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Strong Partners Make Good Partners: Insights About Physician–Hospital Relationships from a Study of Physician Executives

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ABSTRACT

While physicians are likely to respond favorably in concept to hospital-based disease management and other clinical programs, they are less likely to accept their structural and functional characteristics. Because of their role at the hospital–physician interface, hospital physician executives are often tasked with implementing such programs. Given the challenges involved, a deeper understanding of the role of these executives in building the hospital–physician relationship will therefore be an important contribution. To this end, we surveyed senior physician executives at hospitals and health systems ($n = 326$), to assess their view of the hospital–physician relationship at their institutions, focusing especially on the role of medical staff cohesion. This article presents several of our key findings, in particular that (1) many physician executives identified their medical staff as having relatively low cohesion and (2) the perceived level of medical staff cohesion correlated strongly with the level of physician support for organizational priorities, the degree of constructive physician involvement, and success in improving the physician–hospital relationship. In light of these findings, we conclude by offering concrete recommendations for physician executives and others seeking to build medical staff cohesion in the service of clinical improvement.

INTRODUCTION

AHOSPITAL’S MARKET POSITION and community reputation increasingly depend upon the degree to which it is experienced as making an important contribution to the health of the community through its community outreach, care for vulnerable populations, and disease management programs.

Disease management programs require or-

ganizational leadership and support because they rely on large-scale systems and an information infrastructure to address the needs of defined populations. Their success, however, depends upon the acceptance of physicians both in concept and in operations. While physicians are likely to respond favorably in concept to the benefits of disease management programs, they are less likely to accept their structural and functional characteristics, especially

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the use of guidelines, collaborative practice models, outcomes measurement, and public reporting of results.

We have been interested in the value and effectiveness of physicians in leadership positions, relative to both business performance and clinical improvements in areas such as disease management. Over the past decade, hospitals and systems have made significant investments in strategies to enhance the role of the Vice President Medical Affairs and develop the new role of Chief Medical Officer. Our hypothesis is that a deeper understanding of the role of the physician executive in building the hospital-physician partnership will be an important contribution to achieving a hospital's strategy, implementing clinical and disease management programs, and improving performance.

In this article we describe the findings of a study that focuses on the role of the physician executive in building cohesion in the medical staff. Our analysis will explore the implications of the role and offer recommendations for hospital and physician leaders committed to building successful physician-hospital partnerships as the foundation for improved outcomes. These findings, while general, are highly relevant and applicable to hospital and physician executives charged with implementing disease management programs.

THE STUDY OF SENIOR PHYSICIAN EXECUTIVES

The study was conducted by The Bard Group, LLC, in collaboration with the Office

of Health Policy and Clinical Outcomes at Thomas Jefferson University. Data were gathered by means of a survey instrument mailed to 1,412 senior physician executives at hospitals and health systems.¹ All were members of the American College of Physician Executives and/or the Society for Chief Medical Officers. The survey contained 49 multiple-choice and two open-ended items.

Key sections of the study sought insight on two questions:

- What is the current state of the relationship between hospitals and health systems and their affiliated physicians?
- To what extent does medical staff cohesion affect this relationship?

We received 326 responses, for a 23% response rate. Respondent demographics are provided in Table 1.

FINDINGS OF THE STUDY

Current state of the physician-hospital relationship

As predicted, respondents provided a mixed picture (Table 2). On the positive side, 65.4% of respondents agreed or strongly agreed that "the physicians support the strategy and priorities of the organization" (i.e., hospital or system). Sixty-three percent agreed or strongly agreed that "the physicians play a constructive role in establishing the strategy and priorities of the organization."

On the other hand, when asked how successful their institutions had been at "improv-

TABLE 1. DEMOGRAPHICS OF THE 326 SURVEY RESPONDENTS

Title	Organization type		Organization size (number of beds)		
(Senior/Executive) Vice President, Medical Affairs	155	Health system/integrated delivery system	105	Fewer than 100	30
(Senior/Executive) Vice President, Clinical Affairs	5	University hospital	8	100-300	77
Medical Director	40	Community hospital	118	301-500	73
Chief Medical Officer	75	Other	58	501-1,000	63
Other	27	No response	37	More than 1,000	29
No response	24			No response	54

TABLE 2. PHYSICIAN–ORGANIZATION RELATIONSHIP

	<i>Agree or strongly agree</i>	<i>Neutral</i>	<i>Disagree or strongly disagree</i>
The physicians support the strategy and priorities of the organization	65.4%	25.2%	9.3%
The physicians play a constructive role in establishing the strategy and priorities of the organization	62.9%	27.7%	9.3%

Figures may not add to 100% owing to rounding.

ing the relationship between physicians and administration,” only a small majority indicated that they had had some success (Table 3).

The survey concluded with an open-ended item, asking respondents about the extent to which their aspirations had been met in their job. Many offered observations in the following vein:

Physicians are very angry these days—they have a sense of loss of control and are seeing threats to their incomes. This makes it difficult to align interests between the organization and docs.

Some very vocal members of the physician community can still impede progress through a number of avenues and efforts even when the . . . physician leadership appears to be engaged.

Effects of medical staff cohesion

We then used a two-step process to examine our second question: How does medical staff cohesion affect the physician–hospital relationship? First, we asked respondents to rate their medical staffs on two measures of cohesion:

- The presence of “structures that enable effective decision making”

- The ability to “speak with one voice on important matters”

Fewer than 50% agreed that either of these characteristics was present in their medical staff (Table 4).

In the second step, we examined how these results correlated with respondents’ assessments of physician–hospital relationships. In fact, we found a strong connection (Table 5). Respondents who rated their medical staffs as lacking cohesion tended to indicate:

- Lower physician support for the strategy and priorities of the organization
- Less constructive physician involvement in establishing the strategy and priorities of the organization
- Less success at improving the physician–administration relationship

DISCUSSION

Effective partners work together to identify shared interests and goals, develop strategies, establish agreed-upon standards of performance, and hold each other accountable to those standards. An effective partnership is therefore predicated on each partner’s willing-

TABLE 3. IMPROVEMENT IN PHYSICIAN–ORGANIZATION RELATIONSHIP

	<i>Successful or very successful</i>	<i>Neutral</i>	<i>Not successful at all</i>
Improving the relationship between the physicians and administration	54%	37.6%	8.4%

TABLE 4. MEDICAL STAFF COHESION

	<i>Agree or strongly agree</i>	<i>Neutral</i>	<i>Disagree or strongly disagree</i>
The physicians are "able to speak with one voice" on important matters	21.2%	20.4%	58.5%
The physicians have a structure that allows for effective decision-making and follow-through	41.7%	25.9%	32.4%

ness and ability to offer ideas, evaluate options, and make and meet commitments. In short, *strong partners make the best partners.*

However, as indicated by the study findings, many medical staff groups lack the cohesion to do any of these in a concerted way. On the contrary, they tend to be highly disintegrated, with the physicians united by little more than professional training and admitting privileges. In fact, they are likely to be competing with one another for access to a limited supply of patients and clinical resources. Consequently, they are less likely to be focused on care improvement activities such as disease management programs at the hospital or system level.

Hence, many of the partnership-building strategies of the past decade may have "put the cart before the horse." They have sought to build strong partnerships through structural or financial alignment, which requires a level of internal cohesion common within the traditional hierarchical structures of the hospitals or systems, but often absent among physicians.

DEVELOPING MEDICAL STAFF COHESION: A PHYSICIAN EXECUTIVE'S ROLE

Despite imposing obstacles—the culture of physician autonomy, competing affiliations, the recent history of physician–hospital conflict, and a difficult market environment—physician executives can do much to foster the internal strength and cohesion of affiliated medical staffs. Whether focusing on strategy, clinical and disease management programs, or performance improvement efforts, we recommend the following concrete actions:

1. *Seek and develop strong medical staff leadership.* Strong leaders, while more likely to "push back" against an institutional partner, are essential to creating the culture and processes that build medical staff cohesion. Physician leaders can communicate messages with credibility that will not get airtime if they come from a non-physician hospital administrator.

TABLE 5. MEDICAL STAFF COHESION VERSUS PHYSICIAN–ORGANIZATION RELATIONSHIP

	<i>Correlations and p values</i>		
	<i>The physicians support the strategy and priorities . . .</i>	<i>The physicians play a constructive role . . .</i>	<i>Improving the relationship between physicians and administration</i>
The physicians are "able to speak with one voice" on important matters	0.47009 <i>p</i> < 0.0001	0.47389 <i>p</i> < 0.0001	0.36366 <i>p</i> < 0.0001
The physicians have a structure that allows for effective decision-making and follow-through	0.34363 <i>p</i> < 0.0001	0.45528 <i>p</i> < 0.0001	0.38942 <i>p</i> < 0.0001

Effective partners need to *stand* for something: That sense of advocacy is critical to building connection. Medical staffs, by their nature and diversity, stand for many things. As a result, they most often stand for nothing. Experience has taught us that it takes strong leadership to galvanize a position.

This means appointing or supporting the election of appropriate individuals to leadership positions in the medical staff. Given the rotating nature of many of these positions, it also means identifying and nurturing informal leaders among the physicians who are committed to cooperation and have the respectful ear of their colleagues. And it may mean developing their leadership skills, either through training or informal coaching and mentoring.

We often recommend a counterintuitive approach: Seek out *adversarial* opinion leaders. “Turning around” someone who is publicly negative gives more momentum to partnership than involving those already known to be in the favor of the hospital leadership. Strongly negative people are feelings engaged, though usually acting out of frustration or a sense of betrayal. When these feelings are addressed, they will use their substantial energy in a positive way. When their colleagues see this turnaround, they often relinquish their “neutrality” and join.

2. *Establish or enhance forums where the medical staff (or its representative leaders) can meet to generate ideas, make decisions, and improve trust.* In our consulting work, we are often surprised at the isolation of practicing physicians. When a medical staff or its leaders assemble, it is usually to address “hygiene” issues such as credentialing or for updates and Q&A with hospital leadership. Rarely do we see medical staff leaders—much less the rank and file—assemble of their own accord to address the big picture or substantive issues of mutual concern.

When we suggest this, a common response is, “But the docs will only show up if we feed them, pay them, or both.” To which we say, “Give them a reason to show up and they will.” The challenge is to establish forums with teeth, where groups of physicians make decisions that others will

have to live with. If the meetings are carefully designed to address important issues around care, are run crisply, and produce results that affect the physicians, we guarantee that attendance will improve over time.

3. *Engage physicians in creating a clinical agenda that galvanizes and gives them a reason to work together.* In our experience, most physicians ultimately care more about professionalism, integrity, excellence of care, and mutual respect, than about money. What they often talk about, however, is money, because their experience of talking about professionalism, integrity, excellence, and mutual respect is inherently uncomfortable and has not produced results. This emphasizes our earlier point: “Stand for something.”

A compelling and well-executed clinical agenda, focusing on clinical and disease management programs, improved quality, and safety, has the potential to catalyze and channel the energy of physicians in a way that financial and business imperatives rarely will, while avoiding struggles over money and control.

Such an agenda should be both ambitious and unobjectionable. For example, the Institute of Medicine’s 2000 report *To Err Is Human* highlighted the immense costs of medical errors and offered specific recommendations for improvement.² Why not start there, with an endeavor that has the potential to engage physicians’ commitment to excellence of care, while potentially reducing their liability?

4. *“Tell the story,” again and again.* It has been said, “People hear something for the first time after you’ve said it for the *sixth* time in six ways.” All leaders, on both the hospital and the medical staff side, should use every available opportunity to explain why the potential benefits of the future state—increased cohesion for the pursuit of shared goals—are preferable to the likely consequences of the current state.

It’s important that everyone tell the same story—the words don’t need to be the same, but the story should have the same basic three or four points: “In the past, things have been like __. The impact on you and us has been __. We have an opportunity to invent

a new future together. If we can do so, we'll be able to ___." When the physicians hear the same story from both hospital and medical staff leaders and see action in addition to words, they'll start to believe it.

5. *Provide "workers" to do the work.* By their nature, most medical staffs don't have a pool of shared resources to draw on. Therefore, there's often no one available with the time, energy, and skill to keep a process moving along. As efforts to build medical staff cohesion and engagement proceed, the hospital or system should provide medical staff leaders with the human resources needed to support the process—whether for scheduling, logistics, research, communication, or other purposes. Request physicians' opinions, points of view, and interests; minimize requests for time and energy.

CONCLUSION

Our central claim is that physician-hospital partnerships are most successful when built on mutual strength. While financial and structural strategies for building physician-hospital partnerships will continue to be important and evolve, the physician executive's role, supported by hospital leadership, is to build cohesion in the diverse medical staff around a few things that matter to both: quality and safety,

innovative clinical and disease management programs, service to the community, and care for vulnerable populations. When leaders have developed this shared concern and reciprocity, physicians as a group will usually prove willing and able to meet the behavioral and performance conditions required for the partnership to achieve its performance goals.

The paradox for hospital and health system leaders is this: give away some control to strengthen the medical staff, and they will increase the likelihood that you will achieve your organizational goals.

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To build medical staff cohesion . . .

- Seek out and develop strong medical staff leadership.
- Establish forums "with teeth," where the physicians can meet to generate ideas, make decisions, and resolve breakdowns in trust.
- Engage physicians in creating a clinical agenda that galvanizes and gives them a reason to work together.
- "Tell the story," again and again.
- Provide "workers" to do the work.