Partnering with Physicians: A Journey from "I" to "We" to "Us"

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Healthcare organizations require physician engagement in order to be economically viable. Physicians are seeking economic security. The interdependence is undeniable, the need to cooperate is obvious, and failure to do so is toxic. Yet, the relationship is most often tenuous, distrusting, and fragmented. Why?

This article looks at the reasons this relationship can be complicated and ways for physicians and hospitals to move past these barriers and build a strong partnership.

Breaking Down Barriers to Partnership

Most healthcare leaders are primarily businesspersons who speak the language of business and apply business metrics to define success. Clinicians speak the language of clinical medicine and define success using clinical metrics. Each can evaluate the same data set and arrive at totally different conclusions. To each the conclusion is obvious. For the other not to agree must mean that they either cannot see it or choose not to see it. They are either incompetent or self-serving, and in either case not trustworthy.

There is also an ethical divide. Physicians have an ethical responsibility to serve as the individual patient's advocate while administrators must be the patients' advocate. Each of these perspectives has an equally valid but totally separate set of ethics. No one can simultaneously serve both.

The dominant trend in today's market is to employ physicians. The term "employment," while technically correct, has a negative impact on the relationship. True engagement, or better yet commitment, requires an attitude of *partnership*. Too often administrators view independently minded physicians as adversaries to be leveraged in compliance with the organization's business plan.

Administrators oftentimes see physicians as fungible, seeking to employ them as a defensive strategy lest they be employed by a competing healthcare organization. To be fair, there is a political and economic cost to selective hiring. There is pushback from those physicians not included in the hiring strategy, and not enough included physicians to serve the large number of covered lives necessary to avoid becoming a commodity or to avoid an actuarial disaster.

In pursuit of a relationship, the negotiation invariably centers on tangibles like how much money and how little responsibility. When doing the deal is paramount, when it is all about the money, commitment and loyalty are defined by the next better offer. When there is no "big idea," the default is to self-interest.

There is no vision that transcends the business plan. In *Drive*, Daniel Pink states that autonomy, mastery, and purpose are the three primary motivators of those who perform heuristic work.[1] High-functioning teams are aligned to a shared purpose and bound together by a commitment to an agreed upon set of core values.[2] While pay is commonly thought of as highly important, the Hay Group lists money as number 10 in a list of the top 10 factors that contribute to retention in the workplace. In *Built to Last*, the authors conclude that in organizations that have sustained a presence in the Fortune 500 for more than 50 years, the business plan only served as a vehicle for the expression of the core ideology of the workforce.[3] The core ideology was defined as the sum of the organization's vision and values. It is all about the intangibles. Yet, too often there is no vision, and the value hierarchy—the expectations and accountabilities that provide the moral compass for decision making going forward—is rarely identified much less discussed.

What does the organization stand for and how does anyone know if joining is a good fit? In *Small Unit Leadership*, D.M. Malone discusses the importance of skill, will, and teamwork.[4] In his view, skill is an essential requirement for trust.

1 Daniel Pink, *Drive: The Surprising Truth About What Motivates Us*, Penguin Group, 2011.
2 Dave Logan, John King, and Halee Fischer-Wright, *Tribal Leadership: Leveraging Natural Groups to Build a Thriving Organization*, HarperCollins Publishers, 2008.
3 Jim Collins and Jerry Porras, *Built to Last: Successful Habits of Visionary Companies*, HarperCollins Publishers, 1994.
4 Dandridge Malone, *Small Unit Leadership: A Commonsense Approach*, Presidio Press, 1983.

Key Board Takeaways

Partnering with physicians is essential to the success of healthcare organizations. All enduring relationships are built on a foundation of shared and transcendent purpose and a commitment to the behavioral manifestations of an agreed upon set of core values.

Too often, attempts to create this relationship focus solely on "doing the deal." In the absence of a unifying shared purpose, the default is to economic self-interest. The business plan must serve the organizational purpose. Profit should not be directly pursued, but rather ensue from a primary commitment to purpose. That is the only way to access discretionary effort and affect commitment to an identified set of behavioral expectations.

When partnering with physicians, boards should:

- Safeguard organizational purpose.
- Focus primarily on the intangible aspects of relationship building.
- Recruit and retain individuals who see their self-interest served by alignment with group interest.

Individuals want to know that they can rely on the competence of those on whom they depend. Will is the alignment of self-interest with group interest—that which is most important to the individual is most important to the organization. Teamwork results when the individual acknowledges that he or she can get more of what they care most about by working together with others than by continuing to work independently. For the Marines, it is "The Few, The Proud," not any willing provider.

Physicians are no better prepared to forge a successful partnership. They lack a collective identity, making all decisions in the form of a town hall democracy—one person, one vote, and majority rules. Among physicians, where individual autonomy remains the transcendent value, the presumption to leadership is viewed as illegitimate. Generational differences often prevent older and younger physicians from talking together to identify areas of

agreement as to how better to proceed forward. Shift work and ever more narrowed subspecialty practices complicate the orchestration of care.

Integrating physicians into the management of organization work is complicated by significant cultural difference. Physicians work to the principle of distributive justice wherein the end justifies the means. They are great violators of policy and procedure in service of what they believe their patient needs now. Working together with others is actualized by writing orders. By contrast, those who work in healthcare organizations work to the principle of procedural justice. All who might be impacted by any proposed changes must vet initiatives. When this expectation isn't met, passive aggressive behavior results. Until this difference is resolved, dyad management initiatives will meet with frustration.

Two additional barriers deserve mention. First, healthcare organizations all budget departmentally precluding the ability to creatively redesign throughput and facilitate the orchestration of care across time and domains. Secondly, mergers and acquisitions are resulting in ever-larger healthcare systems. Those in system offices too often seek to franchise their component organizations in pursuit of standardization thereby denying the unique characteristics of those units and frustrating those trying to optimize local performance.

Shared Purpose and Values Lead to Integration

In conclusion, to truly integrate physicians into the healthcare enterprise, it is imperative to focus on the intangibles. It's all about shared purpose and shared values. There needs to be an alignment of self-interest with organizational interest at the level of the "big idea." It's not just what you do that matters, but rather why you do it. People don't commit to a vision because it is achievable, but rather because it is irresistible. The business plan must serve the organizational purpose. Money should not be directly pursued, rather ensue from a primary commitment to purpose.

Indeed, in the absence of a great dream, pettiness prevails. It is only the transcendent dream that can move physicians from autonomous "I" to collective "we" to a truly integrated "us" in partnership with the healthcare organization.

The Governance Institute thanks Joseph S. Bujak, M.D., FACP, healthcare speaker, facilitator, and consultant, and Governance Institute faculty, for contributing this article.
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