

Redefining Health Care

A DIALOGUE ON HEALTH POLICY



Strengthening Hospital-Physician Relationships



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Designing for Hospital-Physician Alignment: Values, Economics and Organization



By: Brian Golden

Though my academic appointments have always been in business schools, I have spent my academic career studying and working with hospitals and health systems. My business school colleagues look rather perplexed when I try to describe one of the fundamental challenges that hospitals face, that is, how to align physicians and hospitals.

Perplexity quickly moves to anxiety when I say that inside hospitals are these very smart people (physicians), who aren't really employees, who hold a virtual monopoly on decisions such as which patients to admit and for how long, what procedures to perform, and how this care will be supported by pricey pharmaceuticals and medical devices – all of which impact the costs to the hospital (Burns and Muller, 2008).

All leaders, whether in health care or other sectors, know that their number one job is to align the interests of their employees and staff with those of the organization. That is, to make them *partners*.

Therefore, the most effective and sustainable hospitals and health systems have brought physicians into the tent and have aligned physicians' personal and professional interests with those of the hospitals.

I go on to say that the decisions of physicians impact more than 80 per cent of medical costs globally, and yet physicians typically have no financial accountability for these decisions. In fact, few are provided sufficient information to actually understand the financial implications of their decisions.

Physicians are not to blame; we have designed our health systems and hospitals to result in precisely this situation. Imagine a management consulting firm, for example, where consultants felt and had no accountability for the human resources they devoted to a project (the greatest cost driver), travel costs, etc., nor did they know the revenue generated by the consulting engagement. How long, my colleagues say, would such a firm – typically organized as a partnership – stay in business?

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personal and professional interests with those of the hospitals.

Since the 1990s, researchers have identified the dimensions of effective hospital-physician alignment, yet few organizations consistently get it right.

In my own work on hospital performance improvement and change, which often centres on the hospital-physician relationship, I focus on three types of alignment that hospital leaders must attend to: (1) Values alignment, (2) Economic alignment, and (3) Organizational alignment. All three are critical and must exist simultaneously for both physicians and hospitals to be comfortable with their relationship.

Values Alignment

Physicians experience the most intense socialization processes of any professionals, beginning in medical school but continuing over their careers in their professions and their organizations (Trybou, Gemmel, Desmidt and Annemans, 2017). Research my colleagues and I have conducted has shown that this results in the development of very different mental models of the world, often leading physicians and administrators to value different things (Golden, Dukerich and Fabian, 2000; Dukerich, Golden and Shortell, 2002).

For instance, physicians value autonomy in the pursuit of providing the best care for the patient standing in front of them. Hospital administrators see the world with a lower resolution, focusing less on an individual patient. Their job is to ensure financial well-being and organizational effectiveness in order

to provide the best possible care for all patients coming through the hospital doors. This can often be interpreted by the two camps, physicians and the stewards of the hospital, as valuing different things.

In our research, we found that when hospitals and its administrators' values were aligned with the values of physicians, physicians felt more committed to the hospital. In these organizations, physicians were most likely to partner with administrators and were more likely to make resource-utilization decisions that benefited the hospital - so that the hospital could most benefit its patients (Dukerich, Golden and Shortell, 2002).

Administrators who were largely seen as representing the “business” interests of the hospital reinforced the frequently-seen chasm between physicians and hospitals. Working hard to demonstrate an alignment of values is critical for hospital-physician alignment.

Economic Alignment

A classic paper in the management literature refers to the “Folly of hoping for A, while rewarding for B” (Kerr, 1975) — a challenge that we continue to face today (e.g., paying on a fee for service basis, or for “transactions”, when payers really want improved outcomes, which may be separate from the volume of activity).

This seems like common sense to most managers, but I’m repeatedly struck by how “uncommon” common sense seems to be when trying to align hospitals and physicians. In Canada, this is largely a function of how we

narrowly define rewards, but also the relatively little discretion hospitals have to reward physicians directly.

In contrast, the most effective of systems in the United States (U.S.) have implemented economic risk (or gain) sharing arrangements with physicians such that when physicians utilize hospital resources in the most effective way (i.e., the best care for the least cost), these physicians receive a part of the financial benefit. Despite the somewhat romantic notion of physicians always putting their patients’ interests above anything else, it turns out that physicians are just like other human beings — responsive to incentives.

The most sophisticated hospitals in the most effective systems have found ways to share gains of value enhancement, while also sharing the pain of physicians that lessen the value of health care expenditures (Trybou, Gemmel and Annemans, 2011). These rewards need not be dollars in the pockets of physicians, and instead can be directed to benefiting their programs in some way. As Kerr reminds us, if we truly want A, we must reward for A and not for B.

Organizational Alignment

In order to ensure values and economic alignment, hospitals must be designed, or organized, to share information, support physicians’ understanding of the implications of their decisions, and be structured in a way that facilitates value and economic alignment.

A few years ago, I was working with a major Ontario hospital that had been experiencing severe deficits

for a number of years. The Minister of Health and Long-Term Care appointed a seasoned supervisor and interim CEO who quickly recognized that while physicians were concerned about the well-being of the hospital and truly wanted to help, they had virtually no idea about how their decisions benefitted or harmed the hospital.

As an example, a group of cardiac surgeons in the hospital regularly used a particular stent in procedures that was minimally funded by the Ministry. Another stent used by their colleagues, and considered just as effective, was fully funded. The choice of using the first stent was costing the hospital \$8 million in totally unnecessary costs, unbeknownst to the well-intentioned surgeons. This hospital, on its path to financial solvency, opened up the books to physicians and shared the knowledge that up until this point was protected in administration. The leadership of the hospital knew that making the

hospital's financials transparent to physicians required that these smart individuals be trained to interpret them; few physicians had ever had any exposure to management and business training.

In other hospitals I've worked with and studied, we've seen a commitment to clinical governance and the pairing of clinicians and administrators in a dyad model. This dyad model pairs – or aligns – administrators and physicians to a common cause at the program level. Early adopters of this model were seen in the U.S. (e.g., Mayo Clinic, Intermountain), but today we see this among leading Canadian hospitals (e.g., The Ottawa Hospital, The University Health Network).

Conclusion

I recently led a physician leadership program for a hospital where one physician chief said, "We'd all be better off if we didn't have the

administration." Thankfully this was the start of the program, and by the end of the program – where part of our focus was on helping administrators maintain the health of the hospital so that physicians could improve the health of their patients – this same physician said, "Now I know why they keep saying 'no' to me, and they are right to." The next evolution of this physician development program will include an equal number of administrators working alongside them, and making explicit their mutual interdependence.

It is surprising that in 2017 there are still some organizations that don't recognize the symbiotic relationship that must exist between physicians and hospitals. To effectively manage this interdependency, we need to move beyond the historical divide between physicians and administrators, but this won't happen simply with wishful thinking.

First, hospital administrators must demonstrate that the dominant values of the hospital are entirely consistent with those of clinicians. Simply having aligned values isn't enough; hospitals leaders must work hard to consistently communicate this, and when decisions are made that seem to run contrary to this, some of which is inevitable, physicians must be told why.

Second, values are partially, and sometimes largely, expressed by how hospitals allocate scarce resources and provide reward, which is not only financial. Relative to peer organizations in other countries, Canadian hospitals have somewhat limited discretion in the incentives they have to align their

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interests and those of physicians. At a minimum, they must work to eliminate disincentives to work collaboratively for individual patients and the hospital's wellbeing – thereby supporting care for the broader community of patients.

Finally, hospital leaders have some organizational levers available to them to better align the hospital with physicians. This includes information-sharing, education and training, and the targeted recruitment of physicians to pair up with their administrative partners. As my colleagues Gillies, et al suggest, critical to physician-hospital integration is actively engaging physicians in the planning, management and governance of the hospital (Gillies, et al, 2001).

Just as we don't expect hospital CIOs or CFOs to perform surgery, we should not expect physicians to be naturally able to work alongside administrators. Hospitals must make the necessary investments in supporting the partnering with physicians, showing them they hold common values, tying together their fates, and organizing for alignment. This isn't rocket science, but it is hard work and requires commitment from hospital leaders and their boards.

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