

Physician–Hospital Alignment: The Elusive Ingredient
Commentary on “Hospital Quality: Ingredients for Success”

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This inspiring report tells the story of four hospitals that have achieved high quality at reasonable costs—in other words, predictably delivering “high-value” care. Although they differ in important ways, all four seem to share certain characteristics that, if bottled and distributed, could markedly improve American healthcare. All but the most hard-hearted (or hard-headed) administrator or provider will recognize that a gauntlet has been thrown down. Reading these tales, we are compelled to ask how we can all be more like these hospitals.

These hospitals have created a corporate culture of quality, manifested by a single-minded focus on improvement, through good times and bad. This cultural metamorphosis is particularly remarkable in light of the weak business case for quality and safety in healthcare. The authors highlighted many key lessons along the road to achieving a high-value institution. But from where I sit, one of these lessons needs more attention—the vital role of physician–hospital collaboration. In these hospitals, everyone seemed to be working together toward the same set of goals, which included data-driven performance improvement, adherence to guidelines, implementation of information technology initiatives, and many others. Why is this synergy so hard to create, and how can more hospitals achieve it?

Let’s begin with the problem. The organizational structure and incentives of hospitals and doctors are misaligned. There are so many checks and balances that one could be forgiven for wondering whether America’s founding fathers had a role in their conception. Medicare established two separate payment mechanisms (Parts A and B) for hospitals and doctors for a reason. Hospitals are governed by boards, are responsive to community concerns, and exert direct control only over their employed staff, primarily nurses. Conversely, few physicians are employed by hospitals, so hospital administrators traditionally sought to create attractive practice environments for doctors who brought in the patients—and consequently the dollars—that filled the hospitals’ coffers. In this setting, hospitals had little incentive to actively manage physicians, help organize their work, promote teamwork either between physicians or with hospital staff, or create systems that pushed quality or safety too vigorously, especially since some such initiatives risked stepping on sensitive M.D. toes.

Physicians have been trained and socialized to be fiercely independent. Practicing the art of medicine is a solo endeavor. Moreover, doctors’ income came directly from patients themselves or their insurers; the hospital was simply the workshop in which they plied their craft. Although doctors wanted hospitals that were pleasant and conducive to

high-quality care, the pressures they brought to bear on hospitals reflected their independence and ability to vote with their feet. Since neither physicians nor hospitals saw differential pay or volume based on quality, such pressures generally focused on making it easy to get patients in, on widespread access to the technology needed to practice modern medicine, and on easily available, well-trained, and appropriately respectful support staff.

Several profound and accelerating forces have rendered this status quo increasingly unacceptable and the high-performing hospitals have recognized this, probably without fully realizing how or why. As hospital care has become more complex and sophisticated, both outcomes and efficiency are increasingly linked to the quality of teamwork, not only between various types of physicians but between physicians and the other professionals they depend on, including nurses, pharmacists, and technicians. The office-based physician, previously the cornerstone of hospital care, has now all but disappeared from the hospital ward and doctors' lounge. The impact of this goes well beyond the name on the hospital chart. The primary care physician who spends less than one hour per day in the hospital is simply not going to lead hospital quality initiatives or push the hospital to create better or safer systems. In this environment, it is not surprising that many hospitals report that "volunteerism is dead" among rank-and-file medical staff members. Most physicians are too busy in their offices to willingly participate in hospital committees or emergency department call schedules. But, in the past, this kind of participation was at the core of the medical staff-hospital relationships.

The departure of the primary care physician from the hospital has increased the importance of physicians whose main practice environment is the hospital itself. Some of these physicians work in the traditional hospital-based "RAP specialties" (radiologists, anesthesiologists, and pathologists). Increasingly central though, are those physicians I have called "site-based generalists," those whose specialties are care in physical units of the hospital. The first site-based generalists emerged two generations ago, in the form of emergency medicine physicians and intensivists. About a decade ago, they were followed by the rapid emergence of a new breed of physicians who coordinated hospital care, known as hospitalists.

The importance of these site-based generalists extends well beyond their on-site presence and the fact that they manage increasingly large groups of the hospital population. Their presence and immersion in their practice environments creates fertile soil for alignment of incentives with the hospital and for the creation of high-functioning teams involving these physicians, the other hospital-employed professionals, and the physicians who are comfortable with the precepts of systems thinking.

In some cases, the financial incentives between these physicians and the hospital are already aligned. For example, about two-thirds of hospitalist groups in the United States receive support from their institutions, often to make up the difference between the dollars they can generate through professional fees for direct care and the costs of their presence. In many cases, the physicians are employed by the hospital itself, but even when they are not, the presence of these support payments creates an alignment of

incentives. Physicians who receive 30 percent of their income from their hospitals can be counted on to enthusiastically participate in, if not lead, hospital-based quality or cost-reduction initiatives.

All of the forces coming to bear on hospitals—high patient censuses, nursing shortages, the myriad pressures to improve quality and safety, the successful implementation of computerized order entry and other transformative technologies—cannot possibly succeed if the hospital and physicians continue to operate as two planets circling in independent orbits. The successful medical center of the future will be marked by high levels of collaboration, a sense of shared mission, and recognition by both parties that one cannot possibly succeed without the other.

In some settings, this sort of collaboration is facilitated by organizational structures that link the medical staff and the hospital, even if the former are not employed by the latter. High-functioning academic medical centers generally do this well. In these environments, the shared mission dissonance is created more by the pressure on the faculty physicians to publish and teach in addition to their clinical care, rather than overt conflict with the hospital. Those institutions in which physicians confine their practices to hospitals that are part of the same organization (e.g., Kaiser Permanente) also have a leg up in the creation of physician–hospital synergy. But this report gives us examples in which neither one of these conditions were at play. So what sorts of tools are available to the rest of the hospitals in the United States to create synergy and a shared mission?

The report points toward some of the answers. The high-functioning hospitals were characterized by leaders who managed to engage and inspire the physicians. It is not surprising that virtually all had CEOs who were superb communicators and visionaries and top physician executives who could serve as bridges between hospital administrators and medical staff. Together, they managed to convince the physicians to restrain some of their instinctive sense of autonomy for the greater good of the institution and their patients. The precise methods for achieving this outcome varied and included everything from paying for physician participation in critical meetings and retreats to responding to physician concerns quickly and publicly, but the final product did not.

The high-functioning hospitals of the future will be marked by this kind of culture of collaboration—at the macro level, between the medical staff and the hospital administration, and at the micro level, between hospitalists, nurses, and case managers working on a given ward. The hospitals will create an environment in which surgeons recognize that care will be better and safer if they can agree on standard procedures that everyone uses, rather than pushing the hospital to sustain customized procedures, which are incredibly inefficient and error-prone, to meet their idiosyncratic preferences. They will operate as if the doctors, nurses, administrators, and others recognize their complete interdependency in a shared effort to achieve a single, overarching goal: the provision of the highest-quality, safest, and most-satisfying care to patients at the lowest possible cost. The four hospitals profiled in this report seem to have achieved this status; it remains for the rest of American medicine to discover its ingredients and adapt them to local circumstances.