

Hospital–Physician Informed Consent: New Use for an Old Doctrine

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EXECUTIVE SUMMARY

The relationship between hospitals and physicians has changed dramatically in recent years because of the increasingly competitive healthcare environment. Many healthcare executives have struggled to find a balance between collaborating and competing with the new breed of physicians. A relationship familiar to the healthcare leader may provide a useful framework for effectively addressing physician relations in today's healthcare setting. The physician–patient relationship experienced tensions similar to those facing the hospital–physician relationship, and informed consent arose to establish clear expectations between physicians and patients.

Healthcare leaders might consider adopting an informed-consent philosophy in their physician relations. Four basic components of informed consent govern the physician–patient context: (1) an assessment of the situation, (2) an explanation of the treatment, (3) an exploration of the alternatives, and (4) a documentation of any agreement. These four components can be adapted to the hospital–physician context to foster productive partnerships in today's healthcare landscape.

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Healthcare executives are keenly aware of their role in developing and maintaining effective physician relations. Some argue that physician relations is the top concern of today's healthcare chief executive officer (CEO) and that more CEOs will lose their jobs because of problems in this area than for any other reason (Zismer 2003). The importance of this skill is magnified by its difficulty. Of all the relationships a healthcare leader must manage, successful partnering with physicians arguably requires the most creativity, risk, and effort. Negotiating guru William Ury, who helped broker nuclear weapons treaties between the United States and the Soviet Union during the Cold War, said that hospital-physician relations "makes US.-Soviet relations look like a piece of cake" (Lovern 2001).

THE PHYSICIAN-RELATION CHALLENGE

Although physician relations has always been a vital component of the healthcare leader's work, the current emphasis is, in large part, a result of recent changes in the healthcare marketplace that have positioned many health systems and physicians in direct competition. Indeed, the term "physician relations" may seem like an oxymoron given that physicians are not only a healthcare entity's most valuable asset but can also be its most formidable competition. In today's healthcare environment, hospitals and physicians are simultaneously allies and adversaries.

From Collaboration to Competition

Things were not always this way. Traditionally, hospitals and physicians offered distinct, complementary services. Even when physicians competed against their affiliated hospitals, their efforts were oriented toward low-margin services. But aided by a more favorable regulatory environment (most notably the elimination or relaxation of certificate-of-need laws and other forms of deregulation related to physician competition in ambulatory surgery centers and specialty hospitals), advances in technology, and an increased availability of business partners, many physician groups have severed their traditional hospital ties through progressively competitive options: (1) growing to be the dominant specialty provider in the region; (2) adding profitable, office-based ancillary services; (3) expanding to more sophisticated ambulatory procedures; and (4) building, owning, and operating specialty hospitals (Zismer and Lopes 2002). To prevent specialty dollars from being annexed, hospitals have responded by building integrated delivery systems to keep revenue-producing procedures in-house and by entering the ambulatory market directly.

Doctors and hospitals have thus been on a "'collision course' as doctors invade institutional services and hospitals invade ambulatory care" (Starr 1982). As might be expected, both sides see their efforts as logical extensions of their traditional capabilities, not as challenges to the other's unofficial domain of

expertise—for physicians, inpatient services are extensions of their clinical office practices; for hospitals, new forays into outpatient services are an inevitable complement to their inpatient capabilities. Therefore, instead of always complementing each other as they did in the past, many hospitals and physician groups now have the opportunity to serve as substitutes for one another.

Evolution of the Hospital–Physician Relationship

The current competitive nature of hospital–physician relations was perhaps inevitable given the manner in which the relationship was established. To a certain degree, hospitals and physicians have always faced mixed incentives. While a physician’s responsibility runs primarily to an individual patient, a hospital serves to treat the healthcare needs of patient populations. To address this “organizational schizophrenia” (Harris 1977), hospitals and physicians developed a unique tool to align themselves in an unorthodox arms-length relationship consciously designed to respect the physician–patient relationship: medical staff bylaws.

In this symbiotic relationship, physicians were granted access to the hospital’s technology and facilities in exchange for services to the hospital. This symbiosis, however, was never clearly defined. While establishing general guidelines regarding hospital–physician collaboration, the medical staff bylaws never specified certain parameters—particularly economic

ones—that matter significantly in today’s competitive healthcare environment.

Almost a quarter-century ago, Paul Starr (1982) presciently commented that this setup was entered into without a full appreciation of its future consequences. These consequences are now being realized as hospitals and physicians compete with each other because the rules of engagement have not been explicitly outlined. For instance, part of the historical *quid pro quo* outlined in medical staff bylaws requires physicians to avoid conflicts of interest with the hospital. But as the economic incentives facing hospitals and physicians have become more disparate, this spirit of cooperation is bending to the market’s demands.

CONTRASTING COVENANTS

A Tacit Covenant: The Hospital–Physician Relationship

In short, by not establishing clear parameters for partnering, hospitals and physicians have allowed a tacit covenant to guide their relationship. A covenant is essentially an agreement between parties. It is theoretically very similar to consent and can be viewed from that perspective.

Consent can take one of three forms: (1) presumed, (2) implicit or tacit, or (3) express (Beauchamp and Childress 2001). By its very nature, a person cannot give presumed consent. Rather, it is consent that one person assumes another would make if she were capable of consenting. For instance, parents may make medical decisions for their child under the

child's presumed consent. So, unlike the other forms of consent, presumed consent does not directly involve the consenting person. Implicit and express consent, on the other hand, are given directly by the consenting person, but in different ways.

A person gives implicit consent by inference; his decisions and actions in one area are implied to manifest consent in another. A patient who agrees to undergo a particular surgery, for example, implicitly consents to the necessary steps involved in that procedure. In other words, the patient consents to the end while perhaps having no knowledge of the means. Unlike implicit or tacit consent, express consent is affirmative consent, usually evidenced by a written agreement. Unlike tacit consent, where the patient does not specifically object to certain actions, under express consent the patient specifically authorizes such actions. In the physician-patient context, express consent is referred to as informed consent and is usually established through signature on the formal informed-consent form.

The distinction between tacit and express consent may appear semantic, and in the absence of conflict the distinction actually does not amount to much. But when parties do disagree, the difference between the two types of consent matters significantly. Express consent is attained mutually through all parties disclosing adequate relevant information so that each can make an informed decision. Tacit consent falls far short of this standard. It is based on assumptions rather than explicit agreement.

Hospital-physician relations, governed by medical staff bylaws, remain based on an unstated *quid pro quo*, not express agreement resulting from open dialog. This tacit covenant is becoming increasingly untenable as market forces challenge hospital-physician collaboration. So how can today's healthcare executive change this arrangement? Perhaps the solution is closer than might be imagined. For within the hospital walls, another relationship has progressed through various levels of consent in response to similar changes in the healthcare environment.

An Express Covenant: The Physician-Patient Relationship

Standing in stark contrast to the continued tacit covenant in the hospital-physician context is the development of informed consent in the physician-patient context. Originally, the relationship was very paternalistic; the physician needed almost no consent before treating the patient. Over time, patients asserted more control over the relationship and allowed physicians to treat them only under conditions of implied consent. That is, the physician had to explain to the patient the overall procedure, the steps involved, the possible side effects, and the alternatives. Even then, however, no documentation of consent was involved. If everything was explained and the patient did not object, the physician could proceed with the treatment. More recently, tacit consent has given way to informed consent as the norm—a formal covenant where both parties express

their mutual understanding through written documentation. Thus, the physician–patient relationship has progressed from no covenant to tacit covenant to formal covenant, reflecting increased patient involvement in the medical decision-making process.

Although consent in the physician–patient relationship has evolved to reflect increased patient autonomy, the hospital–physician relationship has not had a parallel evolution to account for increased physician autonomy. Hospitals and physicians have relied on general medical staff bylaws to define their boundaries. In doing so, they have allowed a tacit covenant to continue, despite the need for an express covenant demanded by the new competitive healthcare environment.

A NEW APPROACH: HOSPITAL – PHYSICIAN INFORMED CONSENT

It seems time to bring the historical *quid pro quo* of the hospital–physician relationship out of the proverbial closet and address it in a rational manner. Hospitals and physicians may wish to reestablish their relationship based on “clearly defined, mutual expectations that reflect current realities and each side’s important interests” (Bader 2002). The process of developing the medical staff bylaws could be adjusted to reflect the new reality of hospital–physician interaction. Healthcare executives should consider engaging their physicians the way physicians engage their patients: through informed consent. Just as the informed-consent doctrine has set clear boundaries for the physician–patient relationship, so

too can it serve as a guiding force for a new generation of hospital–physician partnerships.

Generally, informed consent between physicians and patients consists of four basic components: (1) an assessment of the situation, (2) an explanation of the recommended treatment, (3) an exploration of alternatives, and (4) a documentation of the agreement (King, Areen, and Gostin 2006). Healthcare leaders can approach physician relations with the same four components in mind, using the following mnemonic: *Diagnose, Disclose, Discover, and Document*.

Diagnose: Assess the Situation

Engage physicians individually. The hospital–physician partnership, like the individual physician–patient dyad, is very individualistic. No patient is exactly the same as the next. For a physician ascertaining a patient’s condition, there is no substitute for directly assessing the patient. Likewise, no two physicians are exactly the same. Healthcare executives are tasked with ascertaining each physician’s needs and desires. And nothing is as effective as directly asking each physician about her interests. An information request can be used to make reasonable inquiries of each medical staff member concerning material financial relationships with nonaffiliated health entities. In this manner, it can be determined whether the physician has sufficient convergences of interests to make affiliation with the hospital worth his time.

Many hospital executives complain that engaging their physicians is like

trying to hit a moving target (Bard and Buehler 2000). That is because what seems like *one* moving target is in fact many *individual* targets grouped together somewhat arbitrarily under the rubric of the medical staff. The unified medical staff is a fiction; there is no such thing as the collective physician interest. The doctors who make up the medical staff are not a homogeneous, unified group, but rather they are a group of divergent clinicians—characterized by different earnings, temperaments, lifestyles, and values—loosely connected by the traditional medical staff organization. By engaging physicians individually, healthcare executives aim at each specific target instead of a single moving one, increasing the odds of successfully accommodating each physician's unique interests.

Continually monitor the situation. Institutional consent forms are used "at several points in a patient's progress through the institution: upon admission, when a generic form is signed; and before surgery or anesthesia, when more detailed forms may be offered" (Furrow et al. 2000). Thus, hospitals use a two-tiered informed-consent approach to account for changing circumstances as patients proceed through their healthcare encounter.

Hospitals can take the same approach with the medical staff bylaws. General medical staff bylaws can be used in a manner similar to general initial consent forms—that is, to establish relations based on the initial relationship. As conditions between the hospital and physician

change, related documents, such as covenants not to compete, codes of conduct, and conflict-of-interest policies, can be developed. These documents would thereby resemble the detailed informed-consent forms used before various procedures are performed on patients—based on the specific circumstances. Because of market-specific challenges facing each hospital, there is no hard-and-fast rule for determining whether the hospital should adopt, implement, and enforce these related documents. Medical staff bylaws and related documents should be tailored to fit each hospital's specific needs, accounting for the unique characteristics of the hospital, the composition of its medical staff, and the needs of its community.

Addressing hospital-physician relations through the informed-consent rubric, therefore, does not presuppose a particular collaborative or competitive strategy. The whole point of the informed-consent doctrine in the physician-patient context is to allow for individual patient autonomy. Just as each physician-patient relationship is unique and each calls for unique arrangements, so too is each hospital-physician relationship unique and calls for unique partnering arrangements. The way to effectively determine the best course of action in both settings is through continual dialog and consent.

Ultimately, hospital-physician relations, like physician-patient relations, is both an art and a science. Like the process physicians and patients engage in to determine the specifics of their particular relationship, the process that hospitals and physicians engage in

should respect the contingent nature of their changing circumstances. Instead of being wedded to a system, this two-tiered approach allows the hospital to respect the fluidity inherent in its relationships with its partnered physicians.

Disclose: Explain the Treatment

In exchange for hospital executives inquiring into each physician's stance, they could explain the hospital's stance to the physicians. Asking physicians to commit to the hospital without hearing where the hospital stands is like asking a patient to sign an informed-consent form without first explaining the treatment. Hospital-physician collaboration is about mutual assent, not unilateral decision making; there is no informed consent without adequate disclosure. However, according to two recent surveys, physicians have not been receiving such disclosure from their affiliated hospital.

A survey by the American College of Healthcare Executives (2005) revealed that only 40 percent of health-care administrators have developed a set of ground rules specifying the terms of hospital collaboration with physicians, and only 20 percent have outlined the rules of engagement addressing physician competitors. A Governance Institute survey demonstrated a similar approach taken by hospital governing board members. Although 94 percent of respondents believed it important to have written policies outlining the healthcare organization's approach to physician competition, only 30 percent actually had such policies in place (Kazemek 2006).

It may be historical dictum that hospital CEOs avoid disturbing the medical staff out of fear that "when physicians and administrators are at odds, it is never the physicians who leave town" (Bujak 2003). And hospital board members may be correct in believing that engaging physicians in direct conversations regarding competition is radioactive. But if the hospital has a productive working relationship with its partnered physicians, it can address the radioactive issues of competition and conflicts of interest without fear of antagonizing the doctors. Indeed, by *not* addressing the issues, the hospital may be sending the message that it either lacks a clear vision with regard to these matters or, worse yet, that it doesn't care.

Hospitals' failure to communicate a clear message regarding their physician approach can create confusion, lack of respect, and, in some circumstances, defection. Hospital-physician relationships "must be built on trust and mutual support with a common vision" (Hershey and Purtell 2004). Through open disclosure of the hospital's strategic approach to physician collaboration and competition, trust is developed. Instead of focusing energy on deciphering unclear and mixed messages, anticipating future decisions, and making secret plans with outside parties, physicians and hospital executives can put their energies toward the important task of running an efficient and quality healthcare enterprise.

Discover: Explore Alternatives

Physicians have medical expertise, but sometimes a patient simply does

not wish to proceed with a suggested procedure. Medical decisions involve more than clinical variables; there are emotional, psychological, and familial considerations, among others, at play. Despite the physician's advocated position, the decision ultimately involves the patient's body, and the decision remains solely with the patient. A secure physician does not take rejection of her suggestion as an affront to her professional competence. Similarly, a secure healthcare executive respects each physician's decision regarding collaborating or competing with the hospital. If the patient does not give the physician consent, the physician cannot proceed; if the physician does not give mutual assent to the proposed rules of engagement, the hospital cannot force a partnership.

Pursue accord. After ascertaining each physician's interests and disclosing the hospital's position, it may be clear that the two sides have different interests. However, this does not mean they cannot work together, albeit in a nontraditional manner. Hospitals have adopted various approaches to collaborate in flexible ways with the new breed of physicians, mostly focusing on differing structural and financial arrangements between the two sides. Some examples include contractual integration, specialized tax-exempt financing for clinical service lines (through the use of participating bond transactions), clinical services outsourcing and related hospital-physician partnerships, equity joint ventures, and full health-system integration (Zismer and Person 2006).

Perhaps the most promising current trend is the revival of hospital-physician "gainsharing" arrangements, where both parties share gains obtained through mutually achieved cost reductions. These arrangements had fallen out of favor because of their potential to violate various laws and regulations, but they are being used again. The U.S. Department of Health and Human Services's Office of Inspector General recently approved a hospital's proposed gainsharing arrangement with a cardiac surgical group because the hospital proffered credible medical support to clearly link specific cost-saving actions and resulting savings, thereby promoting transparency and public accountability (Morris 2006).

Accept discord. Sometimes, however, successful partnerships are not attainable. In recent years, hospitals have introduced a new concept into medical staff bylaws to address physician competition: enhanced, or selective, medical staff credentialing. This approach moves beyond traditional credentialing practices—physician-made decisions using solely clinical parameters—toward objective-based standards, including financial ones, developed by the healthcare entity as a whole. Both quality of care and financial implications are, therefore, used to evaluate a physician's fit to practice at the hospital. Hospital governing bodies have taken enhanced credentialing even further by instituting specific conflict-of-interest policies, codes of conduct, and various other documents outlining hospital-physician rules of engagement.

Although even the most carefully crafted policy or procedure can lead to litigation, steps can be taken to dramatically reduce the risk of conflict. Principal among these steps are mutual discussion of, development of, and agreement on such policies by both the hospital and the physicians. Through a process similar to informed consent used by physicians and patients, health systems and physicians can protect themselves from misunderstanding by clearly establishing the boundaries together.

Embrace ambiguity. The true challenge and area of opportunity for today's healthcare leaders is arranging flexible physician partnerships when convergence is possible and accepting competitive positions when discord is unavoidable. There is no strict distinction between being allies and being adversaries. Sometimes hospitals and physicians can be both; they can converge in some areas and compete in others. Today's healthcare environment requires hospital leaders who can "master the art of choosing partners wisely, building relationships, and managing the paradoxes" (Bader 2002) where physicians are simultaneously partners and competitors.

Document: Get it in Writing

Use the existing document. The process of informed consent ultimately culminates in a written agreement evidencing the parties' understanding. In the physician-patient context, a new document—the informed-consent form—was created to record the new

relationship's boundaries. In the hospital-physician context, the document for recording the process of informed consent already exists. The medical staff bylaws and related documents are the proper instruments to verify mutual accord. Indeed, the Joint Commission (2006) claims that "[t]he significance of the medical staff bylaws cannot be overstated." They are as important in the hospital-physician context as the informed-consent doctrine is in the physician-patient context. The bylaws governing hospital-physician relations should be at least as detailed in their level of disclosure and documentation of consent as informed-consent documents are in specifying physician-patient interactions. No matter what partnership arrangement hospitals and physicians agree to, it is imperative that the rules of engagement be spelled out specifically and clearly in the bylaws and related documents.

A distinction should be made between well-drafted and poorly drafted medical staff bylaws. Although well-drafted bylaws can empower hospital-physician relations, poorly drafted bylaws can hinder and even prevent a productive relationship. Well-drafted bylaws and related documents are the result of a continual process of disclosure, discussion, and consent. In other words, they are the result of hospitals and physicians engaging in the components of informed consent. In contrast, poorly drafted bylaws are merely copied from a model and periodically updated in a vacuum to comply with accreditation requirements. They involve and foster tacit consent, not informed consent.

Focus on the process, not the product. While the importance of the medical staff bylaws and related documents should be readily acknowledged, it is important to recognize that, by themselves, they do not establish hospital–physician collaboration. Just as consent forms can often “become a substitute for, rather than merely a record of a continual process of disclosure, discussion, and consent” (King, Aren, and Gostin 2006), medical staff bylaws can become the focus instead of the actual relationship. But “better” bylaws are still bylaws. No document can ever take the place of a continual collaborative process.

In the end, the emphasis in the informed-consent *doctrine* is not the informed-consent *document*; rather, it is the process (the means) through which consent (the end) is achieved. In the same way, hospital–physician relations will never be simply about the medical staff bylaws (the end); it will always be about the relationship (the means). Relationships may be defined by documents, but they are developed through dialog.

CONCLUSION

Rosemary Stevens (1999) once described hospitals as organizational chameleons, highlighting their ability to adapt to their ever-changing environment. The new competitive landscape presents arguably the most formidable challenge to hospitals’ adaptive capabilities. Changing the way hospitals involve physicians in decision making will not be easy. It was not easy in the physician–patient context. Disclosure and consent—“obligations

alien to medical thinking and practice” (Furrow et al. 2000)—were unnaturally grafted into the relationship to address increased patient involvement in medical decision making. By adopting an informed-consent mentality in physician relations, healthcare leaders can proactively address and accommodate physicians’ increased autonomy.

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