Hospital-Physician Partnerships: A Fairy Tale?

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At a Glance

To work together more effectively, clinical and finance leaders should:

- Recognize the cultural causes of tension
- Conduct honest conversations to help build trust
- Acknowledge their own blind spots to understanding

Once upon a time, I knew a successful CEO who was widely credited for the economic success of his organization. A considerate and empowering leader, he cared deeply about his institution and the patients it served. There was only one group he disparaged: members of his organization’s medical staff. He frequently told other executives of his plans to author a book on medical ethics. “It would be easy to write,” he said, “because it would be blank—except for a large, black dollar sign in the middle of each page.”

Practicing in the same hospital was a group of successful physicians who were widely recognized for their strong clinical expertise. They were bright, articulate, and competent. Not surprisingly, they had less-than-flattering opinions about the “suits” who attended to the business side of their not-for-profit hospital. One surgeon routinely told nurses that, in his view, hospitals were run by “C” students who couldn’t get into medical school and got undergraduate degrees in basket weaving before an easy administrative course turned them into CEOs. His theory was that executives knew nothing about taking care of patients because they spent their entire healthcare careers locked in the administrative suite.

The irony here is obvious. The hospital would never have been successful without the medical talent of the physicians, nor would it have survived without the business acumen and steady leadership of the CEO. Hospitals and physicians need each other. But for at least a hundred years, the relationship between these two groups has been uneasy. Sometimes, it has been downright hostile.

Bad Blood: The Early Years

When researching early hospital history, management professors Margarete Arndt and Barbara Bigelow found articles and letters in Modern Hospital from the early 20th century on this very topic. Early administrators lamented dealing with difficult physicians, such as those who threatened to damage the hospital’s image in the community if the organization failed to purchase technology the clinicians desired.

Despite the long history of tension between the two camps, clinical and financial leaders alike recognize that the time has come for better partnership. The main reason? Payment reform. The government is steadily moving toward payment systems that will demand more value for patients and payers. The commonly accepted definition of providing value in health care is delivering higher quality healthcare services more efficiently and cost-effectively. To provide value, our camps will need to work together better. We will also need to broaden our mission to treat the sick and keep people healthy.

Today, the truly forward-thinking hospitals are looking at improving partnership—and enhancing value—by adopting shared governance with their medical staff. In some cases, these hospitals are implementing models similar to the nursing governance structures already in place in Magnet hospitals, in which clinicians participate in decision making about patient care, resource allocation, and budgeting. Shared governance is about business managers and clinicians sharing accountability for the organization’s success.

Preparing for Partnership

Beyond adopting shared governance, what other ways can we improve teamwork between physicians and hospitals? Speculation abounds. Some argue that teamwork will likely improve as more females enter medicine. What’s interesting is that some studies suggest that women in medicine are twice as likely as their male counterparts to support overhauling the healthcare system. In addition, research shows that female physicians tend to be engaged in significantly more partnership behaviors with their patients, compared with male physicians. Nonetheless, time will tell whether female physicians’ willingness to partner will have a positive effect on their relationships with hospital leaders.

Many also speculate that hospitals will work better with the next generation of physicians (of either gender), who are more likely to become salaried employees of the hospital rather than private business owners. No one can deny the trend that the number of employed physicians is growing. But the impact remains unclear. Some administrators and consultants think hospitals can gain the entire medical staff’s trust by putting a few employed physicians on the board of directors—even though this didn’t work well in the past when independent physicians were on the board. Other leaders, including current CEOs, predict that the teamwork issues may be solved when all hospitals are led by physicians (after the current CEOs are retired, of course).

Although these ideas may have merit, they are essentially variations on former strategies that did not lead to satisfactory partnerships. There is an old saying, credited to various people, that “madness is doing the same thing over and over and expecting different results.” So what can we do differently to cross the historical divisions between physicians and finance leaders and establish the trust that is necessary to form effective partnerships? And how can we achieve this result in a way that will actually support the transformation of health care? We can begin at the beginning by:

- Recognizing the cultural reasons for misunderstanding between professions
- Engaging in honest conversations
- Abandoning tactics meant to “fix” the other group (in other words, by getting them to see the errors of their ways and the “rightness” of ours)

Let’s start by looking at cultural differences between hospital administrators and physicians, which have already been widely recognized. For example, in Competing on Excellence (Health Administration Press, 2004), authors Alan Zuckerman and Russell Coile blame the cultural clashes on differing loyalties. Physicians tend to be loyal to their profession, whereas hospital leaders tend to be loyal to their organizations. There is also a difference of values: Physicians tend to value autonomy, whereas administrators are more likely to value teamwork.

In The Phantom Telescope (Hillsboro Press, 1999), Stephen Klasko, MD, and Gregory Shea, PhD, point out that the gap between cultures becomes wider when neither group recognizes that its views are culturally based. Thus, each judges the other group by its own norms. The authors also point out the fallacy in assuming that placing physicians in leadership roles—either in operations or on governing bodies—will solve the trust issue with other physicians. As the authors note, “a physician who begins to ‘collaborate’ with administration excites, among other physicians, tremendous suspicion and presumption of betrayal. The physician is portrayed as betraying ‘coats’ and in danger of becoming a ‘suit.’”

What can help solve the trust issue is having honest conversations about cultural norms and values. Some of these discussions may be difficult because we often will be forced to consider opinions that don’t comply with our personal views of the world. Most of us also tend to follow the societal norm of avoiding conflict.

But we need to start the conversation. We need to have honest, administrative-medical staff conversations that explore each group’s assumptions and self-interests, and how best to meet those interests for both parties. And we need to acknowledge that our views reflect our own self-interests, which often may be at odds with the self-interests of others. This attitude requires, of course, that we see each other as people, neither as deities nor villains, and that we admit that our own professional acculturation might have caused us to develop blind spots.

These blind spots might be our biggest challenge in moving to a new, shared culture. Discussions with many of my clinical colleagues often center on the
need for clinicians to “take over” the administrative jobs so we can “fix” our organizations. At the same time, executive peers talk of the need to indoctrinate physicians into the hospital culture—in other words, “fix” them so they adopt our ways of thinking. Again, it becomes them versus us.

We need to let go of the belief that our own culture is the right culture to take us into the future. Let’s face facts: We have not been able to fix each other for the past century. It’s time to try something new. Let’s start with a culture that can grow as our own organizations evolve with the new healthcare system. We don’t know exactly what those organizations may be, but we do know they will likely be different from what we have today.

To prepare for whatever lies ahead, we need to bring clinical and financial leaders together, suspend value judgments based on our own acculturation, and explore how we may take the best from both cultures to move to systems of shared governance. We know from experiences in nursing that shared governance can move different groups toward partnership. Perhaps the first issue we can agree on is that we don’t have another 100 years to work on this. The second is that it takes a willingness to change—among both clinical and finance leaders—if we are to develop a financially and clinically healthy future for our patients and ourselves. That way, all of us may have an opportunity to live happily ever after.

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footnotes