The Technology of Partnership

Physicians Must Play a Larger Role in Decisions Concerning Capital and Technology

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The age of the physician as customer is over. The notion of the independent entrepreneurial physician whose relationship to the hospital and health service setting is primarily that of a guest is an Industrial Age creation. In the 20th century, professionals in all fields sought identity and role clarity. As a result, they were anxious to establish a sustainable place for themselves. Physicians, like members of other disciplines, were eager to position themselves as primary decision makers projecting an image of independence and unilateral authority. Physicians worked throughout the past century to codify a common and rigorous curriculum and training program that would establish their primacy and independence. This attracted single-minded, willful, purposeful people to the profession. The physician's role in the health care system was established as one that was controlling, directing, and decisive. Legal structures were created to protect and ultimately promote that role.

However, the demands of the emerging 21st century require a different set of values to sustain the work of health care and medical practice. The complexity of clinical service and the application of advanced technology have created a different professional and social milieu within which new relationships between physicians, on one hand, and hospital and system leaders, on the other, will unfold. The old alignments supporting physicians' independent behavior are now dissolving. What is needed is a new configuration and affiliation that recognizes and honors the complexity, alignment, and integration of roles in a service agreement, thereby transforming the very nature of the clinical relationship. The building of this new kind of relationship will be challenging, but it will also be vital to those professionals who want to thrive in a new social construct for health care.

Three Needed Things

Much of the negative fallout from 20th-century health care can be blamed on the autonomy, compartmentalization, and polarization of many of its stakeholders. From the division between nurses and physicians, on one hand, to the more general conflicts between individuals and institutions, on the other, everyone involved in health care is today caught in a pattern of behavior that is no longer sustainable. Behavior that is mutually exclusive must change if health care is to thrive in the new century.

Boards of trustees and administrators are, for example, finding it difficult if not impossible to make capital decisions regarding new technology without more clear and direct participation by physicians. In fact, it is becoming increasingly clear that, if hospitals and health systems are to remain viable, physicians themselves must provide strong leadership in the planning process. Gone are the days when physicians were merely consulted about technology and nonphysicians made the vital decisions concerning the hospital or system. Gone also are the days when decisions concerning capital and purchase preferences could be based on political jockeying. Today's health care environment requires consensus and collective vision.

Three things are now needed to ensure the appropriateness and long-term viability of health care technology planning and decision making.

Collaborative Structure To make the best possible decisions concerning capital invested in technology, health care system leaders should establish an organized process in which the system's physicians participate in assessments, recommendations, and approval mechanisms.

Accountability Physician leaders must play a partnership role in technology decisions in a way ensuring that they "own" and are accountable for the choices made.

Vision Decisions concerning the investment of capital in new technology and information systems must always be made in a disciplined and systematic manner. Plans should aim at the comprehensive use of technology that advances both the mission and service viability of the health care system and its participating practitioners.

How can physicians best participate in the decision-making process?

Systematic Physician Involvement

Every health care organization has a technology and capital planning process. Some work well; others do not. In an age in which technology has become a major driving force in the transformation of U.S. health care, the critical factor will be the ability of planners to anticipate the impact and availability of a specific technology and fit it tightly with the health care system's resources and potential future service configuration. Although some technologies (such as information management and billing systems) are applicable to all health care systems, each particular system will have a particular and unique relationship to its community, as will be evidenced by the demographics and demands of those the system serves. No one is closer to the service demands and needs of health care consumers than physicians. Because they are oriented to both the economic and clinical concerns at the point of service, physicians have a unique perspective on the market. Taking physicians' personal practice biases (and such biases are significant) into consideration, one must admit that their experience and knowledge give them a comprehensive picture of current patterns of the behaviors, needs, and demands of health care consumers. Because this is so, administrators involved in information gathering and capital planning should seek input systematically from practicing physicians. And that is just the beginning. Physicians should be educated about the capital planning process and furnished with a better understanding of how decisions are made based on clinical priorities and financial constraints.

Furthermore, because physicians will likely be the users of most of this new technology, they must participate more fully in the decision-making process. In the past, much of that process involved administrators' getting some sense of what physicians wanted. Medical staff members rarely participated in weighing cost against benefit, balancing one choice against another, and determining the substantive fit between choices. Today, however, physician participation in decision making is a critical part of new technology assessment and should be included in the planning and selection process.

But how can physicians best participate in this decision-making process? The medical staff structure at most hospitals does not lend itself to consensus and collaboration, nor to an organizational mind-set. The criteria for medical staff membership have traditionally been clinical. Because of this, medical staff decision making is often deferred to an executive committee typically made up of elected representatives, department chairs, and service line directors. Such people may or may not have the facility's best interests in mind; loyalty to the organization is usually not a prerequisite for election or appointment to this group. As a result, medical staff members tend either to be excluded from capital planning and decision making, or, at best, to play only an advisory role. One way leaders could rectify this lack of meaningful physician involvement is by forming a medical staff subcommittee or work group that would be specifically involved in capital planning and decision making. Criteria for membership in such a group would be:

- Commitment to the hospital or system
- Business acumen
- Clinical knowledge
- Understanding of community needs
- A demonstrated interest in the well-being and advancement of the institution

Appointments to the group should be made by administrators as directed by the board of trustees, rather than by the general medical staff, for the reasons stated previously. The political and financial challenges of such a move would likely be significant, given the current dynamics of many medical staffs and hospitals. But, given the importance of capital and technology decisions and the many potential benefits gained from meaningful physician involvement in this process, the risks seem to be justified.

Physician Competition Crisis

As clinical technology becomes more portable and flexible, health care delivery becomes less

dependent on institutions. Twentieth-century medicine was predominantly manual and mechanical in its application. Twenty-first century medicine will be different. Therapeutic interventions will increasingly be pharmacologic, minimally invasive, genomic, and "chip"-based. These therapeutic approaches will require hospitalization less frequently, and, because this is so, traditional hospital-related care activities will become less important. The contemporary increase seen in outpatient services presages this reality.

The "crisis" associated with this change is that, over time, hospitals will become less relevant to the delivery of patient care. Much of hospitals' current infrastructure is geared toward overnight stays and bed-based activity. Hospitals' old dependence on bed-based activity has created a service and financial model that may no longer be sustainable.

Physicians, too, are affected by increasingly portable clinical technologies. Although they have the opportunity to embrace and take control of these new techniques, their adoption of them is complicated by learning requirements for clinical application and operational management. Unless physicians develop knowledge of and experience with these modalities, they will find themselves in a disadvantageous position—clinically, financially, or both. Significant variation in the use, effectiveness, and efficiency of new technology can be expected until a critical degree of experience and proficiency has been attained.

Medical groups are now taking steps to "own" many of these portable technologies and services, providing them in their own clinical settings, often in competition with hospitals. It is now possible for patients to return home after diagnostic and therapeutic interventions that, until recently, would have required hospitalization. New radiological techniques, cardiac procedures, cancer therapies, and minimally invasive surgeries are among the innovations now commonly performed outside hospitals. As many as 50 percent of curative breast cancer surgeries are now done on an outpatient basis.[1] In time, procedures such as electron beam whole-body scanning may even supplant human diagnosticians. Indeed, these procedures threaten to draw patients away from both hospitals and physicians, thereby radically altering the financial and service landscape of health care forever. The question for hospitals is: How can they remain relevant in a time of dramatic transformation in service design and application?

A New Kind of Leadership

If hospitals and systems are to remain viable, their administrators must acquire fluidity, nimbleness, and capacity for change. One key element of this leadership is a total reconceptualization of the relationship between the hospital and the medical staff. Although various laws and regulations may seem to limit or even prevent the strengthening of such relationships, health care leaders must be willing to test these apparent constraints.

If it is to thrive in the new century, U.S. health care has an immediate strategic and political obligation to address these issues. Several issues in particular must be addressed.

Remove Constraints Twentieth-century laws and regulations that treat physicians and hospitals as independent entities are no longer tenable. Although society needs continued legal protection from profiteering and constraint of trade, it must begin to recognize the interdependence of health care practitioners. If practitioners are to have the opportunity to manage care across the life continuum, they must be given the ability to integrate and collaborate on services in a meaningful way. At present, such integration and collaboration are severely limited by legal, structural, and financial constraints.

Build an Information Infrastructure Health care systems now have an opportunity to create an Internet-linked information infrastructure involving practitioners, services, sites, and health care consumers. Such an infrastructure would go far toward changing the design of health care systems. It would establish essential interdependencies between systems and practitioners, help consumers evaluate the services available to them, and link financial and payment processes in a coordinated model. Many health care leaders have taken a go-slow approach to the creation of such an infrastructure, arguing that it is impossibly expensive. However, the credit card and banking industries have shown that building an effective and forward-looking clinical and financial information system without the Internet is no longer an option. If Visa, for example, can build a network that includes more than 350 million cardholders in every corner of the world, coordinate the activities of four million vendors (with well over three million transactions a day), and get the right information at the right time on an individual's bill regardless of where in the world the transaction occurred, U.S. health care can do it too.[2]

Work Together Physicians and hospitals can no longer do much independently to change health care's political, regulatory, and legislative landscape. Because health care delivery itself has become so complex and interdependent, physicians and hospital administrators must begin to recognize their own interdependence. To collaborate effectively, physicians and administrators will have to work for substantial adjustments in the laws and regulations in a variety of areas. These areas include practice boundaries, business part-

Continued on page 52

THE TECHNOLOGY OF PARTNERSHIP

Continued from page 43

nerships, clinical data management, medical records, confidentiality, payment, quality improvement, and "best practices." To make their collaboration work, physicians and administrators must first change their view of each other, understand their mutual needs, develop collaborative strategies for policy formation, integrate their data analysis, and establish more direct leadership relationships in their boardrooms and executive offices.

FOREVER TOGETHER

A basic tenet of quantum mechanics is that, at some level, everything is linked in an inexorable dance of movement and resonance. Words sometimes used to exemplify this circumstance are *chaos* and *complexity.* Although history shows that physicians and hospital administrators have not always worked closely together, the evidence indicates that such fractured and compartmentalized relationships are no longer sustainable. However, a genuine relationship is not an accidental or circumstantial occurrence; it requires concerted action.

U.S. health care is approaching a seminal moment. Technology, which was once evidence of change, has become the *driver* of change. Recognition of technology's influence on structure and process is critical for the continued growth of health care in this nation. Certainly, the complexities involved should prevent us from continuing to operate as *though the changes were simply* incremental. Physicians, nurses, hospitals, providers, payers, legislators, governments, and accrediting agencies—all are today a part of the new health care mosaic, and, because this is so, must recognize that fact and begin to work together. □

NOTES

1. C. Case, M. Johantegen, and C. Steiner, "Outpatient Mastectomies: Clinical, Payer, and Geographical influences," *Health Services Research,* vol. 36, no. 5, pp. 869-889.
2. S. Davis and C. Meyer, *Future Wealth,* Harvard Business School Press, Boston, 2000, p. 234.

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