New Models for Hospital-Physician Relationships

Hospital leaders around the country are experiencing growing pressures, challenges and changes in their relationship with “their” physicians. Physicians also play a variety of changing and often conflicting roles with the hospital—partner, competitor, employee or independent contractor.

On one end of the spectrum are disinterested and uninvolved office-based physicians. On the other end are hospital-based physicians whose finances and futures are inextricably intertwined with those of the hospital.

As these critical relationships evolve, several new realities are emerging. The first is the disquieting truth that hospitals need physicians more than most physicians need hospitals. The second is that each physician is unique, with different expectations and attitudes based on variables, that include, but are not limited to, his or her age, gender, specialty, income requirements, family situation and personal history. The third—and for hospital leaders perhaps the most challenging truth—is that the traditional vehicle for housing, organizing and facilitating the practice of physicians within the hospital, i.e., the hospital medical staff, is rapidly losing currency and may soon be an organizational dinosaur.

THE DEMISE OF THE TRADITIONAL MEDICAL STAFF

THE TRADITIONAL MEDICAL staff model was originally designed during a period of financial robustness, when both hospitals and physicians could be independent, yet codependent. They were both relatively unaccountable to each other and rewarded by a payment system that reimbursed hospitals for their costs, or beyond them in some cases. Today, this model is showing its age and inappropriateness as the health care market squeezes out inefficiencies at every turn, demands quality and transparency that can best be achieved through real teamwork, and does not tolerate variations in cost and quality.

Symptoms of the declining utility of the traditional medical staff include physicians who: refuse to take emergency department (ED) call without compensation; open ambulatory care facilities that compete with hospitals for profitable patients; don’t attend medical staff meetings; are reluctant to serve as medical staff leaders; and have an adversarial relationship with administration over resource allocation, capital acquisition, strategic planning, quality improvement and patient safety efforts. Most hospitals and medical staff leaders are responding to these issues as they emerge, addressing the symptoms of the problem instead of the core challenge.

Questions for Discussion

1. What are the variety of roles physicians play in your hospital? How have these roles shifted or changed over the past several years?
2. How would you describe the relationship between your hospital and its physicians? If relationships vary between the hospital and different physician groups, what causes these differences?
3. If hospitals need physicians more than most physicians need hospitals, what impact has that had on your hospital?
4. Is the traditional medical staff model still effective for your hospital? If not, what factors signal the need for a change?

THE EMERGING STAFF MODEL

ACCORDING TO Larry Wellikson, M.D., CEO of the Society of Hospital Medicine, Philadelphia, redefining the traditional hospital medical staff model means understanding that the hospital of the future will be much more than just a building. Rather, it will be the hub of health care delivery, with a continuing...
shift from inpatient to outpatient services. Traditionally, he says, many physicians focused on the hospital as a collection of resources and services such as the admitting department, laboratory or surgical suites—those services that affected them directly when they came to the hospital to treat their patients.

For a growing number of physicians today, however, the hospital is their primary workplace. Emergency department physicians, intensivists, hospitalists, anesthesiologists, radiologists and pathologists are among a core group of physicians whose work is tightly integrated with hospital resources and goals. They focus on questions of efficiency, patient flow and performance measurement. Rather than asking “How are my patients doing today?” they are more likely to ask, “How well is the hospital providing care to all pneumonia patients?” Wellikson sees the emerging hospital providing care to all pneumonia patients.

For a growing number of physicians today, however, the hospital is their primary workplace. Emergency department physicians, intensivists, hospitalists, anesthesiologists, radiologists and pathologists are among a core group of physicians whose work is tightly integrated with hospital resources and goals. They focus on questions of efficiency, patient flow and performance measurement. Rather than asking “How are my patients doing today?” they are more likely to ask, “How well is the hospital providing care to all pneumonia patients?” Wellikson sees the emerging hospital providing care to all pneumonia patients.

Traditionally, he says, many physicians have traditionally operated autonomously and rankle at rules that require them to document care and treatment in a clear, timely manner or follow clinical guidelines or protocols. Rohr believes that hospitals can no longer tolerate idiosyncratic approaches to care delivery. However, independent physicians are decreasing their hospital involvement at the very time that hospitals need them to be more engaged. For this reason, Rohr says that there is a need for more formal arrangements in which both parties support each other’s goals.

To be successful, a new medical staff model should not only address the changing needs of the medical staff, but also those of hospital leadership. Hospitals are focusing more on issues such as patient throughput, hiring needed clinicians and implementing technology that will improve care quality and outcomes. These issues require new and different clinical leadership than was needed in the past.

“The medical staff used to function mainly as a fraternal organization that existed to protect its members, rather than focusing on the needs of the public or the hospital,” says Richard Rohr, M.D., vice president of medical affairs, Cortland (N.Y.) Regional Medical Center. “In the past, hospitals didn’t need much more from physicians than their patients. However, today, with pressures for increased efficiency, quality and patient safety, hospitals need a higher level of commitment from their physicians to advance the hospital’s goals.” Rohr says that the medical staff of the future will be a much smaller, tiered group in which employed and/or contracted physicians, whose primary workplace is the hospital, take the lead in both spearheading important clinical initiatives and acting as intermediaries with independently practicing physicians to improve patient care. He suggests that the new paradigm for hospital-physician relationships will be based on volume of patient referrals, resource use and quality of care.

The new paradigm will also require a different style of interaction between hospitals and physicians. Although physicians have traditionally operated autonomously and rankle at rules that require them to document care and treatment in a clear, timely manner or follow clinical guidelines or protocols, Rohr believes that hospitals can no longer tolerate idiosyncratic approaches to care delivery. However, independent physicians are decreasing their hospital involvement at the very time that hospitals need them to be more engaged. For this reason, Rohr says that there is a need for more formal arrangements in which both parties support each other’s goals.

Physicians will increasingly look for hospitals to reward them for services they used to perform voluntarily. Such services could include assisting with utilization review, technology assessment, peer review or treating uninsured or underinsured patients.

Wellikson suggests that home team physicians, particularly hospitalists, are likely to emerge as medical staff leaders of the future, for several reasons. First, they are familiar with the hospital environment, staff, policies and services because they spend most of their time there. Second, they are experts in providing inpatient care and have credibility with both independent physicians and hospital staff. Third, because these physicians are often employed by or have a contract with hospitals, they have a vested interest in finding solutions to hospital problems. Also, they understand the importance of balancing institutional needs and physician concerns. Consultant, catalyst, problem-solver and broker of relationships with other physicians are some of the roles home team physicians can play in the new medical staff model.

Home team physicians already play a variety of leadership roles, such as clinical executives, leaders or participants in performance improvement teams, chairs and members of hospital committees, according to a 2005 survey of almost 400 hospitalist practices, conducted by the Society of Hospital Medicine. With results representing more than 2,500 hospitalists, the study found that, on average, these physicians already devote 10 percent to 12 percent of their time to nonclinical activities. Issues that home team physicians can help hospitals address include practice guideline development, utilization review, patient satisfaction, quality and patient safety improvement, compliance, disaster planning, information technology implementation and nursing/physician extender staffing.

“Important visitor” physicians, Wellikson says, can work in concert with home team doctors and hospital staff. They can set direction and oversee implementation and outcomes of critical cross-functional initiatives, such as technology upgrades or expansion. According to Wellikson, it will be important for some of these physicians to shift from an “only child” mentality to thinking about and leveraging their spheres of influence to help improve overall patient care.

Office-based physicians represent the biggest challenge for hospitals because they are more loosely connected to the organization than the other two groups. Their patients are generally cared for in the hospital by home team physicians or important visitors, so they are actually more consumers of hospital resources and
services, rather than the direct providers of hospital care. As such, their chief concern is knowing whether the hospital is doing a good job delivering patient care because they want to send their patients to the best-performing hospitals.

Office-based physicians can be viewed as ombudsmen that advocate for high-quality, safe medical care on behalf of patients, says Wellikson. Hospitals can engage these physicians in helping to identify and set hospital performance criteria. Under the traditional model, hospitals set the rules and benchmarks, and physicians often resisted because they viewed the rules as too stringent. Implementing electronic health records, educating colleagues about the best ways to care for specific diagnoses, or helping to decide how to optimally transition patients from inpatient to outpatient settings, are examples of how hospitals might engage these office-based physicians.

Incentives for participating in this emerging medical staff model will vary for each physician group, Wellikson says. Home team physicians will want to make the hospital the best workplace it can be. Important visitors have a vested interest in making the hospital an environment that meets their needs and facilitates achievement of their goals. They will want direct involvement in setting performance measures and will not buy into standards set unilaterally by the hospital. Office-based doctors will want to collaborate with the hospital to improve patient care. They can’t send their patients to the best-performing hospitals if they don’t understand how the hospital operates and the level of care quality and safety it delivers.

**NEW HOSPITAL-PHYSICIAN RELATIONSHIPS**

**AS HOSPITAL MARGINS** have tightened, demand for services has increased, the near-term physician supply has remained relatively fixed, and more physicians are working fewer hours, the Medical University of South Carolina (MUSC), Charleston, believes that tighter hospital-physician collaboration is essential to its future success and is involving physicians more in hospital operations. At MUSC, service lines organized around patient and provider needs are led by physician-administrator teams. A steering group, composed mainly of department chairs, hospital-based physicians, and key administrators, oversees the performance of each service line against measures of quality, efficiency, access, consistency, finance and growth. The steering group meets regularly to discuss how service lines are performing and to determine how performance can be improved.

According to Executive Medical Director Patrick Cawley, M.D., surgical oncologists, orthopedists and otolaryngologists at MUSC are among the “important visitors” who increasingly view hospitalists as the primary admitting physicians for many of their patients. In turn, outpatient specialists, such as rheumatologists and endocrinologists, are being offered incentives to work with hospitalists to ensure that more of their patients can be treated at MUSC as well. The medical center is also promoting broader physician involvement throughout the organization. Physician champions help lead IT product selection, development and implementation of major information technology initiatives, and participate in other projects, such as developing clinical protocols and even employee satisfaction improvement projects. Typically, hospital-based

---

**Getting to a New Relationship with Physicians—Tips for the Road Ahead**

The pointers listed here for boards and their hospitals may help smooth the way to forming new relationships with physicians.

1. **Conduct a high-level, honest evaluation of the function and future of your current medical staff.** This real-time evaluation should include: a cultural assessment of the medical staff; a review of the ongoing effectiveness of medical staff leadership and physician perspectives; and an assessment of the value to physicians and the hospital provided by the medical staff, as well as its cost and inefficiencies.

2. **Upon completing the medical staff evaluation, pose and ponder the following medical staff questions:** Is our medical staff “working”? That is, is it, as an organization, effectively performing the functions it is supposed to? What is the “shelf life” of our current medical staff model? What are the likely consequences to the hospital if we maintain the current structure, function, leadership and culture of the medical staff?

3. **Develop an explicit, written compact that defines the mutual expectations that your hospital and its physicians have for working together.**

4. **Inventory and review all the models of engagement and interaction that currently exist between your hospital and its physicians.** For example: How many and which physicians are employed? How many are under exclusive contract with the hospital? How many have nonexclusive contracts with the hospital? Are some physicians partners with the hospital in a joint venture or other business entity? Do any physicians practicing at your hospital receive payments for providing services to the hospital, such as taking call, serving in a medical staff leadership position, or serving in a management leadership position?

5. **Consider what new models of physician-hospital engagement are possible for your hospital.** For example, there are some who believe that in the future, all physicians providing services in a hospital will be employed by the hospital. If the old, voluntary medical staff model is no longer relevant for your hospital, what will you replace it with?
physicians are tapped first to lead these activities, and they, in turn, engage physicians from the other groups to participate.

Win Whitcomb, M.D., director of performance improvement and a practicing hospitalist at Mercy Medical Center in Springfield, Mass., believes that a new system of rewards will help shape the medical staff of the future. Traditional motivations for physicians to participate in hospital activities, such as the value of peer interactions and a feeling of civic responsibility toward the hospital will diminish. Instead, due to increasing time pressures and the growing competition between physicians and hospitals, those motivations will be replaced by incentives such as direct payment and contract subsidies. Pay-for-performance programs tied to quality improvement are likely to grow in coming years as well.

The new reward system for physicians, Whitcomb says, will be based on the fundamental understanding that the current care delivery system is flawed and does not serve patients well. Physicians who are “systems thinkers” and who get satisfaction from improving how care is delivered, will be the physicians leading the medical staffs of the future. For example, a surgeon might join a hospital quality committee to help decrease surgical wound infection rates, or participate in a group studying venous thromboembolism prophylaxis.

Whitcomb believes that hospital-based physicians are the key to quality improvement because they can take the lead on critical initiatives and engage other influential physicians as well. At Mercy Medical Center, a team focused on Centers for Medicare & Medicaid (CMS) Core Measure performance is led by hospitalists and emergency medicine physicians. The hospital’s surgical quality team is co-chaired by a general surgeon and a hospitalist, with strong leadership from an anesthesiologist. Whitcomb says the involvement of important visitors, such as obstetricians, gynecologists, surgeons and cardiologists is critical, not only because they have a big stake in how well the hospital delivers care, but also because they are typically more senior than the home team physicians and already sit on influential committees, such as the medical executive, credentialing, pharmacy and therapeutics, and peer review committees.

Questions for Discussion
1. How would you characterize the makeup of your hospital’s current medical staff? Do the designations “home team,” “important visitors” and “office-based” physicians described above apply?
2. Are “home team” physicians assuming more medical staff leadership roles in your hospital? If so, how do they work with other groups of physicians?
3. What motivates physicians in your hospital or health system to participate in organizational activities? Does your hospital provide incentives or opportunities for participation that reflect the varying needs and motivations of different physicians and physician groups?

The Board’s Role

According to Rohr, it is important for hospital boards to understand that having lots of physicians on the medical staff may no longer benefit the hospital. Rather, hospitals should seek to have a good business relationship with a smaller number of physicians who are significantly involved in delivering care at the hospital. At the same time, hospitals need to develop strategies to engage the larger group of physicians who use hospital services infrequently. Strategies for this larger group should focus on communication and ongoing dialogue about how the hospital can serve them better.

As leaders, boards need to question their leaders continually to ensure that the organization is doing all it can to fulfill its commitment to quality and safety. In addition, trustees can play an important role as liaisons between the hospital and the community. As such, they must be familiar with information that is publicly available about the hospital and help the community understand how the hospital is working to deliver quality, safe care.

“The concept of a closed medical staff is not new,” Rohr says. “However, in the future, rather than protecting economic interests, hospitals may need to close their medical staffs to ensure high levels of quality and patient safety. While it may be difficult for a community organization to do this, at the same time it is critical for governing boards and hospitals to insist on high standards of care. Achieving these standards may require limiting the number of physicians on staff.”

Hospitals need to provide more forums for boards and physicians to work together on improving quality and safety, Whitcomb says. Boards still need basic education to understand the shift from the traditional quality assurance mind-set that seeks to blame individuals for quality problems, toward the system-focused process that is the foundation of today’s quality improvement efforts. Boards should devote a specific percentage of their time to quality oversight and participate with physicians in joint education on quality and safety issues, as well as quality improvement activities, Whitcomb says.

Reprint requests for 100 or more copies should be addressed to:
Margaret Jablonski (312) 893-6890 e-mail: mjablonski@healthforum.com.

Conclusion

Many involved in health care delivery have not fully acknowledged that change is happening. Therefore, new hospital-physician relationship models are still at an early stage of development. Boards need to understand that physician roles are changing, and they should take the lead in helping their hospitals move toward new, mutually beneficial models of partnering with physicians.

Boards can help their hospitals embrace change and set the tone for collaborative, rather than contentious, relationships with physicians, focusing on the mutual goal of delivering high-quality, safe patient care.