

# Time for a New Model for Hospital Physician Collaboration

A collaborative working relationship with physicians has long been recognized as a critical factor in successful hospital and health system performance. Physicians are integral to initiatives for appropriately using expensive resources, improving the quality of patient care and developing programs in emerging areas of medicine.

The 21<sup>st</sup> century is starting out as one of the worst periods in recent

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memory for hospital-physician relationships. Physicians are feeling underpaid and unloved, hospitals are equally challenged, and each is striking back in ways that adversely affect the other.

Why are physicians so angry? Start with reduced reimbursements, such as a 5.4 percent Medicare rollback this year. Physician groups say Medicare pays below their cost for office visits, ignoring rising salary and malpractice insurance expenses. Managed care fees are no better, and getting costly

drugs and tests approved is a hassle.

Physicians are beginning to opt out of some payment programs. The American Academy of Family Physicians reports that 17 percent of family physicians have stopped taking new Medicare patients. In Massachusetts, the state's three largest health plans report that more than 700 physicians have left their Medicare panels in the last year, many saying fees to treat senior citizens are too low, according to *The Boston Globe*.

Physicians report lagging morale and alienation from their profession. In the latest Kaiser Family Foundation survey, 58 percent of physicians say their personal enthusiasm for practicing medicine has declined. Three of every four believe managed care has worsened medical care. Nearly half would not recommend a medical career today, blaming paperwork, loss of autonomy, less respect for the medical profession and inadequate financial rewards.

Another sign of discontent: A small but growing number of primary care physicians is opening "boutique" medical practices. For a membership fee of several thousand dollars per year, doctors promise super-service: same day appointments, the doctor's cell phone number, house calls and unhurried, personalized care. Dr. Steven Flier, featured recently in an article in *SmartMoney*, left a practice with a

panel of 4,000 patients and now has just 300. Each pays \$7,500 a year, plus fees for visits and services, for all the time and attention he can give.

## Physicians' Response Targets Hospitals

One of the primary survival strategies in this environment for physicians—especially specialists—has been to open outpatient diagnostic and treatment centers focused on high volume, financially lucrative patient care. Usually located in well-to-do growth communities or right down the street from the hospital, outpatient centers for ambulatory surgery, imaging, cancer treatment, sports medicine and women's health are designed to be efficient, cater to patient and physician needs and be less stressful for staff than the hospital. And of course, the physician owners share in the profits.

From the hospital's viewpoint, though, patient-focused centers skim the cream of well-insured patients needing simple treatment, leaving the hospital as the safety net for sicker Medicare and Medicaid patients whose care costs more than shrinking reimbursements. As one hospital CEO, Dennis Barry of the Moses Cone Health System in Greensboro, N.C., put it recently, "We are getting niched to death."

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Hospitals are becoming less important to many physicians. Hospitals are struggling to find specialists willing to provide emergency room coverage and accept traditional medical staff responsibilities to chair departments and serve on committees. Even specialists still reliant on inpatient work, such as neurosurgeons, are joining more medical staffs to maintain their volumes and have less time to volunteer at one facility.

### **A Model for Collaboration**

So what's the answer? The solutions of the 90s, such as physician hospital organizations and hospital acquisition of physician practices, generally failed, and bitter divorces have worsened relationships. Some observers foresee a

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division of physician practice between office-based and hospital-based physicians, much as exists in England. Hospitalists are the vanguard of the trend.

Is there any hope? Hospitals and physicians share a dissatisfaction with the status quo. The seeds of their discontent could produce an opportunity for dialog and joint development of a new model for collaboration built around three underlying and interrelated elements: a "flotilla" of physicians who can align with the hospital's vision and goals, a new hospital-physician "compact" that sets expectations based on current reality, and effective leaders who can deliver what they promise.

#### **1. A shared vision and goals with a "flotilla" of physician practices.**

Any successful, sustainable relationship starts with common goals. To bridge differences and divergent self-interests, two parties need to find objectives and values in common, or they will have no basis to cooperate.

Dr. Joseph Bujak, a physician executive and consultant from Coeur d'Alene, Idaho, argues that while "shared and transcendent purpose can overcome petty differences" between hospitals and physicians, hospitals that try to play Noah and put all the physicians in one ark to survive the flood are pursuing a hopeless course. Physicians, Bujak argues, are by nature too independent and driven by the legitimate, economic and professional needs of their practices to find true satisfaction in a single boat, especially one skippered by the hospital CEO (see box, Page 3).

Instead, Bujak argues, hospitals should aim for "a flotilla" of physicians who share the health system's broad vision, such as its commitment to excellent care provided through physi-

cian partnerships. Doctors who can align their practice needs with the hospital's vision join the flotilla when their practice goals and the hospital's are aligned. A radiology group, for instance, might form a joint venture for an imaging center with the hospital. A women's health practice might operate its own outpatient facility but also contract to provide OB/GYN coverage in the ER and perform quality reviews for the department.

A flotilla has multiple captains, each of whom may steer their boats in slightly different directions and even stray from the fleet, so Bujak's concept may be a hard sell for control-minded executives and boards. Realistically though, all physicians won't get in the same boat, so hospital leaders will need to master the art of choosing partners wisely, building relationships and managing the paradoxes (our partners compete with us!) inherent in an organization that they do not control.

#### **2. A new hospital-physician compact that defines mutual expectations based on current reality.**

A compact is the agreement, often unwritten, of the mutual expectations of two parties. In the traditional hospital-physician compact, hospitals provided physicians with a workshop of modern equipment and qualified staff, and in return, physicians volunteered ER coverage, medical staff leadership and so on.

Now, a panoply of external forces is upsetting the compact. Hospitals used to stick to inpatient care and leave outpatient care, except for poor patients, to

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### **Joe Bujak on Why a Flotilla, Not an Ark?**

- Hospitals are angered when independent physicians compete with them, and say doctors should accept their share of the hospital's community service mission.
- Physicians comprise an "expert culture." They form relationships with other experts when it meets their needs, such as referring patients to specialists.
- Physicians are motivated by vision and alignment of goals more than by mission: Their highest ordered needs are served by the relationship.
- In a flotilla, each boat purses the shared vision and goals of the crew, and those are different from the vision and goals of other boats.
- At times the boats sail in the same direction, but the crews decide, issue by issue.
- Within the flotilla framework, opportunities exist to create focused partnerships, so long as the vision and goals align.

physicians in their offices. Now, hospitals and physicians compete for lucrative outpatient business. Specialists won't provide ER coverage gratis any longer amidst worries about malpractice coverage, uninsured patients and the demands of being on multiple staffs to generate enough business.

The path to a new, collaborative relationship starts with a joint recognition that neither is to blame for (and each is buffeted by) external forces that are upsetting the traditional compact. Hospitals and those physicians who want to be in the flotilla need, first, to recognize that they are interdependent and need each other, and second, to agree on a new compact with clearly defined, mutual expectations that reflect current realities and each side's important interests.

### **3. Effective board, physician and executive leadership that is capable of making and keeping commitments to each other.**

None of this will be easy, and that's why effective leadership is essential. Leadership is getting people to do what they either are unwilling or unable to do on their own.

Many medical staffs have failed to choose good leaders. Too often, they exacerbate bad relations by electing their most reactionary and vocal mem-

bers who block cooperation at every turn. Medical staffs need to redesign their structures and elect leaders who are willing to put in the time and approach hospital relations with objectivity and a commitment to work together. Similarly, governing boards and executives need to come to the table willing to be candid and trustworthy and ready to explore new ways of working together that rely less on control and more on shared common purpose and mutual incentives.

There is no simple path to better hospital-physician relationships. Educational retreats for board, management and medical staff leaders are almost always a starting point but cannot be the end. Identification and nurturing of physician champions, development of pilot projects that show the benefit of working together, and a commitment to nurturing communications and the hospital-physician relationship are critical.

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