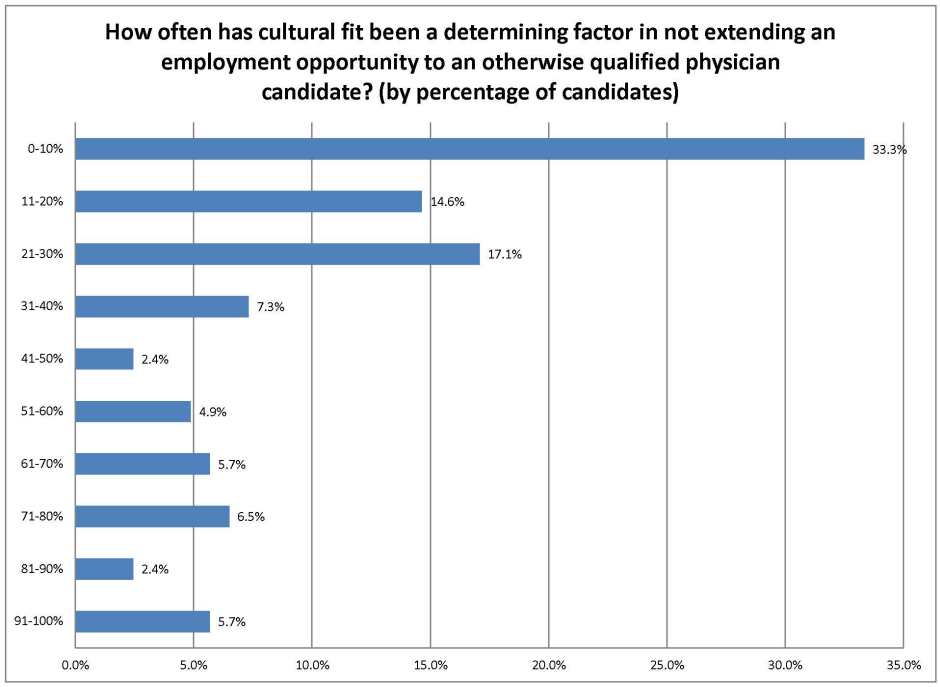
There are a number of possible reasons for this, starting with fear of being ignored, or of a negative impact to their jobs and thus, reluctance to discuss this issue with administration. This theory ties into their generally low scores around transparent communications as an attribute they're satisfied with within their organization. Alternatively, it could be due to not knowing how to frame the issue; as some noted in the comments, the survey often helped them by articulating issues they had felt, but couldn't specifically identify. Additionally, it could also be lack of opportunity or perceived opportunity to provide such feedback such as exit interviews.

The next question was how well administrators felt the cultural fit was between their current physicians and the organization.



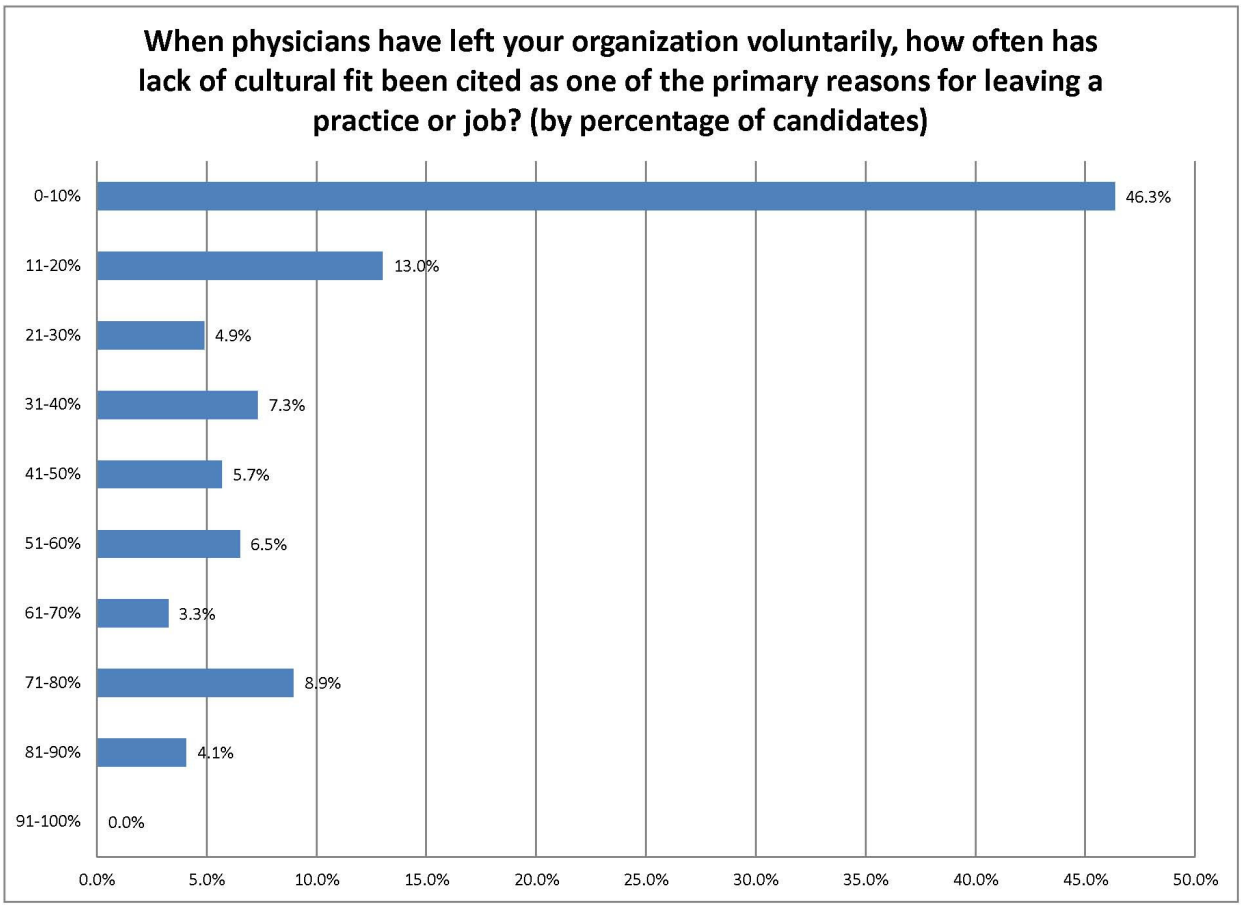
Administrators gave an average score of 7.2 regarding the cultural fit between their current physician population and the organization. This tracked very closely with physicians' self-identified cultural fit at 7.0. This is far from the ideal score of 10, showing much room to improve cultural fit.

The next question was if lack of cultural fit had been a determining factor for respondents in not extending an employment offer to an otherwise qualified physician candidate. Administrators were asked to respond based on the percentage of times they estimated this had happened.



This occurred 36% of the time, on average, based upon the responses. Several of the comments by administrators (see Appendix B) noted how important cultural fit was for them in assessing candidates, with some noting, however, that assessment was often a difficult thing to achieve.

The last question addressed the other side of the employment equation—how often cultural fit had been cited by voluntarily departing physicians as a primary reason for leaving a practice or job. Again, administrators were asked to respond based on the percentage of times they estimated this had happened.



This was a factor 32% of the time, according to administrators. In comparison, physicians' response to the question regarding their agreement or disagreement about whether lack of cultural fit had prompted them to leave a practice or job showed an average score of 6.5, indicating that more than 50% felt this was the case. While the scales used for these questions are not the same, it would appear that there is a substantial gap between what physicians and administrators feel the impact is of cultural fit on decisions by physicians to depart their jobs or practices.

Discussion

The survey results point to the importance of organizational culture as a key issue for physicians in their work lives, and as a primary factor in their evaluations of potential employers as well as in decisions regarding their tenure with their employers.

With regard to the cultural attributes presented in the survey, all were deemed important to physicians' overall satisfaction—with one exception, the average scores were in the uppermost quartile of scoring. This was also true of the administrator respondents. As noted earlier, several from both groups commented to that effect, and when forced to pick the three most and least important cultural attributes, many said this was difficult to do.

Key observations we can draw from the survey findings are as follows:

1. **There is a sizable gap between physicians' expectations and their reality regarding organizational culture as they perceive it.** This is demonstrated in the chart (below) which outlines the gaps between:
   A. How important a cultural attribute is to physicians for their overall satisfaction vs. how they perceive that their organizations demonstrate competence regarding this attribute (reality)
   B. How important a cultural attribute is to physicians for their overall satisfaction vs. how satisfied they are with their organization's focus on this attribute (expectation)
   C. How important a cultural attribute is to physicians for their overall satisfaction vs. the ideal (i.e., a 10 score on the Likert scale)

	Score Gap, Physicians, 10-Point Scale (Top 3 Rank Order)		
Cultural Attribute:	**A) Demonstrates vs. Importance**	**B) Org. Satisfaction vs. Importance**	**C) Org. Satisfaction vs. Ideal (10)**
Patient-Centered Care Focus	(0.9)	(1.5)	(3.0)
Respectful Communication	(1.4)	(1.7)	(3.1)
Team-Focused Environment	(1.4)	(2.0)	(3.8)
Supportive Management Regarding Errors and Mistakes	(1.9)	(1.8)	(3.3)
Collaborative Leadership Style	(2.1)	(2.2)	(4.0)
Clearly Defined Accountability Across Roles	(1.7)	(2.0)	(3.9)
Adapts to Change Readily	(2.1)	(2.1)	(4.0)
Transparent Communication	(2.6)	(2.7)	(4.3)
Clear Performance Expectations	(1.4)	(1.8)	(3.8)
Innovative Approach to Care	(1.5)	(1.6)	(3.8)
Open Dialogue Across Roles	(1.9)	(2.0)	(3.7)
Clear Mission and Values	0.1	(0.7)	(3.2)
Objective Performance Evaluations	(1.3)	(1.4)	(4.0)
Compensation Plan Alignment with Mission and Values	(2.0)	(2.0)	(4.0)

Column C represents the ideal which, it can be argued, is what the real expectation is, not tempered by considerations such as an inherent questions or doubts about the ability of the organization to deliver, regardless of limitations around staff, money, politics and other variables. The question for organizations is if they want to strive to meet expectations—or exceed them.

Clear mission and values is the only attribute where reality meets or exceeds the expectation. However, based upon the rankings of importance, it is very near the bottom of what is important to physicians.

2. **Administrators essentially understand the degree to which specific cultural attributes are important to physicians' overall satisfaction, and their relative importance, but tend to overstate how well their organizations demonstrate competence on those attributes.** This is illustrated in the chart (below) which outlines the gaps between the perceptions of physicians vs. administrators with regard to:
   A. How well the organization demonstrates competence regarding this cultural attribute
   B. How important a cultural attribute is to physicians for their overall satisfaction

	Score Gap, Physicians vs. Administrators, 10-Point Scale	
Cultural Attribute:	**A) Organization Demonstrates**	**B) Importance to Satisfaction**
Patient-Centered Care Focus	(1.3)	0.0
Respectful Communication	(0.9)	0.3
Team-Focused Environment	(1.2)	0.3
Supportive Management Regarding Errors and Mistakes	(1.6)	(0.2)
Collaborative Leadership Style	(1.9)	0.2
Clearly Defined Accountability Across Roles	(0.6)	(0.4)
Adapts to Change Readily	(0.9)	(0.4)
Transparent Communication	(1.6)	0.3
Clear Performance Expectations	(1.1)	(0.1)
Innovative Approach to Care	(1.1)	0.1
Open Dialogue Across Roles	(1.4)	0.1
Clear Mission and Values	(1.5)	0.2
Objective Performance Evaluations	(1.5)	0.0
Compensation Plan Alignment with Mission and Values	(0.7)	(0.3)

There is no cultural attribute where physicians and administrators were in total agreement about how well their organizations demonstrated competence. This represents an inherent barrier to reaching cultural congruence, if there is disagreement about how well the organization is meeting expectations. However, in most cases administrators over-projected the importance of a cultural variable to physicians compared to physicians, themselves. This is a positive sign, in that administrators generally have some level of empathy and understanding for what motivates physicians, even with minor variations, as discussed earlier, in relative levels of priority.

3. **What's important? It's all important.** As noted earlier, on a 10-point Likert scale, all the cultural attributes were important to physicians' overall satisfaction, with all but one average score in the top quartile (and the remaining one was just below that). All but 3 attributes scored at or above 8.0. After a patient-centered care focus, which was at the top, the rest of the attributes are clustered in terms of importance to overall satisfaction.

In our experience, there is no perfect or ideal culture—each is unique. There are some themes that emerged, however, based upon the overall importance to satisfaction scores, which were scored independently of each other vs. the forced rankings of the top and bottom three attributes questions:

- Communication is key. Respectful (8.6—the highest score), transparent (8.4) and with an open dialogue across roles (8.3); these are all hallmarks of what should be the starting point of any organizational culture initiatives. Indeed, we have found that nothing can happen without effective, honest communication. In terms of gaps between what physicians feel drives their overall satisfaction and how satisfied they are with their organization's focus, respectful communication shows the smallest gap at 1.7 points, but transparent communication shows the biggest gap at 2.7 points, with open dialogue between roles at 2.0 points.
- A supportive management approach to errors and mistakes is very important. At a score of 8.5, it ties into some of the dynamics we see with organizations, and the fears expressed by physicians when we speak to them individually. At a time of rapid change and increased pressures in healthcare, physicians not feeling supported in this as part of the culture could be a barrier, with the obvious point that patient safety always needs to come first.
- A patient-centered care focus is equally important to physicians. While it was critical for physician satisfaction with an average score of 8.5, physicians' satisfaction with their organization's focus on this averaged just 7.0. There may be several reasons for this, but there may be fundamental differences on what this attribute means to different stakeholders in the organization.

4. **Cultural fit is a prime driver of physician satisfaction and dissatisfaction with their jobs.** Physicians rated the importance of cultural fit at an average of 8.4 in terms of its importance to their job satisfaction, but only 7.0 in terms of their perceived cultural fit in their jobs. Administrators scored 7.2 on the question of their current physicians' cultural fit. Is that where your organization wants them to be?

   Almost half (48.5%) of physicians responded with a score of 8, 9 or 10 that a lack of cultural fit prompted them to leave a practice and almost two-thirds (62.2%) likewise said that their expectation of cultural fit was a determining factor in their accepting a practice opportunity. So, it's a significant factor for most of the respondents to this survey.

   Organizations that do not accurately assess cultural fit in candidates, positively convey their practice culture, and then support the enculturation of newly recruited physicians place themselves at a significant recruitment disadvantage and risk for turnover.

   This is likely to be the case, given the fact that a) 65.0% of administrators believe that culture is a determining factor in a physician selecting their practice in fewer than 30% of instances; and b) 64.2% of administrators believe that physicians leave due to cultural fit in fewer than 30% of voluntary departures.

Turnover and prolonged vacancy can cost a practice upwards of $100,000, when all recruiting expenses and human resource costs are combined with the investment in practice start-up costs and lost revenue during the vacancy.[4] Given the importance that physicians place on cultural fit in their decision to join—or leave—a practice, organizations should address cultural fit on a continuous basis: before, during and long after the recruitment process is complete.

Turnover among physicians in the first three years with a practice averaged 14.3%[5], which represents an operational and financial cost that few practices can afford. The return on investment available through an effective recruitment assessment, onboarding and mentoring program can pay dividends.

It's clear that organizational culture and cultural fit warrant a much closer look by healthcare organizations and administrators as a way to encourage greater physician engagement—and, by extension, improve other quality and operational metrics, as well.

What Can Be Done?

Changing culture doesn't happen overnight, and everyone realizes that. However, acknowledging the need for change is a very good first step, and can send a strongly positive signal to physicians who might be contemplating another opportunity. If change is pursued in the right way, the process, itself, can increase engagement.

As noted above, each organization is unique, and each is going to be at a different place on the cultural fit and engagement continuum with their physicians. In addition, there are other variables to consider, such as employment models, practice settings and the depth of physician leadership, to name a few. However, there are several basic steps to consider, and tools and resources that can be helpful.

- **Determine what your organizational culture is—and where you want it to be.** Some organizations work for a long time defining their mission and values—and then stop there. And, as the survey results indicate, a clear mission and values is among the lowest ranking cultural attributes (although still important). Organizational culture needs to support the mission and values.
    - Define your current culture. We developed the cultural attributes for this survey after reviewing several standardized survey instruments which were developed for healthcare organizations, specifically, and then narrowed the attributes down to ones which we felt were most applicable to physicians and reflected the experience we have working with physicians and healthcare organizations. There may be others which resonate with your physicians. Develop a list and definitions, ask for input, and then let your physicians rate where your organization is strong and weak—and how they feel about it. Confidentiality is a must.
    - Share the results, then ask your physicians to help you prioritize where to begin the process of change, based upon the biggest potential impact, or the biggest gaps between expectation and reality.

[4] AMGA and Cejka Search Physician Retention Survey
[5] Ibid.

- Identify the key stakeholders and potential change champions. Think broadly, but make sure physicians are involved—and, potentially, leading—subsequent efforts. Look at the cultural attributes you've identified, and then think about who can have an impact.

- **Be deliberate in your approach.** After prioritizing, pursue the one or two attributes that will have the highest impact, and follow a defined path toward achieving meaningful and positive change. Do not let this initiative die in committee—set tangible benchmarks and accountabilities, and develop formal action plans.
  - For each cultural attribute, ensure that there is agreement about what it is, and the day to day behaviors and actions that support it at the individual, workgroup and organizational levels. This is where the key stakeholders and champions come in. They will lead this effort and, ultimately, become accountable for results.
  - Then, develop a roadmap on what needs to change, communicate it and act on it. Allow no exceptions. Make it as tangible as possible, and provide tools and resources to support those who are impacted.
    - Ensure that physicians are involved in decision-making at every step, and if possible, leading key initiatives and activities.
    - Provide training to leaders on how to identify and address barriers effectively.
    - Discuss the initiative openly, at the individual and group level, including physicians and key stakeholders. Sometimes outside facilitators can be helpful in encouraging openness and creating a safe environment to share ideas and concerns.
    - Provide individual coaching and mentoring for those who need more help or who are struggling. Holding all accountable will be key—in particular, those who have not been held accountable in the past.
    - Measure progress periodically and adjust tactics, as needed. Communicate results honestly and constructively.
    - Provide training and education on areas that support the change, e.g., communication skills, civility and behavior coaching, conflict management, coping skills around stress and burnout, developing resilience around change.
    - Be willing to acknowledge when a physician is a bad fit, and act on it, respectfully and fairly.
  - Provide adequate time for your physicians to work on change initiatives. Simply adding committee meetings and additional work without placing value (monetary or otherwise) on the time and initiatives developed will be counterproductive.
  - When significant progress has been made around the first one or two cultural attributes, start on the next priorities.

- **Institutionalize the cultural attributes.** Organizational culture also needs to be reinforced and nurtured.
  - Recruit for cultural fit. Develop assessment tools and processes to ensure that physician candidates understand the organizational culture and demonstrate their ability to fit in and support the culture.
  - Use behavioral interviewing techniques to drill down with candidates regarding such things as conflict management, teamwork and communication—making sure they tie clearly into the desired cultural attributes.

- Create onboarding programs that educate new hires and reinforce cultural norms in as tangible a manner as possible.
- Choose physician leaders who personify the desired cultural attributes and can model them. Avoid rotating these positions based only on seniority or other benign qualities. Offer real incentives to keep your excellent physician leaders in these roles for extended periods of time.
- Develop a mentoring program with specific roles and accountabilities for the mentor and the mentee.
- Incentivize the behaviors and attitudes that support the desired culture. Incorporate them into performance appraisals and assess them objectively.
- Continue to measure progress against the desired cultural attributes. Work at exceeding expectations.
- Celebrate your culture as desired changes are achieved. This will breed ongoing change and commitment to the process and goals.

Ultimately, this is about changing behaviors and attitudes—not just those of your physicians, but those who manage them, recruit them, work alongside them and support them. Insofar as communication is important to them as a cultural attribute, it is also the way to effect change in culture—respectfully, transparently and openly across roles in the organization.

VITAL WorkLife/Cejka Search Organizational Culture Survey
Demographic Variable Analysis Addendum

To further understand the impact of organizational culture on physicians, single-variable analyses were done on the aggregate physician survey results for five questions to see if there were significant differences when looked at by:

- Gender
- Age group (under 40, 40-59, 60 and over)
- Specialty (primary care physicians (PCP) vs. specialists
- Organizational leadership (physician-led or non-physician led)
- For-profit vs. nonprofit organizations

The scoring was analyzed on two levels. One level, used for all questions, was that of average scores across a 10-point Likert scale. The next level, used only for the cultural fit-related questions, was based on a low (1-3), moderate (4-7) and high (8-10) scoring range basis to better understand trends that might be obscured by overall average scores. Results were examined based upon statistical significance at least a level of $p \leq .05$.

The questions analyzed were:

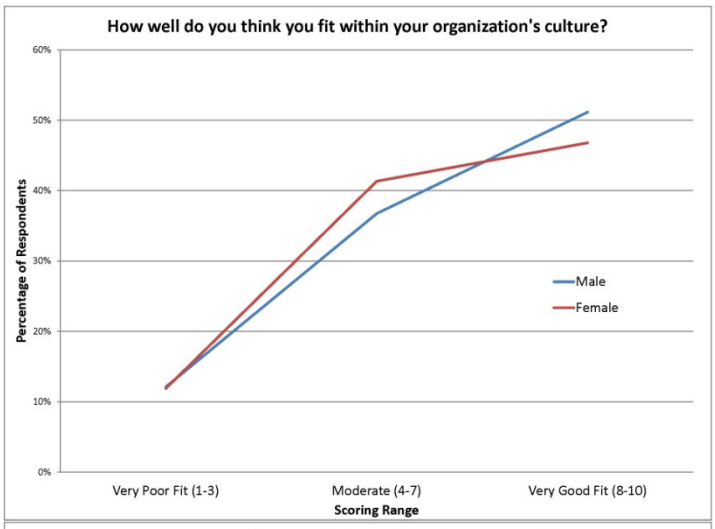
1. Please select the top 3 cultural attributes that are important to you.
2. How well do you think you fit within your organization's culture?
3. My fit with the organization's culture influences my job satisfaction.
4. My expectations of cultural fit have been a determining factor in accepting a practice or job opportunity.
5. Lack of cultural fit has prompted me to leave a practice or job.

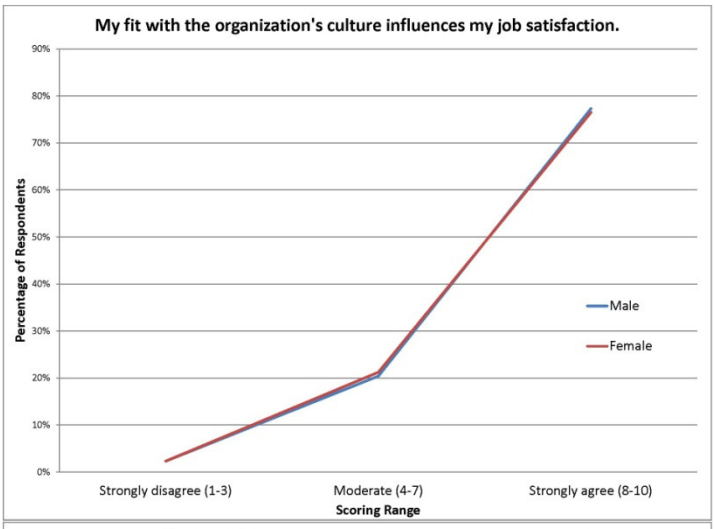
Variable: Gender

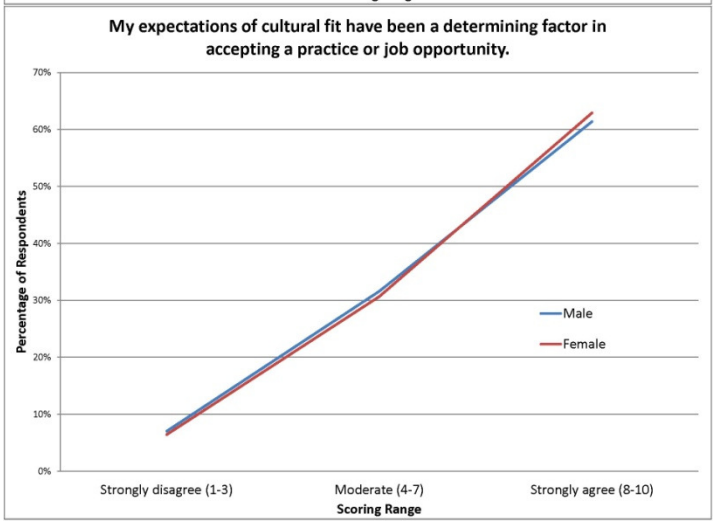
With regard to the top 3 cultural attributes, a patient-centered care focus remained the top choice for both male and female respondents by a wide margin, with minimal differences between genders. However, respectful communication, which was the second choice in aggregate, was much more likely to be chosen by female respondents (12.7%) compared to males (9.2%), a 3.5 percentage point difference. This also changed the rank of this attribute to third for males, while remaining second for females. A supportive management approach to errors and mistakes was similarly more highly valued by female respondents (11.2%) compared to males (8.4%), a 2.6 percentage point difference. This also changed the rank of this attribute from fourth in aggregate to third for females and remaining at fourth for males.

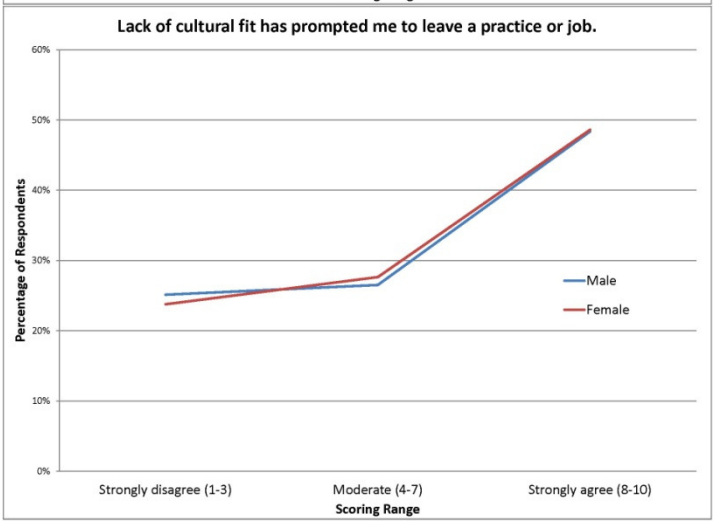
Further down the rank order, a team-focused environment was third in aggregate, with minimal differences between genders, but moved to fourth in rank for females. An innovative approach to care, tenth in rank in aggregate, was chosen by over twice as many males (5.8%) than females (2.7%), changing the ranking to ninth and 13th, respectively.

Gender was not a statistically significant variable when it came to the cultural fit questions at either the average score or scoring range levels. One slight trend observed was that females were less likely to feel a strong cultural fit with their organization than males, scoring higher in the moderate range.









Variable: Age

Under 40 Cohort

For the top 3 cultural attribute question, this cohort put more emphasis on the top four attributes in the aggregate ranking, and by higher percentages other than for a patient-centered care focus. A team-focused environment came in second in rank (and over 3 percentage points higher compared to the other cohorts), versus third and fourth for the other age cohorts.

For the question regarding their cultural fit with their organization, this age cohort had the highest average score, although they were lowest on the two highest individual scores (9 and 10 on a Likert scale). In terms of the impact of cultural fit on their job satisfaction, their average score at 8.5 was the highest among the age cohorts, but not at statistically significant levels overall. However, they led the scoring in the moderate range for this question, which was statistically significant.

With a 7.8 average score, the highest among the age cohorts, this cohort also said their expectations of cultural fit had been a determining factor in accepting a practice or job opportunity. However, as a cohort they scored the highest in the moderate range and lowest in the high range around the question of whether lack of cultural fit had prompted them to leave a practice or job. This could be a reflection of their age and the lower number of jobs they are likely to have had and therefore, left, compared to the older cohorts.

The results show that cultural fit is important to this cohort, and they are using it to a high degree to evaluate career opportunities. They also are much more specific in what they value compared to the other cohorts, with an emphasis on a team focused environment, respectful communication and a supportive management approach to errors and mistakes.

40-59 Cohort

The middle (40 to 59) cohort followed the aggregate rank order with regard to the top 3 cultural attributes, but by somewhat lower percentages for the first five-ranked attributes. Scores for the next tier of attributes, however, were higher than the aggregate and, by extension, the other two cohorts. The ultimate result was that this cohort, after a patient-centered care focus, appeared to value the other attributes more evenly.

This was the lowest scoring age cohort for the question around cultural fit with their organization, with an average score of 6.9. While the average scores for the question about the importance of cultural fit to satisfaction did not show statistically significant differences, this cohort led in high range scoring (78.0%) by 1.6 to 3.4 percentage points compared to the other age cohorts, signaling a significant gap between their current situation and their expectations.

This cohort also had 62% scoring in the highest range around the question of cultural fit as a determining factor in accepting a practice or job opportunity, and also led the highest range, at 52%, for the question about whether lack of cultural fit had prompted them to leave a practice or job.

Thus, this cohort is the least likely to feel they fit within their organization, despite scoring that shows they especially value cultural fit. They are also the cohort most likely to act on the basis of cultural fit when evaluating career opportunities.

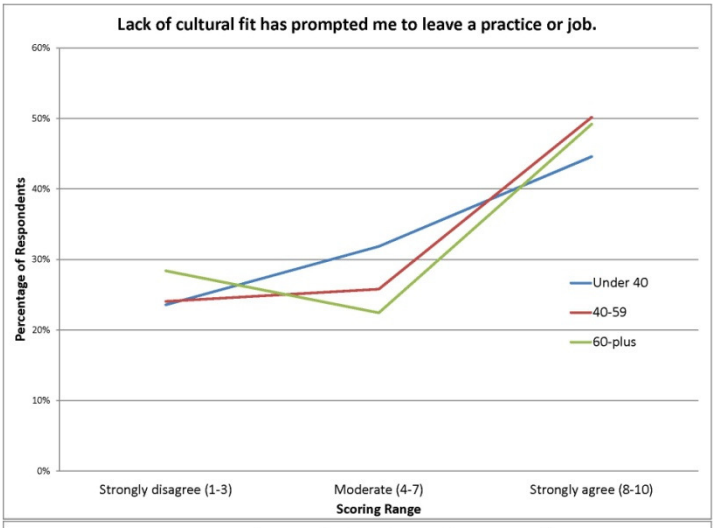
60 and Over Cohort

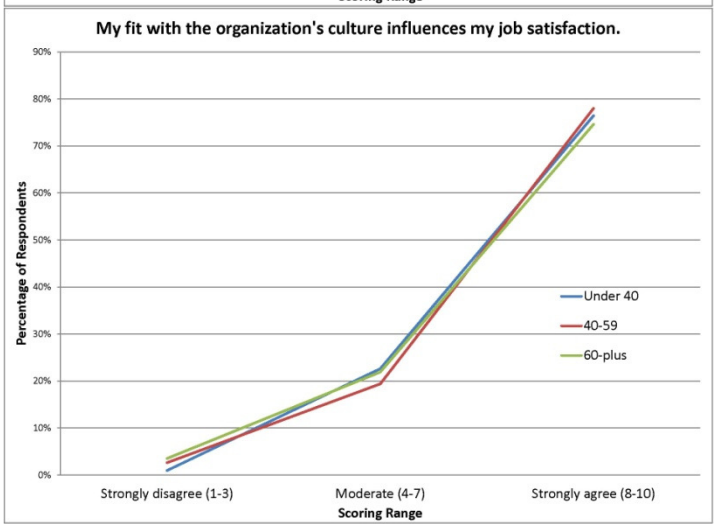
This cohort valued a patient-centered care focus by 3.6 percentage points over the other age cohorts, and while a team-focused environment dropped from the top 3, it was supplanted by a collaborative leadership style, which may signal a higher comfort or familiarity with more hierarchical vs. flat organizational models. Contrary to conventional perceptions of this age group, adaptiveness to change and an innovative approach to care were attributes that were valued by this cohort at slightly higher rates than the aggregate, and compared to the youngest cohort.

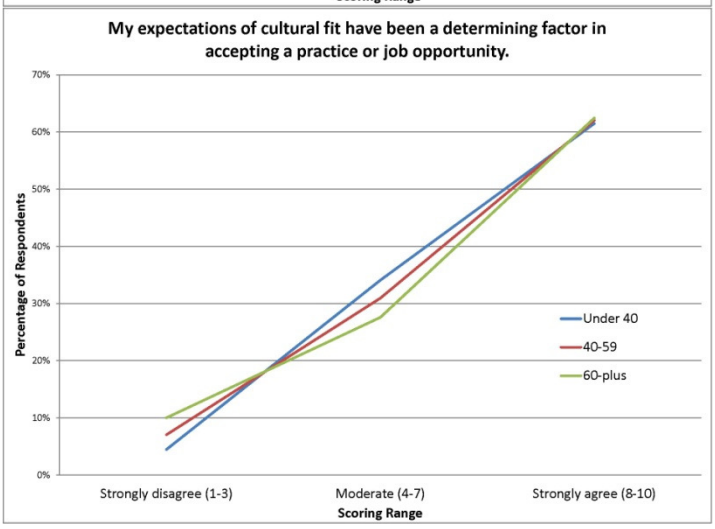
This cohort is both the most likely and the least likely to feel they fit within their organizations, based upon the ranges, and yet are also the least likely to say cultural fit is important to their job satisfaction, albeit by just a few percentage points compared to the other age cohorts on the low and moderate scoring ranges, which was statistically significant.

With a statistically significant average score of 7.5, this cohort is also the least likely to say that cultural fit has been a factor in accepting a practice or job opportunity, and also somewhat less likely to score that lack of cultural fit has prompted them to leave a practice or job.

Given their career stage, this cohort still values cultural fit, but is possibly less likely to act on it.







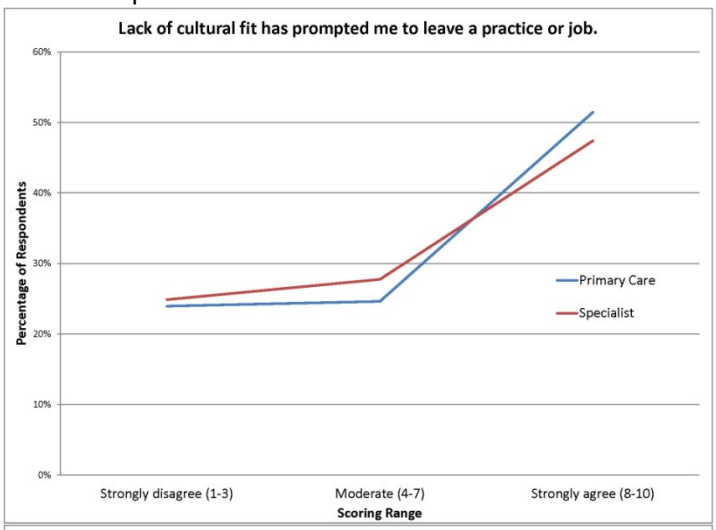
Variable: Primary Care Physicians vs. Specialists

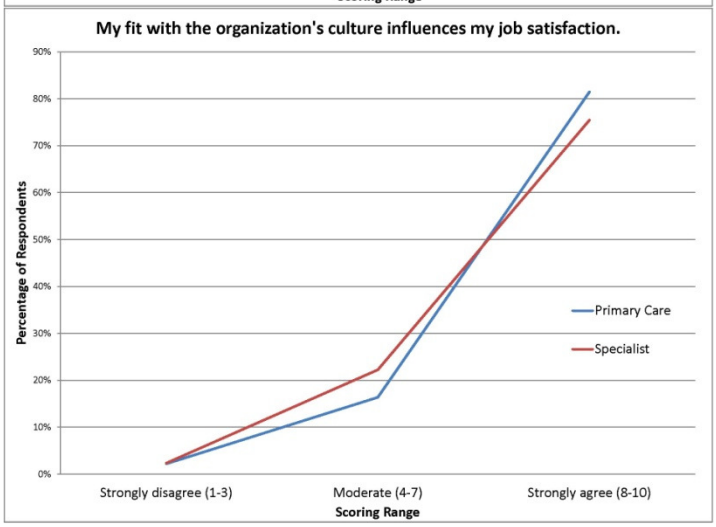
Whether a physician was a PCP or specialist was a statistically significant variable in most cases. In terms of the top 3 attributes, both cohorts ranked patient-centered care focus very similarly, but PCPs scored that they valued respectful communication, a team-focused environment, a collaborative leadership style and clear mission and values to a higher degree than their specialist counterparts. Specialists, by contrast, valued accountability across roles, transparent communication and an innovative approach to care more than the PCPs.

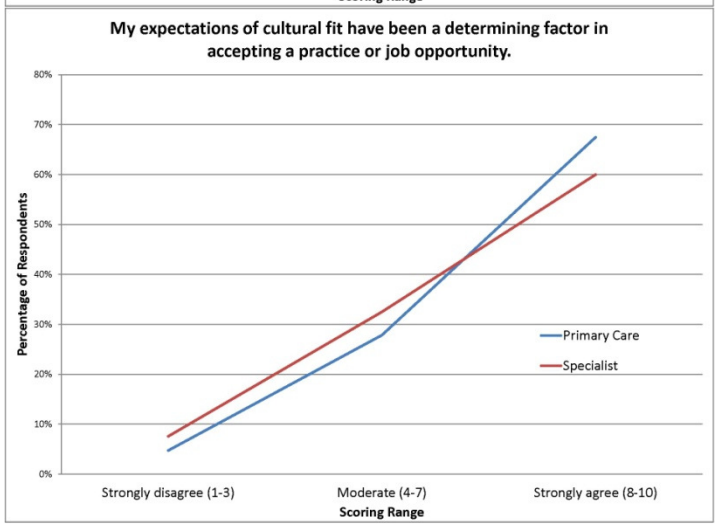
PCPs were more likely than specialists to feel a cultural fit with their organization, and scored in the high range on the question of importance of cultural fit to their job satisfaction more than specialists.

PCPs were also more likely to say cultural fit was a determining factor in accepting a job or practice opportunity, and that lack of it has prompted them to leave a practice or job.

It appears that cultural fit is more important to PCPs than to specialists, but there are certain cultural attributes that stand out more for them, as well, focusing on teams, collaborative leadership and respectful communication.







Variable: Physician-Led vs. Non-Physician Led Organizations

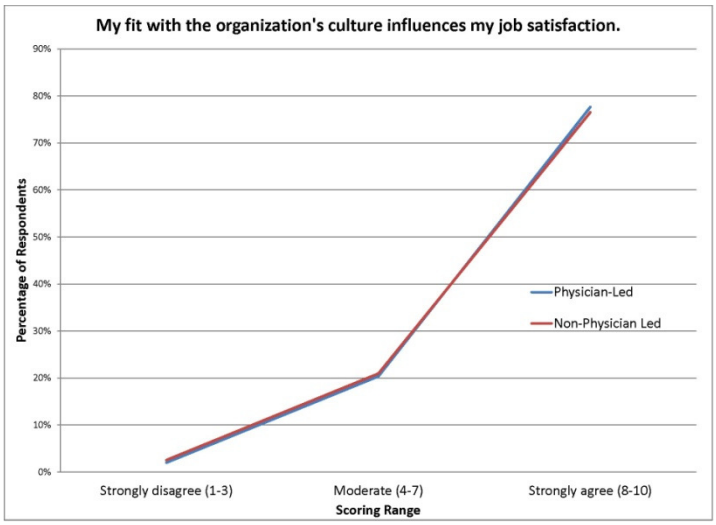
Whether a physician worked for a physician-led organization or not led to some statistically significant differences. For the top 3 attributes, both cohorts reflected the aggregate rank for the top four attributes, but the physician-led organization cohort valued a patient-centered care focus by 2.1 percentage points over the other cohort. They also valued accountability across roles and adaptiveness to change more than their non-physician led counterparts. That cohort, on the other hand, valued a

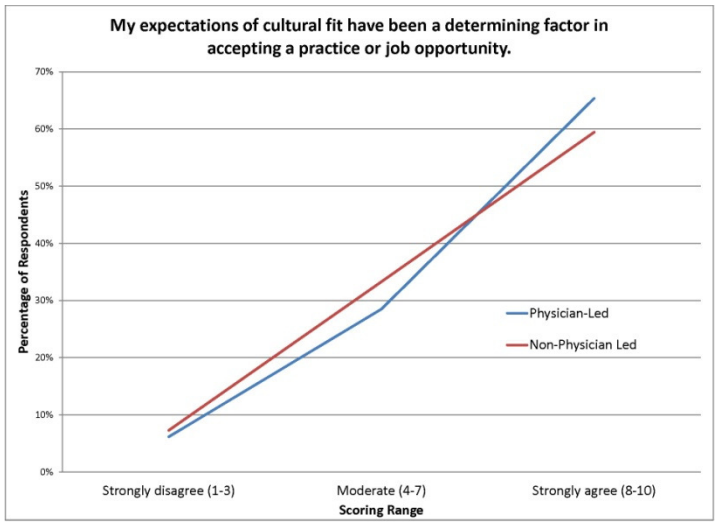
supportive managerial approach to errors and mistakes more highly than their physician-led counterparts.

Physicians working for a physician-led organization felt a stronger cultural fit than those working for non-physician led organizations, at average scores of 7.2 versus 6.8. There were no statistically significant differences in how they scored about importance of cultural fit to job satisfaction.

In addition, physicians working for physician-led organizations were also more likely to say that expectations of cultural fit had been a determining factor in accepting a practice or job opportunity, at an average score of 7.8 compared to 7.5 for those working for a non-physician led organization, and scoring 5.9 percentage points more in the high range. However, physicians from non-physician led organizations were more likely to say that lack of cultural fit had prompted them to leave a practice or job; average score differences between the groups were not statistically significant, but scoring ranges were, with those physicians scoring 1.1 percentage points more in the moderate range and 1.5 percentage points more in the high range.

These results indicate that physicians who are currently working at physician-led organizations felt a stronger cultural fit, and were more likely to use it as a factor in evaluating potential career opportunities, yet it had been somewhat less of a factor for them in deciding to leave an organization. It raises the question, unanswered in this survey, about whether or not there is more inherent cultural congruence because an organization is physician-led, and also whether this was a factor that these physicians looked for in their current positions.





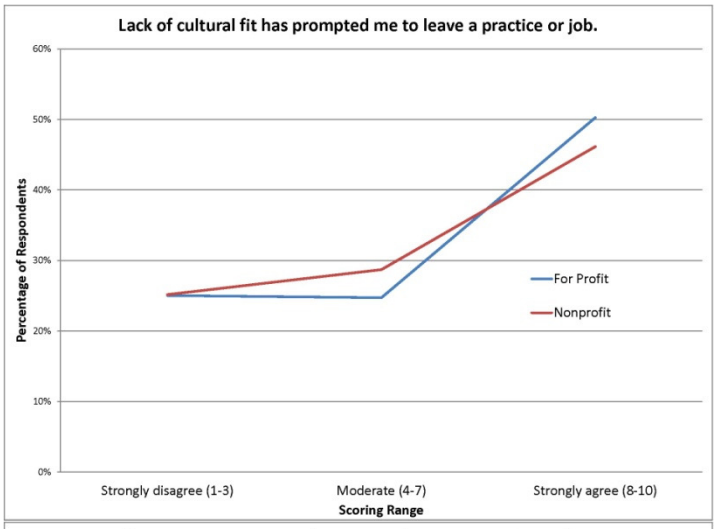
Variable: For Profit vs. Nonprofit Organizations

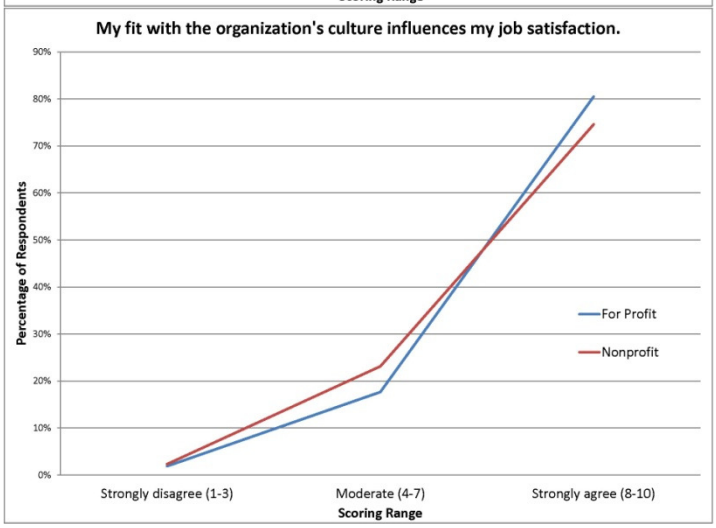
Whether a physician worked for a for-profit versus nonprofit organization was a statistically significant variable. For the top 3 attributes, both cohorts reflected the aggregate ranking for the top four ranked attributes, but the physicians working at for-profit organizations valued a patient-centered care focus by 3.2 percentage points. They also valued a team-focused environment more than the nonprofit cohort. Physicians working for nonprofit organizations, by comparison, put a higher value on a collaborative leadership style, transparent communication, clear mission and values, and objective performance evaluations.

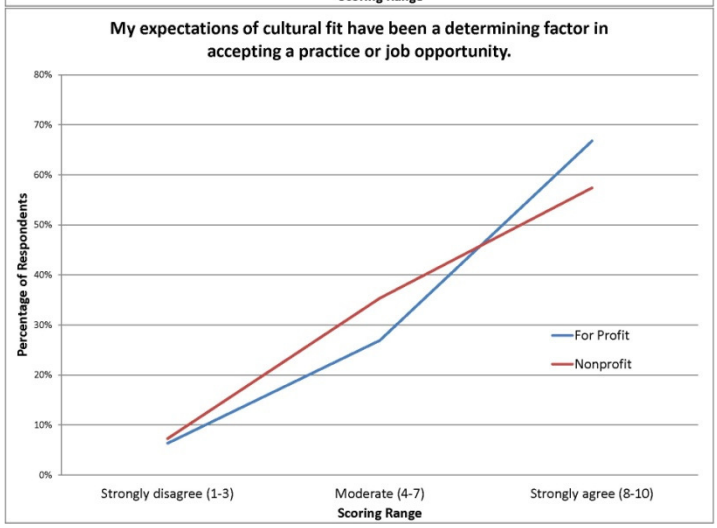
By a wide margin, physicians working at for-profit organizations felt a stronger sense of cultural fit than those working for nonprofits, with average scores of 7.2 versus 6.7. They also scored higher, at 8.6 versus 8.3 average scores, that cultural fit was important to their job satisfaction.

Physicians working at for-profit organizations also had higher average scores around the question about cultural fit being a determining factor in accepting a practice or job opportunity, at 7.9 compared to 7.5 for those at nonprofit organizations. Although the overall scores were not statistically significant for the question about lack of cultural fit prompting them to leave a practice or job, this cohort was statistically more likely to score in the high range by 4.2 percentage points compared to physicians working for nonprofits.

The results indicate that, across the board, working at a for-profit organization correlates more highly with experiencing better cultural fit as well as valuing it more highly, and using it more as a criterion for evaluating potential and past career choices.







Discussion

The results of this demographic variable analysis show that when it comes to organizational culture and questions around cultural fit, there are clearly variables which correlate with specific desired cultural attributes, as well as cultural fit and how it may impact retention, turnover and job satisfaction, overall.

The overall survey data made it clear that organizational culture is an important consideration to physicians in terms of their satisfaction, as were all of the cultural attributes, based on the individual attribute scores. The top 3 cultural attribute survey question, which forced respondents to choose just three attributes, largely correlated with the rank order of the individual attribute scores. However, by its nature the question results also overstated the differences in the value placed on each individual attribute. Thus, the variations seen in this analysis are relative, not absolute, but still give insight into what physicians value.

As the preceding analysis shows, and Table 1 summarizes, for the most part the rank order of the top 3 cultural attributes remained the same as that for the aggregate for all physician respondents, and still led with a patient-centered care focus by a wide margin, but there were a few notable exceptions and

Table 1—Top 3 Cultural Attributes Ranking by Demographic Variable

	Aggregate Results		Gender				Age						Specialty				Organizational Leadership				For-Profit vs. Nonprofit			
			Male		Female		Under 40		40-59		60-plus		Primary Care		Specialist		Physician-Led		Non-Phys. Led		For-Profit		Nonprofit	
Cultural Attribute:	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%
Patient-Centered Care Focus	1	18.8	1	18.7	1	18.9	1	18.2	1	18.2	1	21.9	1	18.9	1	18.7	1	20.0	1	17.9	1	20.3	1	17.1
Respectful Communication	2	10.5	3	9.2	2	12.7	3	12.0	2	10.0	3	9.6	3	11.2	2	10.2	3	10.1	2	10.8	3	10.5	2	10.2
Team-Focused Environment	3	10.4	2	10.5	4	10.3	2	13.0	3	9.8	4	8.4	2	11.5	3	10.1	2	10.3	3	10.6	2	11.3	3	9.8
Supportive Management Regarding Errors and Mistakes	4	9.4	4	8.4	3	11.2	4	11.6	4	9.1	5	6.9	4	9.4	4	9.4	4	8.7	4	9.9	4	9.3	4	9.3
Collaborative Leadership Style	5	7.5	5	7.7	5	7.3	5	6.6	6	7.3	2	9.8	5	8.5	6	7.2	7	7.2	5	7.8	6	7.0	5	8.2
Clearly Defined Accountability Across Roles	6	7.4	6	7.5	6	7.2	6	6.4	5	8.2	7	6.3	6	6.4	5	7.7	5	8.2	6	6.8	5	7.6	6	6.9
Adapts to Change Readily	7	6.6	7	6.9	8	6.0	7	5.7	7	7.0	6	6.7	7	6.1	7	6.8	6	7.5	8	6.0	7	7.0	8	6.3
Transparent Communication	8	6.2	8	6.2	7	6.1	8	5.6	8	6.6	8	5.5	8	5.3	8	6.5	8	5.9	7	6.4	8	5.6	7	6.7
Clear Performance Expectations	9	5.0	10	5.2	9	4.6	9	4.7	9	5.1	9	5.3	9	5.0	10	5.0	9	4.9	9	5.1	9	5.0	9	5.2
Innovative Approach to Care	10	4.7	9	5.8	13	2.7	10	4.5	10	4.7	10	5.0	12	3.4	9	5.1	10	4.5	10	4.8	10	4.4	10	5.2
Open Dialogue Across Roles	11	4.1	12	4.0	10	4.2	11	3.6	11	4.2	12	4.2	11	4.3	11	4.0	12	3.7	11	4.3	11	3.9	12	4.2
Clear Mission and Values	12	3.9	11	4.2	11	3.4	12	3.3	12	4.0	11	5.0	10	4.7	12	3.7	11	3.9	12	4.0	12	3.2	11	4.6
Objective Performance Evaluations	13	3.1	13	3.2	12	2.9	13	3.0	13	3.2	13	3.1	13	2.8	13	3.2	13	2.7	13	3.4	13	2.6	13	3.7
Compensation Plan Alignment With Mission and Values	14	2.3	14	2.4	14	2.3	14	1.8	14	2.6	14	2.3	14	2.4	14	2.3	14	2.4	14	2.3	14	2.4	14	2.5
Total		100.0		100.0		100.0		100.0		100.0		100.0		100.0		100.0		100.0		100.0		100.0		100.0

variances. In addition, even when the rank order stayed largely the same, there were times when there were statistically significant differences in the percentage of respondents who chose those specific attributes depending on which demographic group and cohort they were in.

What does this mean? Above all, it's a signal that depending the type of organization and the composition of its physician population, not all cultural attributes may be as valued—both for the organization as a whole and between the different physician demographic groups within it. For example, a physician-led organization may find that even though the most valued cultural attributes may reflect those in this survey, if they have a larger number of under 40 physicians, they might wish to put a greater initial emphasis on a team-focused environment than they might normally.

It also underscores the importance, as suggested in the overall survey conclusions, of clearly defining what each attribute means to an organization and its physicians with a high degree of specificity, and in a manner that ties to measurability wherever possible. This will ensure not only a clear understanding by all parties, but also help with operationalizing the cultural attributes. As an example, a team-focused environment may mean different things to an administrator, or a physician who is under 40 versus one who is in the 60-plus cohort—or, a PCP versus a specialist. When broken down into the things that may contribute to a team-focused environment in a given organization, e.g., what constitutes a team, expectations around shared responsibility, how team performance is measured, etc., critical differences may emerge that need to be resolved before any effort around cultural congruence can be successful.

When looking at the analyses for the cultural fit-related questions, there were some interesting dynamics that emerged.

With regard to the question asking about their degree of cultural fit within their organizations, the degree of cultural fit varied across all group analyses except gender. It was more of a factor in the for-profit versus nonprofit organization variable, followed by primary care versus specialist, and whether or not the organization is physician-led. Based on the analysis, groups more likely to feel they fit within their organizations were:

- The under 40 physician age cohort
- Primary care physicians
- Physicians working for physician-led organizations
- Physicians working at for-profit organizations

Given that the vast majority of respondents felt that cultural fit strongly influenced their job satisfaction, with an average score of 8.4 in aggregate, it is perhaps not surprising that this unanimity carried over to all the demographic groups and cohorts, with few exceptions. Where there were statistically significant differences, those tended to be reflected in smaller variances than seen in the previous question regarding physicians' own cultural fit within their organizations. Groups which most strongly agreed that cultural fit influenced their job satisfaction were:

- The 40-59 physician age cohort
- Primary care physicians
- Physicians who worked at for-profit organizations

Regarding the question about if organizational culture had been a determining factor in accepting a job or practice opportunity, as with the previous question, this could be another one where the relatively high aggregate average score, at 7.7, may have contributed to some flattening of differences within

demographic groups. While the influence of cultural fit on accepting job or practice opportunities varied across all group analyses except gender, it was more of a factor in the for-profit versus nonprofit variable, followed by primary care versus specialist, and whether or not the organization is physician-led.

It was also a factor for the age cohorts, but the pattern was more ambiguous, with the oldest cohort scoring highest in both the low and high ranges. Given that physicians have more occasions to consider new jobs and practice opportunities as they get older due to increased experience and the passage of time, the trend line on this may be a result of that dynamic.

Based on the analysis, groups more likely to feel their expectation around cultural fit was a determining factor in accepting a job or practice opportunity included:

- Physicians who were 40 or older—and the trend line showed it was a factor that increased with age
- Primary care physicians
- Physicians working for physician-led organizations
- Physicians working at for-profit organizations

Finally, the question about whether lack of cultural fit had prompted respondents to leave their practice or job also showed fewer variations within demographic groups. The distribution of scores was much more even across the aggregate for this question, perhaps reflecting, to some extent, that there were some physicians who might not have changed jobs in their careers, thus explaining the much higher number of "1" scores. It could also be a reflection, given how the question was phrased, that cultural fit was not the deciding factor in leaving a job, but an influence.

Age was the only subgroup where there were statistically significant differences, and the middle cohort most strongly agreed that it was a factor, by followed very closely by the oldest cohort. As with the previous question, this could be a consequence of physicians having more opportunity or likelihood to leave jobs just through the passage of time.

Thus, scoring trends showed a higher influence of cultural fit on voluntary departures with:

- Physicians who were 40 or older
- Primary care physicians
- Physicians working for non-physician led organizations
- Physicians working at for-profit organizations

As with the top 3 cultural attributes analysis, the questions around cultural fit also point to the need to look more deeply at the question of organizational culture depending on the type of organization and the composition of the physician population in determining where the need for change lies, because there were differences—sometimes notable.

With regard to age, the variable analysis results point to younger physicians feeling a stronger cultural fit, but it begs the question of whether that will continue, given that physicians' sense of fit for the older cohort lessens. It might also be the case that younger physicians are more attuned to cultural fit issues and have purposefully selected positions and organizations that meet their needs, so that metric will remain stable. It could also be the case that, as they gain experience and if their organizations' culture does not keep pace with their expectations, they will look for organizations that offer a better fit. The

40-59 age cohort also bears watching for organizations. Their sense of cultural fit is less, in contrast to their higher likelihood of feeling this influences their job satisfaction, and also their higher likelihood to have used this as a criteria in career decisions. This points to the need for organizations to improve cultural congruency with this group if they wish to keep them engaged—and retain them.

Another interesting dynamic is around PCPs. They're more likely to feel a stronger cultural fit within their organizations, but also shown that they have used cultural fit in making career decisions, indicating how important it is to ensure an even stronger sense of cultural fit to retain them.

Finally, while there are still gaps for physician-led organizations and for-profit organizations in terms of cultural fit, it raises the question of what those organizations may be doing that is different in giving them an edge. However, the variable analysis results show that even for physicians from those kinds of organizations, they are still using cultural attributes as a factor in career decisions, especially those working at for-profit organizations.

For healthcare organizations, the results point to what was noted in the main survey report—taking a one-size-fits-all approach to organizational culture may not work, especially for larger, multi-specialty, multi-location groups or systems where understanding the underlying dynamics of a more disparate, dispersed physician population can be valuable. Also, at a time of increasing acquisitions and mergers of physician practices and health systems, an acknowledgement of the importance of organizational culture and examination of key differences between groups can create greater understanding and, if addressed effectively, smooth and facilitate integration efforts.

In some areas, the results raise more questions that were beyond the scope of this survey. Overall, however, the results should provide food for thought as administrators look at their own organizations and physician populations with regard to cultural congruency, and take steps to close the gaps that exist to improve physician engagement, boost retention and develop more effective recruitment strategies.

Appendix A
Physician Open-Ended Responses

1. It is hard to answer these questions as there has been a cultural shift while I've been here. The lack of mutual respect and suspicion has undermined the primary mission. The sense of the primary mission being to make money by taking care of people is a subtle but real shift from the emphasis of taking care of patients and capturing all the costs that is possible.
2. EHR has significantly affected my personal feelings about my employer who has forced us to use a program that is a burden and affecting our ability to function, yet they are unsupportive and unsympathetic to what we must go through daily.
3. Lack of cultural fit has led to me "taking the temperature" for employment opportunities.
4. Must have a strong goal.
5. Academic medicine is in dire straights with not enough money and too many demands. It is made dramatically worse by feeling undervalued, and not included in decision making by the Chair.
6. I don't know whether this came through, but I really enjoy the collaboration, support from colleagues and constant learning that occurs in academic medicine. I would, however, ALSO appreciate competent management and robust financial return which academic practice often lacks. Finally, I am finding more and more that too much paperwork and too little nursing support (often an indirect reflection of poor management) can cancel out the most collaborative, pleasant, collegial environment.
7. Cultural fit is extremely important, but due to the environment in medicine, it is difficult to make changes to find that "perfect" practice and at times one must stay put despite less than ideal circumstances.
8. I just switched organizations for all the reasons your survey is focusing on. Thanks for helping me see the words and themes which prompted me to seek out a new job and my subsequent satisfaction with my new organization. The new 'culture' is much more in alignment with my beliefs and personal values. I enjoy work more when I work with like-minded people (not just like-minded physicians).
9. Under stress the lack of innovation becomes apparent.
10. I have worked at a number of very dysfunctional organizations in my long career. I have worked with many dysfunctional doctors in my long career. I entered medicine as a profession. It has now become a crass business. This is sad and a major reason why I am retiring.
11. I recently left my organization because of its lack of consideration of patient care concerns. Those senior doctors (who earn big money for their "productivity") tend to bully or intimidate junior doctors.
12. This was difficult to answer as I am a sole practitioner – I focused on the work I do that intersects with other agencies and groups. Hence, clear goals, communication, roles, accountability, etc. are important. Performance evaluations are not – if I do not do a good job, I don't have work.
13. For the very last question, I selected strongly disagree because I am in my first job and so far has been a very good fit, so I have never left a job before. On the other hand, I could have chosen strongly agree, because if it was not a good cultural fit, I would be strongly prompted to leave.

14. Read Doug Krug "The Missing Piece in Leadership" which may help healthcare leaders chart the future. I have tried to lead without the need for a title but some say, "when you tell the truth duck."
15. Good idea and insight.
16. As a woman physician, I agree that having no gender bias in compensation and opportunities is a key to success for women.
17. The docs on the front lines have no say in administrative decisions.
18. It is now very difficult for a doctor to work solo.
19. Doctors eat their young.
20. It was hard to answer the "3 least important" question.
21. Recent purchase by a hospital has led to a collapse of internal physician governance.
22. This doesn't quite capture what is going on. It isn't just culture, it's a broken medical system, a broken reductionist model that treats isolated symptoms and doesn't know how to really get people well. This is the century of systems biology and medicine needs to transform to catch up and get with the program.
23. As I own my own small practice, I am able to run a practice with what I consider ideal culture. however, this is not rewarded financially in the present market and I always worry I will be forced out of business and into a culture less ideal.
24. The most important thing is to be able to work to support my family. This trumps all other considerations.
25. I am actually changing jobs ASAP.
26. Our practice management is primarily business/corporate run with less than ideal clinical insight and less than ideal physician involvement.
27. The west coast public medical school that I have worked for in the last four years has the highest rate of student mistreatment in the country and this issue starts from the top. When you have a dean who calls himself the "CEO" and who screams at faculty calling them "f++++ assholes," you are not going to be able to change a culture of abuse. People in positions of power should not hold onto them for decades, which is the case in this particular situation. When an organization is as hierarchical as this one, with power centered in a handful of individuals, without open dialogue or transparency, you are not only blocking innovation and change, you are creating a hostile work environment. Having spent decades in another institution, I know that medical schools can be run with respect. This questionnaire forced me to pick three of the least important variables and I did it randomly as I feel that every value listed is important.
28. There is not much dialogue concerning night shifts.
29. My current work is more administrative, the business aspects or focused on infrastructure building so some of my responses could be improved if the right expertise is recruited and infrastructure improves.
30. I joined my practice because of good cultural fit. The entire structure of the group has changed since joining 6 years ago. I'm completely unsatisfied with new structure.
31. The culture of a workplace is difficult to know until after you work there. If only there were some way of finding out beforehand…

32. I don't find listing the least important three attributes worthwhile – they are all important to me.
33. The culture at my current practice is greatly undermined due to the ownership of the contract by a third party thus making us independent contractors. I think this is a very poor model for forming a good cultural environment.
34. Academic healthcare tends to reward those who are successful garnering research dollars by promoting them to leadership positions for which they are very ill prepared and for which they lack the appropriate innate qualities.
35. I recently left a position I was in for 20 years due to a shift in culture toward profit and away from respect for each physician's skills.
36. My passion is medicine. My patients and medicine change a lot, which is kind of disappointment because I love my career
37. I'm looking forward to progressive change that benefits those most deserving.
38. I think our organization is spectacular. We really are one big family--we care about each other, we are supportive, and we're all about rowing in the same direction. If anything we are overly communicative! We honestly enjoy working together--I don't abhor Monday mornings--I say, "Great, I get to go to work today!" I wouldn't trade this position for anything--I started here as an internist 14 years ago, and became Medical Director 6 years ago and I still take care of 1,000 patients and love it.
39. The organization changed around me despite my efforts.
40. 1. I have been in same location since 1976.

    2. "Please select the 3 least important cultural attributes to you." This I answered by default. None are least important.
41. As a black female board certified OBG, I have found the field to be very bigoted and there is a wall blocking me built by my white male counterparts to have OR time or participate in new surgical procedures. There is a huge racial discrimination problem with all the top Hospital Boards and Corporations. I applied for twenty opportunities, I never had any lawsuit against me, scored high on all my exams in the 99 percentile rec'd honors and awards but still can't get a hospital employed job if a white doctor applies for it too, and has lesser accolades than I.
42. I think all of the cultural attributes are important – so I arbitrarily picked the least important selections.
43. 1) Medicine is far too controlled by AMA people taking their orders from Big Pharma and many of its ineffective, overpriced drugs that let people die, when cures are available (see below).

    2) Extremely effective, curative, inexpensive alternatives are being completely ignored; there are many of them, like the ones described below:

    http://www.mwt.net/~drbrewer/canart1.htm https://vimeo.com/39553638

    3) medicine is anything but free market and freedom oriented; what has controlled it since 1910 it has made medicine restrictive, fascist, punitive, dishonest, and murderous, since so many people who died did not have to die.

    4) George Washington's personal doctor predicted that all of this would happen: http://conservapedia.com/Benjamin_Rush "The Constitution of this Republic should make special provision for medical freedom. To restrict the art of healing to one class will

constitute the Bastille of medical science. All such laws are un-American and despotic. ... Unless we put medical freedom into the constitution the time will come when medicine will organize into an undercover dictatorship and force people who wish doctors and treatment of their own choice to submit to only what the dictating outfit offers."

5) More proof in first 7-10 minutes of this talk by Dr. Laibow: http://video.google.com/videoplay?docid=-5266884912495233634

6) the people who did this to medicine, and patients, should be prosecuted for murder as the little fish were at Nuremberg; the big fish got away, but should not have been allowed to

7) Milton Friedman, Nobel Prize winning economist, told doctors at the Mayo Clinic some of what is really wrong: http://www.youtube.com/watch?v=-6t-R3pWrRw

8) People need to get together and doctors need to be cross-trained, in a fee for service environment, independent of government control, control by AMA, control by medical boards, control by evil people with subversive goals, which is what New World Order Communism really is

9) Punishments need to be administered to people, and organizations, who interfere with freedom, and free markets, causing the deaths of millions of people who didn't need to die. Rules regarding genocide were put into place, in Russia, after Yeltsin was out to protect the people from predatory monopolistic control of the medical system

10) In the U.S., this must come from the ground up; the rot at the top will only try to prevent the necessary change

44. I was in four different jobs over 4 years due to lack of cultural fit--this is extremely important.
45. Great survey.
46. Having leadership support for one's practice is of paramount importance for a successful practice.
47. I am currently relatively dissatisfied with my organization as I feel the administration has dealt poorly with some recent issues. I have not always felt this way and I expect things to get better--maybe that's the optimist in me. My LIFE in my current job/town is very good, so I feel I'm willing to put up with some dissatisfaction in my job to stay where I'm at personally. My organization is the only show in town!
48. I have left two practices of which I was a partner, because of these issues. In my current practice, I am an employed physician with no hope of partnership. The owners are non-physicians and there are a lot of frustrations relative to this.
49. Strong dedication and hard work with an open dialogue are key for success.
50. Team focus is very important and also communication amongst colleagues, administration, staff and providers.
51. Culture and alignment of goals between hospital and doc are difficult to separate. The degree to which culture supports my goals determines my satisfaction.
52. I started the practice with only 1 associate and have brought on 10 other partners and physician extenders. I made the decision early on to be just one of the associates and therefore lost control.
53. Leadership is important if the leader listens to colleagues' opinions.
54. I have a job that I love because I am doing a number of different things including patient care, teaching medical students and residents and being involved in patient safety, quality,

and documentation among other things. I make myself happy at work by being involved in areas that I am passionate about. I do this in spite of our hospital administration and likely to their dismay.

55. This is a very overlooked issue–thank you for doing this. I knew I didn't fit in when one of the other internists called my preventive style of care a "boutique" practice because I focus on health and not on treatment of disease.
56. Thanks.
57. I work for a community health center and I see no concern for provider well being, only for the mission.
58. The leadership does not understand the role of our subspecialty!
59. I like having my own business, but I'd like to collaborate more closely with others or partner.
60. Fit within an organization is very important to me. I've had previous positions where there was simply no fit and the culture was terrible. It was a very unpleasant job experience and eventually I left. I am very happy with the fit at my current position.
61. It seems like many anesthesia groups decide what they'll say yes to based primarily on how many CRNA's they can just baaaaaaarely pretend to be supervising at once, and based on surgeons threatening to go elsewhere or throw temper tantrums if inappropriate requests aren't granted. I'm a patient too and a lot of what I've seen scares me!
62. Even when there is a lack of cultural fit, a leader may need to move an organization to where it needs to go. That is, to change the culture to ensure best care and patient focus.
63. Vanderbilt is the worst institution of its kind.
64. There are too much politics in my organization regarding leadership roles. A leader is someone good at playing politics.
65. I worked for a hospital based system one time, and then went into private group practice. The difference was night and day. In private practice, employees are accountable to you and not a system, rules are made by the doctors not some administrator, when something isn't working it gets fixed immediately, not some 2 to 3 week process, lets have a couple committee meetings about it and then maybe we might fix it…
66. Hospital-owned multispecialty groups are not in the best interest of the patient or physician. They are designed to maximize profits for the hospital and in the end at the expense of both the physician and outpatient.
67. As a surgeon, with a missionary mind-set, most important to my job satisfaction is delivering the highest care possible in the area of greatest need. This is often not the goal of colleagues or administrators and I don't mind that so much. When my career is finished I hope to have cared most for the least among us.
68. I left the military because of cultural issues–relationship among medical staff, medical clinics are "military" in culture, you practice in military attire, constant awareness of military environment with saluting, etc.
69. This is a good collection of information regarding institutions.
70. Government control of medicine, politics, and poor billing have prompted me to move on. The result of ACO and early intrusion of Obamacare has resulted in the "equalization" of physician and ignoring superior performance.

71. When the organization puts money and profit first over patient care and physician well being then you have a recipe for disaster.
72. Thank you.
73. Left practice in a very large corporation (Cleveland Clinic) due to lack of respect of my department's ability to self-govern, e.g., medical director making critical decisions without consulting the physicians
74. Sadly, medicine is becoming more corporate so that there is not the variety of work choices there used to be. And many managers really don't understand medicine, only business.
75. I for now am trapped.
76. There are more important factors other than those in the hospital that make me decide whether to stay or move.
77. I have a substantial amount of autonomy at work and am able to define my own criteria for performance and seek to meet them. It is the autonomy/control over day to day work more than anything else that makes the job satisfying and none of this is addressed in your questions. I agree strongly with the mission/values of the company and respect their history – and they respect my training and approach to the work. It is a good fit and I stay although the money is not as good as it would be elsewhere (and I have had offers for elsewhere).
78. Times have changed. The surgeon is no longer a customer of the hospital but rather an employee. No longer respected and accommodated to be at an institution.
79. All practices seem the same now, K-mart like.
80. Cultural fit and Administrative awareness and prioritization of this would go 90% of the way to job satisfaction.
81. Failure of leadership to elicit and learn from frontline staff feedback and impunity of leadership to system failures leaving them largely unaccountable has prompted me to search for a different employment opportunity than my current environment.
82. I have been in practice for many years. In course of my time I see that the paperwork is increased tremendously, some of them necessary and important for patient care but some of them not so important, but we still do them. Doctors enjoy caring for patients. The paperwork sometimes is perceived as unnecessary. This might in my opinion be an important cause of BURN OUT syndrome in practicing physicians.
83. The physicians are focused and good role models but the staff, especially management, is unorganized, unfocused, disrespectful and has no accountability. This will kill our practice!
84. I'm not satisfied with physician role. Nurses and unions seem to have changed medicine for the worse.
85. The problem is not the culture of your clinic, it's the personalities of your closest partners and peers.
86. I left my former job because the cultural fit was not in alignment with my personal values.
87. Cultural fit is very important.
88. Most of the factors mentioned are quite important. And any of them might be significantly messed up. And that in turn might significantly mess up anything else.
89. Physicians are human. We have moments of weakness where we display human attributes like dissatisfaction, irritability and fatigue. Yet, we are not forgiven for this. Instead, we now have literature on the "disruptive" physician. How about the 30 hours straight, no lunch, no

dinner, no breaks, extended patient hours and now more and more paperwork literature? Not to mention unsupportive management hiring mid levels/CNAs who cannot review meds/send labs/help with prescriptions/take phone calls etc. Physician roles seem less about patient care and more and more about meeting "goals" such as RVUs and “meaningful use.” I bet the patient would appreciate 10 extra minutes of the physician’s time as more meaningful than me spending hour after hour on their EMR. I love OB/GYN, there is nothing more miraculous then welcoming a newborn to a parent's first journey. The bureaucracy of medicine is endangering the joy and passion of practicing medicine.

90. I left a hospital employed position because of the cultural gap.
91. I just left an organization for these reasons.
92. Objective performances are overrated and contribute to poor relations with administration.
93. I won't work in a "mill." I did that for one year after HIP went out of business. I’m now in group without walls.
94. Not only cultural fit is important, but having good relationships with my work team is even more important. This depends partly on personal character of work mates.
95. It is very hard to ascertain what the culture of an organization is, until you are in the job. If it is not a fit, then one must adapt, or leave. In my case, there are compelling reasons to adapt.
96. I recently left a hospital I practiced at for 42 years. Now I am in a Catholic Hospital that takes care of anybody who walks through their doors whether they are insured or not.
97. My org focused almost exclusively on money.
98. I did leave a job because of a problem with the culture.
99. Outstanding survey.
100. One's ability to communicate well with others, be successful at their job and be treated with respect helps determine one's happiness at their job.
101. As long as we force ourselves into increasingly complex bureaucracies, satisfaction will continue to be ignored or irrelevant.
102. There is always room for improvement.
103. I was hired under false pretenses. I have no option to leave as I am at the end of my career. Medicine is not fun any more. Money was never an issue since I never made much in my specialty.
104. "Please select the 3 least important cultural attributes to you." This is a most difficult question to answer. In fact, every attribute mentioned is important to me.
105. Patient health is the goal. This is why we work. We don't go to work to gather personal points. We do well when the leadership is respectful. If they are arseholes, we are not idiots– but we will be patient for a while, in order to respect the patient.
106. I am in a solo practice, having tried both small (3 docs) and larger (8 docs) practices and being unhappy there because of practice philosophies being inchoate.
107. My organization's cultural attributes are what has encouraged me to put off my retirement. It is a pleasure for me to work here.
108. Organization changed around me. It is not the same place as when I joined.
109. Expectations, if individually set and driven toward the mission, are effective in driving change.

110. All cultural attributes are important. It is hard to say any are "least important." Our 5 man group was very far along in the process of merger with a 36 man group and stopped due to perceived culture differences.
111. An administration that is secretive and deceptive, not being truthful and not following through on promises is a recipe for a short association. Honesty is the most important attribute and when you're dealing with an organization which profits from your work. Being in a Joint Venture helps even the playing field and is a structure that would likely improve a physician's satisfaction.
112. I am currently in the process of resigning due to these issues.
113. Culture has a direct effect on organizational outcomes. It impacts all areas of the system of care and in order to change the system outcomes, the culture needs to adapt.
114. Physicians do not ever work well together.
115. I work in a single specialty group that works well but we are owned by a hospital and my comments have more to do with being owned by a hospital which is really our admin structure.
116. You guys must be living in the la la land. Do you have any concept of reality? This hospital has been losing money for years and finally became sold last week. Best hospitals have 3 cath labs and university affiliation. Evidence based medical practice is essential. Being nice to nurses and giving them chocolates is very helpful. Giving the hospitalists quick consults and helping them fast makes them happy. Diplomacy, decency and honesty are the bare necessities. Help the administration save money and they will support you.
117. Personal professional and philosophic alignment within a committed group of people can make any challenging job satisfying regardless of the imperfections of the organization.
118. It is almost impossible to evaluate a position without working there for several months. I wonder how much more our talents will be wasted by lack of support stuff and amount of paper-work. Why does an RN have an assistant to boss around and the internal medicine physician does not, working alone taking care off all the business nobody else wants?
119. I am self-employed. I have been an "employed" physician in the past and that was a mistake. I'm much happier now.
120. My employer deals with everything being a secret and they use fear as their biggest motivator. Physicians that supply the income to pay everyone are not respected, thanked or acknowledged for a job well done.
121. I worked as an anesthesiologist in a community hospital that catered to surgeons regardless of patient safety. The operating room mission was to complete surgical cases with little regard to available expertise (i.e., fellowship trained anesthesiologist) or staff morale.
122. I just joined a new group, having been in independent practice for 5 years. This influences my feelings.
123. Lack of cultural and philosophical fit caused me to leave my prior employer and take a position with my current organization which has been a perfect fit. My prior employment was very closed-minded and unwilling to hear or entertain any suggestions or recommendations. They gave zero support and created an extremely counter-productive, competitive environment.
124. I have published a paper in this field.

125. You should have NA as a choice. You don't leave any room for the culture that is non-medical–e.g., non-medical people doing all the admin and MAs and MDs doing the patient care–very unsatisfactory.
126. For my current position, I did not adequately assess these factors. It is very difficult to adequately assess from the outside.
127. Sometimes you don't realize an organization's true culture until you've been there awhile. The tighter job market makes it difficult to consider a change.
128. Most of this is buzz words, basically meaningless to the community and most of the people. I am not a great fit with the leadership in my medical center, but I like it.
129. I don't think or feel that corporate administration is concerned about culture and fit for physician employees.
130. Emphasis on culture excludes some individuals who challenge the organization. Any cultural system should make an effort to channel challenging thought into effective change.
131. You covered them all.
132. Sometimes you have to take what you can get and just put up with the problems within the organization.
133. There need to be sub cultural groups within the larger structure that provide team effort and reward. The system I am in has attempted to do that without any restructuring of the organization which has foiled all attempts to accomplish these aims.
134. I am the only physician in a CRNA-owned group. I am caught between an administration that wants a Physician-ran group and what we currently have now. In reality I need complete control of anesthesia group because, I am underpaid by the CRNA owner of the group. I was also left out on the hiring of some of the CRNAs. One of the three he hired has already left. Two others he hired need to leave. One of two thinks and wants to be in charge and was told by the owner of group he would be. Administration did not want this so medically I am charge but I can't make all the changes need to make at the current time.
135. You need to consider each country and culture differently.
136. I've been a solo practitioner most of my 40+ years in Medicine and Surgery. My three ventures into corporate/group practice have heavily contributed to my comments in this survey. My least favorite practice option was corporate (working for a hospital) followed by group practice. Nothing beats solo practice (if you can afford the overhead) for malleability and satisfaction. Alas, the recent reimbursement woes in healthcare have made solo practice a vanishing mirage... once we get to a single payor system the mirage will completely disappear.
137. I am seeking employment with another company at this time because of exactly the above.
138. MAs do not show much respect to doctors. An MA complains to the supervisor, and the doctor gets in trouble. They do not give the doctor the benefit of the doubt. The MA should go to the doctor first if there is a problem and the two should be encouraged to work through the problem rather than going over the doctor's head to a supervisor.
139. I don't believe that any of the above address the true problem with medicine. Too much work, too little pay. The above could all be perfect and I still would not be half way satisfied. If I didn't have to exhaust myself physically and mentally daily seeing seriously high volumes of patients and taking on huge responsibility for less than what an architect makes we might be half way there. The general public have a misconception about what doctors can do or

should do for them. There is also a serious American disease of placing unrealistic expectations upon us and wanting to be in the "driver's seat" when they have no working knowledge of how to "drive" in medicine. We need to bring respect back for doctors who have put up with a lot of crap over the years. And there's no such thing as a free lunch.

140. I'm a resident, so I'm kind of stuck with my organization.
141. Some questions were not smart. We're a private group–almost all staff members get along and we hardly fire anyone. Just like a family–maybe questions re more fitting for a large group such as a university where everyone is so sensitive about every little thing under the sun that we're afraid to even talk or use certain words, which is wrong.
142. Management and physicians are at odds with new healthcare implementations and honestly physicians should show and lead by example. More physicians should be in management of healthcare organizations.
143. The tail wags the dog in my clinic.
144. Good topic. Most of my answers apply to my job in LA, really enjoyed time at Stanford and continue to work there part time.
145. I am an interventional radiologist and most centers do not have a single group to perform these procedures and therefore the morbidity increases. The doctors in the center are great but leadership at the top has been lacking. The theory being is that your hospital is only as good as your weakest department. This is lacking.
146. The one issue I have with my current organization is the lack of "objective" performance evaluations. The evaluations that I receive are truly subjective, which is very disheartening. I do appreciate the mission of my organization, which is what led me to this particular job. However, there has been lack of transparency which actually may cause me to leave this job.
147. I haven't left a practice.
148. All of the attributes are good attributes–it's hard to select 3 least desirable ones.
149. I left my recent work as the MD, FACS, FACP, FACHE VP for Patient Care Quality and Safety and CMIO at a major Southern academic medical center because of my ongoing dissatisfaction with the entrenched persistence of a very conservative, "good ole' boy" med staff orientation at that institution that resulted in infighting between the medical staff and virtually every other element of the organization, unclear and inconsistent messaging by unprepared/unqualified senior physician executives, and lack of accountability for performance related to patient care quality and safety, most notably among physicians. My four years of work toward creating a safety culture in this environment had some notable successes but, frankly, ultimately burned me out. My impression is that physicians have begun to sense the winds of change and adapt to them in some locations, if not at this one; but it is a shame that it has taken federally imposed financial penalties to get the attention of our provider community.
150. Good survey. This is indeed important for adjustment and satisfaction with practice. It has caused me to leave some practices for others.
151. Interesting and necessary study.
152. Cultural fit and respectfulness are very important to the physician satisfaction and maximum productivity.

153. Times are changing very rapidly and it is hard for physicians to keep up with them all, it is a time for transition, so morale can be low. Expectations of work satisfaction have also changed a lot in my time in practice.
154. I just want to do a good job and be told once in a while that the institution is satisfied with my work.
155. Hasn't caused me to leave yet but, I'm considering it.
156. This is a poor fit for me, but I'm stuck and too close to retirement to change easily.
157. Emergency Medicine is driven by national or regional contract groups whose primary motivation is revenue.
158. Primary care providers are the "ugly little step sisters" that get second priority to the needs of the surgeons. Leadership is fraught with cronyism at current location. Staying at this employment site due to location.
159. I am the owner of this practice and I'm sure I have a little different view of things than my junior associates. We are having some issues of practice succession that have caused some hard feelings and difficulties, but are working through them.
160. Having missions and Value statements on paper, which don't mean much to anyone, has no value. None of this survey touched upon compensation, cost-of living and lifestyle issues. I think those are the most important factors why people leave and join another job.
161. I have an MBA so I have studied Org Behavior. They ALL could do better. "Sunshine" or Transparency would help a lot!
162. The success of an organization is only as good as the individuals who comprise the whole. It is unfortunate that even the best appearing organizations (on paper) are not necessarily the best when it comes to pt care or organizational effectiveness because we spend more time "treating the paperwork requirements" more than our patients.
163. Physician professionalism should be driving the development of a culture. Organizations treating physicians as employees should not be creating cultures and trying to mold physicians. There are huge faults on both sides being driven by the wrong incentives.
164. I have always worked in a good work environment, but this is the worst two years of my life and I will be looking for a change in the near future.
165. Degree of physician engagement and collaboration with physicians is a major driver of satisfaction.
166. Cultural fit is important.
167. Jobs are sufficiently difficult to find in academic medicine, especially when you are in a two-career situation with your spouse. Cultural fit is a wonderful concept, but not a realistic goal for married academic physicians.
168. Any cultural aspects can be handled by first having respect and openness to learn and listen.
169. It is tough to tell which cultural issues are part of my organization and which are cultural issues of society at large. Would the culture changes that prompt me to look elsewhere be just as bad elsewhere?
170. The general culture in the ER is one that is worsening over time. The stressors are high and seemingly it is all based on profit. There is a very large addiction culture that we are currently dealing and living with that is eroding the system. This is very poorly dealt with by these organizations and I feel it is being done for the sake of profit. A very dangerous path for sure.

171. A good fit outweighs remuneration.
172. Objectivity with clear guidelines is a rare find!
173. Family happiness is an important factor.
174. I would have inquired whether the answerer is currently looking to leave, feels that they cannot due to outside influences like family.
175. I feel there is a definite lack of accountability currently within my organization. This is frustrating.
176. Interesting survey. I never participated in anything similar.
177. Patient-centered focus means life of staff and physicians is poor. Having a leadership team that does not like conflict is bad. I don't think the head few guys listen. I was telling a story of the start of our organization to the head guy and after he walked away I heard him ask the manager, "Why do people think I care about that?" I overheard that. So he is probably here for money, not for cultural integrity.
178. Not very satisfied with my team's collaborativeness, performance objectiveness, respectability and making the environment friendly and a good place to work.
179. I have never had to leave a job because of lack of cultural fit but I can see myself doing that.
180. Great survey – good questions. How is this going to be shared and used?
181. If one can not influence their culture to change for the good than you must look at alternatives to their status as your employer.
182. Thank you
183. I am also the Program Director of Internal Medicine. I see a significant change amongst the graduating residents. They are less committed to their profession. They are more interested in their life style, earning more money and are less committed to their profession.
184. Being in solo practice has been the most liberating experience for me. It has given me the ability to adapt to changes more quickly such as implementing EMR in 2007 which is a decision I made. I was not as satisfied being an employed physician for a group as I felt that a group of doctors really had a hard time agreeing on anything. As a solo practitioner, I am able to implement change on my time scale. I am very different from most other practices as I have been able to implement my ideas more quickly than I would have in a group practice.
185. I am presently exploring other opportunities.
186. My practice is in-hospital only. Relationships with non-physician health specialties assume a much bigger importance in job satisfaction, particularly for someone not in any way related to hiring or firing. You left that out entirely.
187. Diversity and attention to all aspects of it are vitally important to me as I see patients of many different backgrounds. Respect for multicultural staff is also important.
188. Alignment between physicians and administration continues to be a nationwide problem.
189. I think it is very tough for any primary care internist today to be in total alignment with his/her institution's missions. My hope is this will change. Luckily for me my peers and direct supervisor share my values.
190. As we move to quality metrics, it will become increasingly difficult for physicians to be satisfied when employers continue to push quantity with moderate compensation. Physicians, contracted or otherwise, need to feel that concerns are heard and will be addressed.

191. The wording of this survey seems geared towards a certain outcome.
192. Great Survey. I hope it helps to mold the future of multi-group specialty clinics.
193. Definitely being a good fit is important.
194. I'm working for the federal government and it is so disheartening that it is almost impossible to change anything.
195. All the items are important, so I can't really consider 3 that are not important or least important.
196. This is precisely what I have had to go through this past year. I feel I have been rejuvenated and able to continue my profession due to a change of work environment that is more suitable to my values.
197. Well-worded survey about an important topic.
198. Unrealistic performance expectations have led me to quit jobs.
199. It was well thought out and planned.
200. The place I just left had a punitive culture, but advertised having a non-punitive culture.
201. We just sold our practice, which I loved, to an extremely large and fast growing organization. This change is a challenge.
202. The main attribute to working for the VA is that the stated hours and responsibility are good. However the communication between those administrators that control the flow of patients and the services available to the physician are very poor. They insist that the busiest and highest paid physicians perform menial tasks that are usually carried out by the secretarial staff.
203. It is not always possible to do due diligence before accepting a job. Sometimes you have to do it because of many situations with no solution in sight.
204. Since there is a move towards patient centered medical home… and there are many hoops to jump through in this regard… I was not sure if that is what you were referring to when using patient centered care.
205. While these issues are important, I am satisfied with an organization that pays me well and stays out of my way.
206. "Focusing" on teamwork does not necessarily mean that true teamwork is being propagated. They speak about it incessantly, speak the talk, but it is, much too much in "name" only, too much talk and not enough action, not enough focus on true safety issues and tackling them by, yes, holding ourselves accountable for errors or near-misses, instead of this "kudos, kidso," kudos," when the patient almost died! Let's instead get to the bottom of the problems together, face them, fix them together, now that's real teamwork. But you are criticized for constructively criticizing "the team"! Too many awful decisions are being made by the top—who are obviously administrators, responsible for "the budget," and they're people who are NOT working in the clinical arena. I've seen so many bad decisions re: electronic records, electronic order set, cumbersome "systems" to caregivers; time wasted on computers, just logging in a million times a day! Painstakingly typing. Or, learning yet another new system. For what? For more comprehensive billing, yes, they make no bones about it. But it is NOT better for patient care. There is no chart anymore, and too often no continuity, and resultant poor communication rendered by the lack of an orderly chart....all in the name of the Paperless God…and the almighty dollar…and those systems' sales reps

who sold the administration this BILL of goods. Because these systems cost the hospital millions.

207. I work as a geriatrician for the VA, I have worked with Indian Health Service, nice patients horrible culture and incompetence and a huge clinic where I was a shareholder and the culture was all Scandinavian, very cold, repressed and controlling and tasted like bad spoiled fish.
208. Psychiatry is a team specialty. The safety and care of the patient is first with business model second.
209. We have things we are working on but nothing insurmountable.
210. I started my own practice, in part, due to some of these issues.
211. This survey does not apply well to a solo practice with only two part time employees.
212. The impact of cultural fit on job satisfaction is huge.
213. I lost my job because my organization decided that my style no longer fit their needs despite 23 years of service. Another job has not been found. I am happy to no longer be working for the organization, but would have liked to have a compatible job as I am now somewhat bored in my "retirement."
214. Important issues have been brought up here. The results should be interesting!
215. New experience in such an institution.
216. My job involves seeing patients in their homes or assisted living; I love this part of the job. I feel that the company officials are in an ivory tower with no concept of what I do, and they have made it very clear that profit is the driving force in the company. But my feelings for my patients keep me in this job.
217. As a small owner-run partnership where everyone is compatible, highly talented, and flexible, we are all very satisfied. We are, however, planning to either close down, eliminate our participation in Medicare or move abroad, once Obamacare takes hold. Our core values are incompatible with being subject to a hospital CEO's micromanagement of our practice.
218. Surgeons run the place and disparage anesthesiologists, in front of OR staff, janitors, everybody. They even disparage each other in public. They want to cut, and the patient's best interests are ignored. Sometimes I wonder whether they even went to medical school! No real physician could be that ignorant of basic concerns about patient safety!
219. Fewer resources should be spent on productivity and more on ensuring quality.
220. One of the partners believes he is the owner and the boss.
221. The change in cultural fit has been a great cause of job dissatisfaction and has prompted me to do some locums work outside the system but it is difficult to move the entire family.
222. Medical culture has generally been slower to evolve and remained very hierarchical in comparison to the technology industry, for example. In some ways, this does not affect overall patient care, but it does make for less flexibility to innovation. On the other hand, medical culture is also a reflection of the history and current practice of medicine. It is difficult to envision how to change this culture if medical education and training remains the way it is now.
223. The “culture” is often more mythic than fact as companies espouse many platitudes such as “team” and “patient-centered” but act mainly with the bottom line their true principle. So it doesn't matter that much to me whether an organization claims to use these as guiding

principles. Typically the “team” approach allows non-medical administration to be in charge as the team leader and “patient-centered” is a way administrators imply caring about enabling us to help patients but in reality is a way of deferring to Medicare based patient satisfaction measures—again it's all about the nickels and dimes of reimbursement. Perhaps you should add a question in your poll about whether we believe our organization actually practices what they preach. Not whether they do a good job meeting my satisfaction, but whether we really believe they believe what their “culture” is.

224. Interesting study.
225. The new standards are different than my experience as a resident, fellow and young staff. Although I have not entered the water of job search at my late career stage, I did look at a senior position in a new organization as their stated mission resounded with me (other issues led me to not pursue that new position). Our own mission (and many others) use similar claptrap ("excellence in care") but when it requires "skin in the game" the leadership is not quite willing to commit to the innovation, new therapy, marketing that would be necessary to move the next stage. Increasingly, it feels as though government and educational mandates are forcing our center not to excel but be dragged back to mediocrity. My problem is that we are going along like sheep rather than kicking and screaming as we should.
226. I have never left a position; I have been here 24 years.
227. The specific reason why I left surgery and went into PMNR was due to a complete disconnect between what I felt my values were compared to a surgeon's. This is obviously a generalization, but it was enough of a motivating factor for me to change careers to rehabilitation medicine.
228. Other determinants have significant weight when it comes to staying or leaving.
229. The cultural attributes you cite are redundant terms.
230. Transparency and open evaluation in a non-manipulative manner are a major pitfall. Ultimate practice demise will ensue if not present.
231. Culture is influenced far more by the parent organization than at the practice itself. I love my practice but dislike the administration so much that I contemplate leaving about every 3 months.
232. All points brought about are very relevant to our practice of medicine. Furthermore, patients are more informed of their problems, and expect that their questions will be answered adequately by the physician. Patients now have access to the Internet, they read, discuss about their issues in the Internet forum, and believe it or not many times are more educated and some doctors. Patient satisfaction assessment has become mandatory. Surveys are currently performed in the post discharge phase. Remember, we are in the midst of technological evolution, and all branches of medicine too.
233. Building teams and giving them support.
234. I will be leaving this job in 9 months due to the fact that their values do not align with mine.
235. I left a position at the Department of Public Health because the cultural climate did not welcome change or innovation, even when it benefits the patients. I now work at Kaiser which is a very patient-centered organization with an excellent electronic medical record.
236. I have been taken advantage by former partners.
237. Cultural acceptance, sensitivity and spirituality are very important measures in our structuring.

238. Please email me a copy of this survey and final results.
239. Focus on patient satisfaction has eroded professionalism and made physicians to feel like service providers in retail. The fact that every complaint needs to be documented and researched is distracting from the ability to provide good care by making physicians second guess decisions based on how a patient will “feel” about being told no despite it being the right medical decision. If a patient is not happy with being told no, they can call and complain to any level of management and then the physician must answer why this patient is complaining about them. This is not in anyone's best interest, yet it is the culture in our clinic system.
240. I came to medicine late in life and feel like a misfit because of this.
241. Professions should be personally rewarding because you enjoy and are proud of the work performed. This is something not able to be measured by dollars. Organizations with leaders consumed with their own performance appraisal instead of safe, prompt, precise, and caring treatment of the patient by all are not team builders and give only lip service to Mission statements.
242. These topics are general and vague. Often practice “fit” relates to smaller things such as work hours, call schedule, support from physician extenders, and physical plant–i.e., out of date equipment.
243. I think a cultural fit is important, but ultimately the most important is being able to provide quality care to patients. You do want to have an organization that supports you in this role. Particularly with technology and assisting you in the changes that have been coming up in healthcare…medical home…documenting quality indicators in a way that is reportable…etc.
244. Not all of these questions fully match my form of practice but answered them as best as possible.
245. I wish it were better.
246. Lack of support for physicians is growing. The ever changing environment in medicine is great. The lack of adaptiveness to the environment is great. I will be leaving my current practice as will several others.
247. There are racial, sexual orientation, and gender dynamics that affect the cultural orientation of the institute as well.
248. I have tried to have a collaborative, supportive, transparent, non-hierarchical department but the overall organization is very power-based and secretive.
249. As a younger physician, I am unwilling to accept that an older physician has power or authority over me. Physician groups must be democratic and transparent or they become dysfunctional quickly.
250. My most important criteria for evaluating a practice are transparency, equity and good leadership that applies these principles aggressively. I left an academic medical center and joined the VA and have been very happy since. I could definitely make more money elsewhere but I feel very supported and valued where I am and that keeps me coming to work happy most days. I've done a variety of locum stints where I could make more but the transparency and equity issues were nowhere.
251. People have to like and respect one another, share the money fairly, and divide the work equally. Innovation is critical to make doctors feel like they are doing the most modern

medicine possible, and so that they feel rewarded for giving their patients the best that medicine can offer them.

252. Get government out of the practice of medicine. Dismantle "Obamacare" immediately. We do NOT want to go the way of Europe.
253. An administrator to be a physician supervisor has to be of the same intelligence and educational level.
254. Synergy and strong alignment between administrative and Physician realms is exceedingly important. Physician led organizations are imperative as majority of all Physicians (in my opinion) see Medicine as "their" Profession supported by all others. We need to equate the Profession to its initial roots of Physician solo driven. Again, that's my perception. I want ownership of the Profession back.
255. While our hospital is a profitable organization and provides excellent patient care, and decent physician support, it is very difficult to change things here and to get clear answers about many things, like why collections are 18% or less.
256. Your questions are difficult to evaluate appropriately. I am employed by a physician owned company, managed by another group, working within a hospital environment. There are 3 different ambiances to attempt to coordinate the best outcomes for good patient focused care. The hospitals provide an entirely different culture than what the mission and values are of the owners of this contracted physician group.
257. I honestly don't know, this is my third job since leaving the army. There was such a clear definition of where I stood in the army, I haven't seen it since.
258. I'm in a private group practice, the cultural problems for me stem from the changes in the hospital system that I take most of my patients. I am a busy surgeon performing approx 2200 procedures a year, this brings a lot of business to the hospital despite this they are quietly moving towards an employed staff and paying people to compete with me. My cultural animosity had its roots in the hospitals lack of transparency.
259. Recruiters have one goal, fill a slot. They will lie, misrepresent, whatever is necessary to fill the position, the company comes first.
260. Lack of clear vision and acceptance of stagnation and lack of future goals is important.
261. This survey is totally irrelevant to a physician in private practice who owns all the stock in her PC. Idiotic. I pity the poor young docs who are employed in a staff model. I would never go to med school again if I could redo my life and none of my children want anything to do with the practice of medicine. It is all about corporatizing medicine and that is why we waste so much money on medical care now. Most of the money goes to the corporations not to the doctor. What a waste of my MD.
262. Thanks.
263. This survey ASSUMES that touchy-feely concepts like respectfulness and transparency should be valued. This is what is wrong with America today. The erroneous assumption that people should respect each other or tolerate mistakes without punitive action is absurd. If my people (I am CEO) make a mistake, they are fired. Period. The fear of termination keeps them from making a major mistake. They also get berated verbally for insubordination, minor mistakes and when I generally feel like doing so. We work as individuals, not as a team, because the job demands an individual rather than a team approach for the good of the patient. Collaboration and teamwork are nothing more than pathetic excuses to compensate for the shortcomings of other team members. It should be shoved up the appropriate orifice.

264. I am satisfied with the culture of the organization.
265. The focus on patient care has been lost amid all of the other "issues."
266. "When the rate of change outside is greater than the rate of change within, the end is near," Jack Welch. "One must prepare for the second half of a career," Peter Drucker. "Success is hard work. Hard work requires sacrifice… that why only few achieve the final goal," paraphrased Steve Jobs.
267. Cultural fit was not as important.
268. I am leaving this organization in 3 months. Some of these factors had influence on my decision.
269. Values related to cultural sensitivity are just spoken words that are not translated in real life.
270. It's a problem when culture changes and leaders are unable to lead their coworkers.
271. I believe both patients and practitioners would appreciate it if cultural attributes of a group were made more explicit. Often they are given lip service in marketing but not in practice so it is often hard for patients and practitioners to know until they have significant experience with a group whether they will be a good fit. I do think culture is one of the most important determining factors in retaining happy physicians. (This is an area that I teach about!)
272. My job satisfaction has more to do with regulatory factors than my work environment per se. It's not too great to be a doc now.
273. I love my co-workers, my patients and my profession. The majority of my career has been in academic medicine. I am presently employed in a small corporate medical school where the CEO/dean and the nursing director are sociopaths. Physicians have no say in nursing or administrative staff, or executive level decisions. I've had it with corporate medicine, with its exclusive focus on revenue generation. "No margin, no mission." The amount of money is so big that things won't change easily. If I were younger, I'd move to another country
274. Respect is a thing of the past for physicians. We just don't get that anymore. We are used to make money. We are told only the information we need to know. We are used. I have never had a job yet that treats me like the educated professional that I trained so many years to be. I leave a job when it gets so bad I can't take it anymore. Usually people with little education, let alone medical education are telling me how to practice. We are making less and less money and the future does not look good. I will never be able to pay my student loans off until I die. If I could find something else to do, that made decent money, I would. I don't understand why any young person would decide to take this path in this day and age. I love my patients. I love the work. But, it is impossible.
275. These responses are based on the job that I will be leaving at the end of October, and are central to my decision to accept a new role, a leadership and clinical role at an organization that values the same things as I do, at least based on what I could glean during the interviewing process.
276. "The Mission" as stated is not the true mission.
277. Teamwork, communication, flexibility and patient-centeredness is the key.
278. Very interesting & expanded my thoughts on how I fit & don't fit in the practice.
279. Private practice is gone. Big organizations advertise a lot, and say they are interested in patient care, but dollars are what matter.
280. Teamwork with good communication, respect and strong collaboration help the clinic perform better.

281. University system has a power structure at division level that doesn't believe in leadership and team attributes. Private practices all power is where money flows.
282. Very important to feel comfortable where you work.
283. For-profits will die with the affordable health plan, Obamacare. We might as well send all 3rd party payors off the island and have a single payor, national health plan. Bottom line, we all would be doing the same thing without the freaking epidemic whining.
284. I quit the group practice recently. I had significant differences in practice with the group.
285. The just culture concept is the best idea I have seen come down the pike for many years. Modern healthcare management nationally seems to ignore it.
286. I want to be a part of an organization that supports physician executive development and has a clearly defined path(s) for mid career physicians seeking this type of opportunity.
287. My organization is way ahead of the curve when it comes to cultural awareness and work culture. They have foresight and I believe our management is good at what they do.
288. Due to verbally abusive behavior by ownership toward all staff including physicians as well as lack of payment of wages I have given notice of termination of my contract.
289. Most of the attributes that are listed are expressed to some degree in any organization, but may represent areas of significant weakness. Some attributes are expressed insincerely, such as open dialogue without responsiveness or feigned respect. Hubris among the leadership contributes greatly to cultural divide.
290. The organization chief should have proper training and a psychological evaluation before given post.
291. It is important to share info with all physician members and not on a need to know basis.
292. I left a group practice with a poor cultural fit to start my own solo practice, in order to establish a practice that would be a perfect cultural fit.
293. Since I just left the organization, I responded as retired. The organization that I left was a very poor fit which led to my departure. My greatest disappointment is the effect that lack of leadership has on morale and ultimately patient care. The question on three least important attributes is inane! All of the attributes are important, and the selection of the three "least important" is not germane at all.
294. I work at a veteran hospital, we're doing exceptionally well in this regard.
295. I believe that Cultural sensitivity and competency are very important needed features in any successful Healthcare Program, no matter what.
296. Interesting topic. Sometimes difficult to read the culture of an organization from the outside.
297. You don't ask about gender disparities. There are clearly issues that women culturally deal with that men do not. My current employer is NOT family/woman friendly.
298. We need more trained physician leaders.
299. Docs have all responsibility with little sometimes no authority. Amend HCQIA so that SHAM peer review doesn't destroy good docs.
300. The ability to deliver innovative patient-centered care can carry me through the cultural challenges.
301. I left a practice after 12 years because I felt my partners did not value me or value team work. My new practice is totally opposite–respectful and team-oriented and I am MUCH happier.

302. My current organization is 100% profit-oriented without any level of accountability or responsibility towards patient care, leadership responsibility, or individual accountability. As a result, individual physicians are profit-driven and very much against team-based initiatives or collaboration. These issues are the primary reasons not only to choose to leave this practice but also to leave the area as I do not want to compete with a company with these values.
303. The team culture is vital to my day to day job performance, satisfaction, and overall happiness.
304. People in an interview process have to be totally honest about what they are saying about the position and not just hope that things will work out when you arrive to work.
305. I work in a large organization, but in a small satellite office. I am very happy with my primary location and the culture there.
306. Medicine is a thriving industry and a dying art.
307. This survey will surely bring out different ideas how to change culture at a physician's work place, and will also give physician an idea what changes need to be made at the work place for better care of the patient as well as work satisfaction.
308. The culture of my workplace for the nurses, physicians and staff is outstanding. The managers and top leaders are becoming really out of touch with the rest of us. It's very disappointing.
309. Most of my patients and staff are Asians. I am a Caucasian man. However, I always do everything I can to learn and be culture sensitive and understand my patients' and employees' needs.
310. I value honesty, mission, transparency and teamwork. The organization's employees need to understand the future direction of healthcare and be ready to lead, even at lower levels. Leadership's job is to develop more leaders, not more followers. I have left organizations that were not transparent.
311. More cultural-related surveys are needed.
312. With the job market the way it is, concern with culture is a luxury. I'm glad I have a consistent paycheck.
313. All it takes is a few loyal hard working people (nurses and staff) to make patient care a primary focus, and job satisfaction can rise to the top, without performance goals stated, or without great leadership or ideal communication.
314. I am leaving my current position because it's a bad fit since it became a for-profit hospital; my new position should be a much better fit.
315. My prior group lost focus and accountability.
316. I'm in a toxic environment, starting with administration, which is why they keep losing good doctors and I can't wait until I am out of there.
317. It is tough to select least important cultural attributes as they all are important.
318. Culture eats strategy for lunch.
319. These questions are very similar, every setting has its own way of running business. With different measurements to evaluate popularity or the competence of physicians. We all learn to be a team player, reliable, flexible during residency or we wouldn't pass the task, so what these questions are reflecting are more suitable for residents.

320. The job market is so bad I have no choice but to stay in my current organization even though I think it could do better in nearly every aspect of this survey.

Appendix B

Administrator Open-Ended Responses

1. It was very hard to pick the bottom three cultural attributes! They are all important.
2. Generally physicians leave because of money or family issues.
3. Our recruitment process is very comprehensive and focuses on making sure the candidate understands our organization to ensure they will fit with our culture.
4. As time has evolved over our history, cultural fit has become a more important consideration in who we hire and the strategic directions we take.
5. Although focus in selecting is based on performance-based interviewing, an organization would do well to define characteristics that describe their culture to establish questions that would determine the cultural fitness of a candidate.
6. Great survey.
7. This is primarily a private practice medical community where the physicians are very focused on their private practices but still need the hospitals for inpatient care. From a hospital perspective it's hard to get adequate physician focus.
8. It is often difficult for organizations to really define the working culture vs. what culture they are trying to achieve.
9. Sometimes a departing physician may not cite cultural fit as his/her reason for leaving, but it can be inferred from other discussions/activities.
10. My organization thinks these matters are very important, as do I. The Studer group has been hired to help. I was enlightened by the Stephen Beeson three books.
11. We have been doing behavioral panel interviews with all physician candidates for about a year. More to discern a "hard stop" to cultural fit. Again, this is but a part of our interview process.
12. We only have CMOs as employed physicians, the medical staff is voluntary. Hospitals in California, w/exception of Kaiser and UC System, cannot employ physicians. Our physicians are driven by "what's in it for me" in most instances. However, our mission/values are religious driven and this is very important to many of our medical staff.
13. Culture is critical, and distinguishes our group from our competitors. Molding and institutionalizing this culture is of primary importance to the success of our group.
14. In an ideal recruitment world, where supply approximates demand, there would be even greater emphasis on cultural "fit" because the hiring organization could feel that there wasn't a need to select the first or second candidate who came along.
15. The patient's culture is also a factor in Pain Management.
16. Physicians enjoy practicing within their specialty when staff is knowledgeable and ancillaries and easily arranged. They want to be noticed by the "system."
17. We know what we need regarding fit within us, but it hard to assess during the recruitment process. One truly knows once the doctor is here onboard and then it may be too late. It does, however, give us the opportunity to actively work on that "fit" so the doctor will stay and be happy and productive.
18. We are poorly aligned right now but working on it.
19. The physicians fit very well within the current culture, which they created. The organization will not be successful long term with the current culture.
20. Most of our physicians are not employed by us. They are recruited into groups who use our facilities because of their technical expertise.
21. I think many of the cultural attributes go hand in hand. When you have the basics like patient centered-focus, transparency and supportiveness, other attributes come naturally, such as respect, open dialogue, clear performance expectations and clear mission and values.

Appendix C

Physician Specialties

What is your primary area of practice or specialty?