Notable Grand Rounds

of the

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Wayne State University
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Detroit, Michigan, USA

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HOSPITAL CULTURE: BUILDING ISLANDS OF EXCELLENCE IN ADVERSE ENVIRONMENTS

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September 3, 2025

About Notable Grand Rounds

These assembled papers are edited transcripts of didactic lectures given by mainly senior residents, but also some distinguished attending and guests, at the Grand Rounds of the Michael and Marian Ilitch Department of Surgery at the Wayne State University School of Medicine.

Every week, approximately 50 faculty attending surgeons and surgical residents meet to conduct postmortems on cases that did not go well. That “Mortality and Morbidity” conference is followed immediately by Grand Rounds.

This collection is not intended as a scholarly journal, but in a significant way it is a peer reviewed publication by virtue of the fact that every presentation is examined in great detail by those 50 or so surgeons.

It serves to honor the presenters for their effort, to potentially serve as first draft for an article for submission to a medical journal, to let residents and potential residents see the high standard achieved by their peers and expected of them, and by no means least, to contribute to better patient care.

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Hospital Culture: Building Islands of Excellence in Adverse Environments

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September 3, 2025

Editor's Note: This paper is an abridged version of the authors' presentation at Surgical Grand Rounds.

Author Note. The perspectives summarized here do not necessarily reflect on any particular institution except those specifically identified by name.

Introduction

This article examines the decisive role of culture in hospital performance. Measures such as patient safety ratings, infection outcomes, patient experience scores, and independent grading systems reveal sharp contrasts between institutions. Hospitals that consistently rank well —such as Mayo, Cleveland, Ochsner, and Lahey —demonstrate that cultural commitments to collegiality, transparency, physician leadership, and patient dignity translate into measurable safety and quality. In contrast, hospitals with persistently poor ratings reveal the consequences of cultural collapse: administrator-driven identities, fragmented communication, disengaged physicians, and neglected patients.

A Department of Surgery stands at the crossroads of this contrast. Surgery dramatizes culture in action—in the operating room, in training, in the daily handoffs that either build trust or sow distrust. Departments can choose to emulate the traits of high-performing institutions, even within struggling hospitals. By fostering ownership of patients, civility in the OR, structured communication, and transparent measurement of outcomes, surgical departments create micro-cultures of excellence.

These departmental cultures, once established, can ripple outward, influencing other specialties and eventually reshaping the broader institution.

Thus, while hospitals may be graded as a whole, their cultural renewal can start in one department. A Department of Surgery, by choosing to act as if it were already part of a high-performing hospital, can lead its institution away from decline and toward renewal.

Hospital culture determines whether institutions thrive or decline. While technology, finance, and infrastructure are important, the decisive factor is the set of values and behaviors that guide everyday practice. Top-performing hospitals—exemplified by Mayo, Cleveland, Ochsner, and Lahey—show that physician-led governance, interdisciplinary collaboration, transparency, and attention to patient dignity create environments where safety and quality flourish. By contrast, hospitals that falter exhibit cultural neglect: fragmentation, disengagement, and the erosion of trust.

For surgical departments, culture is not an abstract concern but a lived reality. It is experienced daily in the operating room, in residency training, and in interprofessional collaboration—or the lack thereof. Departments of Surgery can either inherit the malaise of their host institutions or serve as incubators of resilience, innovation, and cultural renewal. This article argues that a department can, in fact, grow a successful culture even within a hospital whose institutional ratings suggest deep systemic problems.

Drawing on lived experiences and institutional exemplars, it explores how surgical departments can cultivate ownership of patients, foster collegiality in high-stress environments, and measure outcomes in ways that mirror the best hospitals. These micro-cultures of excellence, once established, do not remain isolated. They radiate outward, influencing other departments and potentially reshaping the trajectory of the entire institution.

In this way, the path from low-performing institutions to centers of excellence does not begin in the boardroom. It begins in the operating room—with a department that chooses to live as though excellence were already its standard.

Hospital Culture

Hospital culture is an elusive but decisive factor in determining whether an institution thrives or falters. It is more than mission statements or branding. It is the composite of values, behaviors, and expectations that govern how staff interact, how patients are treated, and how leadership decisions are made. A single lapse in behavior—a sharp word, an unresolved conflict—can define a physician's reputation for years, not because of medical incompetence but because of cultural context.

Good hospitals cultivate cultures of ownership, collegiality, and accountability. They emphasize teamwork over hierarchy, patient partnership over transactional encounters, and rotational leadership over entrenched authority. Poor hospitals, by contrast, often outsource culture to administrators, leaving physicians disengaged, communication fragmented, and staff demoralized.

The Mayo Effect

Mayo Clinic embodies what a culture of excellence looks like. Its "Mayo Effect" rests on integrated clinical practice, research, and education, but more deeply on a spirit of collegiality and shared mission. Characteristics include:

- **Patient ownership**: The first physician who encounters the patient assumes responsibility for coordinating care.
- **Time to listen**: Appointments are unhurried, enabling deeper trust and accuracy.
- **Rotational leadership**: Leadership positions rotate regularly, ensuring freshness of ideas.
- **Physician-led governance**: Mayo remains a physician-led nonprofit, with

administrators in partnership rather than command.

- **Salaried staff**: Physicians are paid on salary, freeing them from volume-based incentives that erode quality.

The result is not just internal harmony but external recognition. Independent measures of hospital quality—including safety grades, patient experience surveys, and national rankings—consistently place Mayo among the highest performers.

Cleveland Clinic

Founded on a cooperative military model, Cleveland Clinic has extended the group practice ethos into a modern, multispecialty structure. Hallmarks include:

- **Institute model**: Care organized by disease systems, integrating medical, surgical, diagnostic, and support services under one roof.
- **Transparency**: The Clinic publishes annual outcomes books, openly reporting complications, mortality, and innovations.
- **Access improvements**: Wait times for new patients were cut in half; pathology turnaround improved by 88%; chemotherapy delays reduced from 60 to 20 minutes.
- **Employee wellness**: Programs for weight loss, exercise, and smoking cessation, with measurable outcomes such as 82,000 pounds lost by employees over a few years.

Cleveland Clinic's achievements are widely admired, though its ratings across different scoring systems remind us that even strong cultural models are vulnerable if values are not consistently translated into everyday safety outcomes.

Ochsner Clinic Foundation

Ochsner's origins trace back to a small group of physicians pooling modest resources to create a clinic modeled after Mayo and Cleveland. From its beginning, Ochsner emphasized hospitality in healthcare—an innovation often dismissed as cosmetic but which, in practice, reframed the patient experience. Comfortable patient rooms, attention to environment, and an ethos of being "served as if in a hotel" helped to foster trust.

Culturally, Ochsner operates with guiding values of service, healing, leadership, education, and innovation. Its mission is local—to provide care in New Orleans—but its aspirations are global: to integrate compassion, teamwork, and innovation across every discipline. Physicians and nurses alike are recognized as part of a unified staff, rather than siloed competitors.

The outcome of these cultural commitments is reflected in its safety and quality performance. Ochsner routinely performs well on measures of patient experience, access, and safety, and its quality scores are typically in the higher range. These outcomes situate it among hospitals that succeed in delivering safe, efficient care despite the economic and social challenges of its community setting.

Lahey Hospital and Medical Center

Founded in 1923 by Dr. Frank Lahey with a deliberately multispecialty team—anesthesiologist, nurse, surgical assistant, gastroenterologist—the Lahey Clinic was revolutionary for its time. Its mission continues to highlight:

- Providing superior health care leading to the best possible outcome.
- Exceeding patient expectations daily.
- Advancing medicine through research and training.
- Promoting wellness through community partnership.

The Lahey model demonstrates the power of shared purpose across specialties. By embedding collaboration in its DNA, Lahey avoids the turf wars and interdepartmental silos that plague less successful hospitals.

In independent assessments of hospital performance—including national rankings, patient satisfaction surveys, and safety metrics—Lahey consistently scores well, underscoring that its culture of collaboration translates directly into patient outcomes and trust.

The Common Threads of Success…

Across Mayo, Cleveland, Ochsner, and Lahey, certain patterns emerge:

- **Physician-led governance**—culture is not outsourced to administrators.
- **Rotational or distributed leadership**—preventing entrenchment and promoting innovation.
- **Collegial teamwork**—across specialties, disciplines, and professional hierarchies.
- **Attention to environment and hospitality**—recognizing that architecture, comfort, and patient dignity are integral to healing.
- **Transparent outcomes and accountability**—through published data, patient feedback, and continuous measurement.

Hospitals that embody these traits reliably perform well on multiple independent measures: patient safety scores, infection and complication rates, access metrics, patient satisfaction surveys, and third-party ratings. By contrast, institutions that abandon these commitments risk sliding toward mediocrity or failure.

…and Failure

If Mayo, Cleveland, Ochsner, and Lahey illustrate the traits of high-performing institutions, hospitals at the other end of the spectrum show us what happens when culture collapses. These are the hospitals that consistently perform poorly on quality ratings—whether patient experience surveys, infection and safety outcomes, or external grading systems—and their deficiencies signal systemic breakdowns in patient safety, communication, and trust.

Many failing hospitals did not begin that way. Some were founded before the great clinics—during the Civil War era or the late 19th century—with strong commitments to service and training. Yet over time, they slipped from innovators to laggards. Where Mayo developed a "Mayo Effect," these hospitals lost any unifying spirit. Their public histories may cite outdated achievements, with no mention of contemporary excellence.

A review of struggling hospitals reveals common features:

- **Administrator-led identity**: Culture is defined by mission statements crafted by marketing departments rather than lived by staff. Acronyms and slogans look polished but rarely reflect authentic day-to-day behaviors.
- **Physician disengagement**: Faculty and staff struggle to articulate their institution's mission or core values. Departments do not feel ownership; instead, they feel disconnected from leadership.
- **Fragmentation**: Specialists avoid collaboration, even refusing to communicate across disciplines. Patients are transferred to external institutions for services that should be provided internally—a tacit admission of incapacity.
- **Erosion of accountability**: Faculty and residents encounter indifference during morbidity and mortality conferences,

where distraction or disinterest is tolerated rather than constructively addressed.

- **Patient neglect**: On the wards, requests for pain relief, ice, or assistance are acknowledged but often not fulfilled. Small failures accumulate into a reputation of indifference, magnified by patient surveys and safety data.

The consequences of this erosion appear across all quality indicators: higher rates of infection, surgical site complications, preventable falls and pressure injuries, longer lengths of stay, and even mortality from otherwise treatable complications. Public rating systems make these failings visible, but they are already evident to patients and staff who experience the culture daily.

Departments of Surgery as Seedbeds of Culture

Hospitals do not succeed or fail solely on the basis of their financial resources, buildings, or technology. They succeed or fail on the strength of their culture. Culture, in this sense, is the invisible scaffolding that shapes daily behavior—whether colleagues treat one another with respect, whether patients are viewed as whole persons or as problems to be solved, whether leadership renews itself or clings to power. In good hospitals, this scaffolding is visible everywhere, from the way appointments are scheduled to the way residents are trained. In failing hospitals, it crumbles into fragmentation, disinterest, and mistrust.

A Department of Surgery is uniquely positioned within this tension. Perhaps more than any other specialty, surgery dramatizes the stakes of culture. A single episode in the operating room—a sharp rebuke, a dismissive gesture—can mark a surgeon for years, as the author has personally witnessed. In the absence of shared norms, one lapse can define a reputation and limit leadership opportunities. Yet in a different environment, with colleagues who frame conflict as passion rather than anger, the same individual may be celebrated, supported, and even beloved. This lived reality underscores the point: departments generate their own micro-cultures, and those micro-cultures profoundly shape professional identity.

Summary

The great hospitals—Mayo, Cleveland, Ochsner, Lahey—illustrate what happens when culture is nurtured and institutionalized. Mayo's insistence on physician ownership of patients, rotational leadership, and salaried staff created an ecosystem where collegiality is the default. Cleveland's institute model integrated specialties in a way that encouraged transparency and accountability. Ochsner reframed the patient experience through the language of hospitality, demonstrating that environment and dignity matter as much as clinical acumen. Lahey's founding on multispecialty collaboration showed that silos need not exist at all. Their high ratings across multiple systems—including national rankings, safety measures, and patient experience scores—are the visible scorecards of these cultural commitments.

By contrast, hospitals that have lost their culture display the opposite tendencies. Culture is outsourced to administrators and expressed in slogans rather than lived behaviors. Physicians no longer know, let alone believe in, their institution's mission. Communication across specialties is minimal; referrals leave the system altogether. Faculty disengage at M&M, residents feel isolated, and patients notice the neglect in unanswered call lights and indifferent explanations. These are not simply lapses in efficiency; they are symptoms of a broken culture.

Yet within such an environment, a Department of Surgery can act as a seedbed of renewal. Even in a failing hospital, a department can choose to articulate its own values, set its own tone of collegiality, and model ownership of patients. It can insist that operating rooms be places of

mutual respect rather than bullying. It can preserve habits of communication—structured handoffs, interdisciplinary collaboration, attention to patient dignity—that mirror the practices of high-performing institutions. In doing so, the department creates an island of culture that stands in contrast to its surroundings.

The persuasive power of such an island should not be underestimated. When a department adopts transparent outcome metrics, celebrates teamwork, and demonstrates improvements in safety and access, it provides evidence that culture and quality are inseparable. In time, these practices radiate outward. Nursing staff, anesthesiology colleagues, and even administrators begin to notice that the surgical service is different—more disciplined, more responsive, more humane. This reputation can alter perceptions within the hospital and beyond, just as Mayo's "effect" became a national referral phenomenon.

The promise, then, is that a Department of Surgery can both shelter its members from the corrosive effects of a failing hospital and simultaneously offer a blueprint for institutional renewal. The very measures that expose the failures of poor hospitals—infections, falls, surgical site complications, communication breakdowns, mortality from treatable conditions—can be tracked and improved within a department. As improvements accumulate, the department demonstrates in microcosm what the entire hospital could achieve if culture were taken seriously.

In this way, culture becomes contagious. A low-performing hospital does not have to remain so. By cultivating its own norms of respect, ownership, and accountability, a Department of Surgery can begin the work of shifting the institutional tide. The transformation of a hospital's reputation may begin not in the boardroom, but in the operating room—one department choosing to act as if it belonged to a top-performing hospital, and eventually making that aspiration real.

Conclusion

Hospital culture is not incidental; it is the very determinant of whether a hospital is a place of healing or a place of harm. The contrast between high-performing institutions and those that lag is not primarily a matter of wealth, geography, or technology. It is a matter of lived values: whether physicians lead with ownership, whether staff communicate across boundaries, whether patients experience dignity, and whether leadership renews itself rather than clinging to the past.

Departments of Surgery occupy a singular role in this landscape. Surgery is high-stakes, multidisciplinary, and public: every case involves collaboration across professional boundaries under the most stressful conditions. When a surgical department models professionalism, teamwork, and ownership, it provides a vision of what the entire hospital could be. When it chooses instead to indulge arrogance or fragmentation, it accelerates institutional decline.

The lesson from successful systems is that culture produces outcomes. Their consistently strong performance across quality measures—including patient safety, access, transparency, and external ratings—reflects structural commitments to collegiality and patient-centeredness. The lesson from struggling hospitals is that when culture erodes, safety and trust collapse with it. Departments cannot wait passively for hospital leadership to set the tone. They must cultivate their own culture, prove its impact with measurable outcomes, and offer it as a model.

In this sense, a Department of Surgery is not merely a clinical service line. It is a cultural engine. By setting and exporting its own standards, it can transform not only the perception of surgeons but also the trajectory of the hospital. To borrow the logic of contagion, a high-performing culture can spread even in a low-performing environment. And when it does, the hospital itself may yet be redeemed.

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