Teaching Goals

The relationship between physicians and healthcare organizations (HCOs) has often been problematic, but it doesn’t need to be. Thanks to protocols, service lines, and evidence-based medicine, leading organizations are developing stable, effective physician groups and physician-led clinical teams.

This chapter presents the following lessons:

Lesson 1: Physician loyalty is as important as any other associate loyalty. Physicians are internal customers and partners, not adversaries. Learning the language of physicians and having effective communication strategies are keys to building loyalty.

Lesson 2: The physician-organization relationship is not a blank check. HCOs provide capital and human resource that are essential for most medical practices. Physicians are associates on the terms implied by the mission, vision, and values. They have an agency duty to their patients that they share with the HCO. Service lines allow alignment and accountability. Goals can be negotiated, performance can be measured and improved, and rewards can be shared.

Lesson 3: A sound relationship begins with

- clear rules that are mutually understood and accepted (the bylaws);
- screening to eliminate candidate who don’t understand, or can’t fulfill, the contract (credentialing);
- effective use of the hospital’s right to control supply, ensuring neither too many nor too few physicians (planning);
- high performance from the rest of the team (nursing, clinical support services, supplies, information, and marketing teams are particularly critical); and
- maintenance of high levels of communication so that any physician question is promptly and effectively answered. (Governing board membership is only the beginning of a communication system.)

Lesson 4: Pay for performance works. Physician compensation is wildly complicated. Most physicians work under multiple compensation schemes; most schemes should be reviewed by legal counsel. The criterion for compensation—what a similar effort would earn elsewhere—holds for physicians as for all other associates.

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These four lessons go a long way toward an effective medical care system for a community. They don’t solve every issue, but they provide a framework for solving most issues.

Different strategies can be used to convey the information in this chapter. Traditional lecture is used to explain the medical staff credentialing process, medical staff bylaws, medical staff structure, models of physician-hospital integration, and the physician’s role in clinical quality and safety. Students can be paired with a third-year medical resident(s) for a 24-hour shift with an accompanying assignment. (Contact Ken White kwhite@hsc.vcu.edu for information about the assignment and how to set it up.)

In a Few Words

Physicians are the clinical leaders of the healthcare organization. They are associated with the organization principally by a contract for the privilege to treat patients, but also by employment, joint ventures, and volunteer activities. They are accountable for the quality of care through service lines and monitoring of their individual performance, but they are given substantial autonomy to fulfill their role as agents for individual patients. The physician organization implements systems for improving the quality and efficiency of care, approves the credentials and monitors the performance of individual physicians, assists in planning the number and kinds of doctors, conducts continuing education for its members and other caregivers, facilitates communication between physicians, the organization, and the governing board, and participates in designing compensation and other features of employment contracts. The performance of physicians is measured directly from patient care; the performance of the physician organization is measured primarily by its effectiveness in recruiting and retaining it members.

Chapter Outline

Organization Design
- Building communications links so that every doctor has an “open line.”
- Developing effective physician leaders.
- Balancing service lines and independent practices

Achieving evidence-based medicine
- Accountability for clinical quality, safety, and efficiency
- Selecting and implementing protocols
- Individualizing care when indicated
- Managing the complex patient with multiple diseases or conditions

Credentialing and recruitment
- Recruiting qualified physicians
- Monitoring and improving individual performance
- Providing continuing education to physicians and other caregivers

Compensation
- Assuring physicians a competitive income
- Rewarding quality and effort

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Powerpoint Slides
See Learning Tools.

Questions to Debate
Slides of the individual questions are downloadable. We have prepared some summary thoughts on the content of class discussion. Obtain this information by writing (conventional mail) on academic letterhead to:

John R. Griffith
School of Public Health
The University of Michigan
109 Observatory St.
Ann Arbor, MI 48109-2029

(Please include an academic (dot edu) e-mail address.)

1. From Figure 5.1, the surgeon decides the patient should have appendectomy. What does the surgeon contribute to the hospital mission by doing the surgery? What does the surgeon expect from the hospital? How is this relationship changing at the beginning of the 21st century?

2. The emergence of service lines tightened the bonds between physicians in similar specialties and their accountability to the governing board. The service lines contracts often include employment, risk sharing, and joint capital investment arrangements that go well beyond the traditional privileging. Why might this be a positive development? What are some alternatives, and where will the relationships go in the future?

3. Many primary care physicians claim that they no longer need medical staff membership or hospital privileges to take care of their patients. They feel it is an inefficient drain on their time, and it is difficult for them financially. Should the hospital ignore their concerns and let them drift off from the organization? If not, what should the hospital do to make affiliation attractive?

4. Some physician organizations elect leaders. Management may hire a Chief Medical Officer (CMO). What is the relationship between the elected leaders and the CMO? Can the CMO represent the interests of management and the physician organization at the same time?

5. Some flash points in physician relations are recurring and predictable. How would a well-managed organization deal with the following:
   - Interspecialty disputes: orthopedics and imaging; surgery and anesthesia; primary care and specialists?
• Emergency referrals: providing specialist care to emergency patients, who often arrive at inconvenient times and without insurance or financing?
• Multi-specialty group versus single specialty groups?
• Impaired physicians?

Additional Discussion Questions

The following questions may also be used to stimulate debate:

1. Privileges and credentialing
   1.1. Why should physicians not own the healthcare system in a community?
   1.2. (See Chapter 3, Discussion Question 9) All clinical professionals working in the well-managed healthcare organization are “credentialed,” in the sense that their preparation and performance are reviewed. Why are physicians (and some others, see Ch. 6) credentialed under formal peer review and board approval? Would you consider expanding either formal review or board approval to other professionals, such as nurses?
   1.3. How can credentialing be related to the use of final product protocols? Under what conditions would you suggest that the medical staff discontinue privileges for physicians who fail to follow protocols?
   1.4. What safeguards are appropriate to use outcomes quality scores to evaluate physicians?

2. Medical staff planning
   2.1. The institution may use its medical staff plan to improve quality and reduce overall cost of care by evaluating demand and cost for expensive referral specialty services. If it does this realistically, it provides an advantage to a competent specialist who is already a member of the staff and to a newly arrived specialist who is considering application. What are these advantages? (Hint: an advantage that might be overlooked relates to the number of primary care physicians.)
   2.2. How can an institution ensure that its medical staff plan is realistic? List the specific steps you think would be important, and which would make a reassuring checklist when presented to physicians.
   2.3. How can an institution make its medical staff plan convincing to physicians? List the specific steps you think would be important and which would make a reassuring checklist when presented to physicians.

3. Medical staff leadership (see Chapter 3, Discussion Question 8). Why should medical staff leadership be appointed by and accountable to the governing board, as opposed to being delegated entirely to the medical staff or to the executive?
4. **Medical staff representation.** What is the goal of communication with physicians? How is that goal attained in large organizations? How would you answer a young doctor who says, “I know doctors are on the board and that my department votes each year on new programs and equipment priorities. But what do I do if I need some equipment, or need to expand my office, or need to take in a partner? Will the health system help me with these things?"

5. **Medical staff bylaws (see Chapter 3, Discussion Question 7)**
   
   5.1. One way to look at the medical staff bylaws is as a large set of contracts with independent agents. What kinds of topics would these bylaws cover?
   
   5.2. Why is approval of the bylaws vested in the board?
   
   5.3. What might happen if the medical staff did not participate in designing the bylaws?

6. **Education.** How can continuing medical education be related to the use of patient management protocols?

7. **Physician compensation**
   
   7.1. What is the goal of physician compensation? Why is the goal difficult to achieve? Why are there so many alternative approaches?
   
   7.2. Explain why a well-managed healthcare organization might adopt a strategy of supporting all (or nearly all) the financial relationships shown in Figure 6.10 (p. 236 in the book). A closely related question is, “Why did salaried staff organizations like Kaiser-Permanente and Henry Ford add fee-for-service payment and shared-risk contract arrangements, while simultaneously hospitals with traditional fee-for-service relations were adding salaried physicians for clinical services, service contracts, joint sales agreements, and shared ownership?”

8. **Measures of medical staff performance**
   
   8.1. How do you measure the effectiveness of the physician organization per se?
   
   8.2. See Figure 6.12 (p. 242). Who is accountable for collecting and reporting these measures? How can they be used in a continuous improvement process?

9. **Managing the physician relationship.** See
   
   - Case 4: The Primary Care Instrument Panel at Central Community Health Plan, pp. 106-15
   - Case 6: A Proposal for the Restructuring of Wise Medical Center, pp. 157-63
   - Case 10: Organization Design for the Breast Service at Easter Medical Center, pp. 248-53
Questions for Examination

These questions are less ambiguous than the discussion questions. Obtain these questions and the authors’ answers by writing (conventional mail) on academic letterhead to:

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School of Public Health
The University of Michigan
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Ann Arbor, MI 48109-2029
(Please include an academic (dot edu) e-mail address.)