Employing Physicians: The Imperative of Doing It Right

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Executive Summary

Healthcare delivery in the U.S. is undergoing a major transformation as it strives to improve the parameters of quality, service, and cost. The evidence of this evolution is everywhere and one of its major facets is the changing of practice arrangements for the nation's doctors.

HOSPITALS AND HEALTH SYSTEMS HAVE BECOME THE employer of choice for physicians in these volatile times for the healthcare industry. Whether organizations have engaged in physician employment proactively or reactively, the process rarely proceeds without some significant challenges, which can put the financial health of a hospital at risk or jeopardize key features of its strategic plan. There is a lot at stake in getting physician employment right.

Physician employment in the 1990s had disastrous results on hospital and health system bottom lines, deteriorated working relationships with doctors, and failed to strengthen the competitive position of their institutions. The 21st century has seen resurgence in the attractiveness of physician employment. The drivers of this renewed interest are more complex than those behind the first wave of employment. Early in the second wave, hospitals and health systems began making offers to physicians in those specialties that supported mission-critical service lines. This second employment wave has also been fed by the increasingly tenuous position of private medical practice. Meanwhile, a new generation of freshly minted medical residency graduates has been making clear its strong preference for hospital/health system employment over private practice. And more than a third of practicing physicians are expected to retire in the next 10 years.

In the decades ahead, it is patently clear that most hospitals will have significant numbers of employed doctors. Most will retain a hybrid medical staff of private and employed physicians. This means that hospital and health system boards and leaders will have to understand the realities and pitfalls of physician employment and manage the recruitment and retention processes successfully.

Common missteps in employing physicians (and other practitioners) include:

- Hiring the wrong practitioners
- Offering the wrong deal
- Failure to preemptively set and communicate expectations of employed physicians and describe critical features of the employment relationship
- Failure to adequately consider various compensation models and involve employed physicians (through representatives) in the ongoing study, design, and revision of the compensation model
- Deploying an inadequate administrative infrastructure to manage practices of employed doctors
- Treating physicians like "employees"
- Allowing employed physicians to remain aloof from the activities of the organized medical staff
- Underestimating the organization's need to recruit and retain primary care physicians
- Reluctance of hospitals to share comprehensive financial information transparently with employed physicians
- Emphasizing recruitment of physicians to the neglect of retention efforts
- Failure to organize employed physicians into a single multispecialty group practice
- Inadequate investment in leadership development
- Insufficient clarification of leadership responsibilities and accountabilities leading to role confusion between employed and non-employed physician leaders
- Failure to design a mechanism by which the board can assess whether its physician employment strategy is returning value to the organization

Best Practices for Employing Physicians

What gives a hospital a competitive edge when it comes to employing physicians? Some competitive elements may not be under managerial control, such as geographic location or overall institutional size. On the tactical front, it certainly helps if an organization takes steps to avoid the hiring mistakes above. More important, however, is a strategic game plan to make the hospital or health system a rewarding professional home that makes these institutions destinations of choice for doctors and other critical clinicians. Such strategic plans typically emphasize two critical and complementary approaches.

The first is the organization of employed doctors into highly effective multispecialty group practices. A group practice model for employed physicians:

- Provides a vehicle to allow physicians retention of significant autonomy over their professional lives
- Facilitates efforts to redesign and integrate care through increased collaboration and coordination of clinical activity
- Creates a sense of professional community that counterbalances the growing practice isolation of physicians

- Drives innovation when groups have strong internal leadership coupled with financial stability, control over a broad range of resources, and a history of teamwork and collaboration
- Liberates hospital administrators from the time-consuming and contentious tasks of managing employed physicians directly
- Is an attractive model for recruiting and retaining clinical practitioners
- Can promote development of a culture of excellence, teamwork, and patient-centered care

A second important activity is to engage these physicians in a thoughtful leadership structure for the hospital or health system that is not simply "jury-rigged" around historic leadership roles. Physician leaders guiding multispecialty group practices need a much broader set of management skills than their colleagues in medical staff offices. Acquisition of such skills requires careful planning since most employed physicians are paid based on productivity and therefore incented to focus on clinical work rather than leadership education. In planning an employed group practice, healthcare leaders should consider the creation of specific incentives to support the management education of physician leaders.

It is also important for the board and management to commit to true partnership with physician leaders. In many institutions this partnership is captured by the declaration that the organization will be "physician led and professionally managed." This concept recognizes that great results can be achieved when physicians combine their medical expertise with the managerial skills of their administrative colleagues in a true dyad partnership.

Good results from employed physicians can't be accomplished without good leadership, and boards should insist on robust physician leadership development programs and thoughtful succession planning. They may also have to mediate retrenchment of historic physician leadership positions to avoid unnecessary conflict and confusion among old and new leadership roles.

Discussion Questions for Boards and Senior Leaders

- What are the major strategic advantages of employing physicians for our organization? How is physician employment embedded into the strategic plan, and is it done so in an appropriate manner?
- Based on the strategic plan, what are the reasons and goals behind employing physicians? Are those the right goals to move the organization forward?
- How can we make our organization a more rewarding professional home and destination of choice for doctors?
- What is our current employment structure? Is it meeting the needs of our community? If not, what needs to change?
- If we need to hire more physicians, which ones do we need and why?
- What are some critical aspects to consider when hiring physicians and determining whether they will be the right fit for our organization?
- Is our physician leadership structure effective for both employed and independent physicians? If not, how should the leadership structure be changed?
- Do our physician leaders need training and education to be better leaders? What else do they need to increase their effectiveness?
- Do we have an effective mechanism in place to assess whether our physician employment strategy is meeting our goals and returning value to the organization?

Introduction

Healthcare delivery in the U.S. is undergoing a major transformation as it strives to improve the parameters of quality, service, and cost. The evidence of this evolution is everywhere and one of its major facets is the changing of practice arrangements for the nation's doctors.

OVER THE PAST 10 YEARS, PHYSICIANS HAVE BEEN ABANdoning the private practice of medicine in droves. Today, a majority of the country's practicing doctors are employees of hospitals, health systems, and other organizational entities. This represents a true "sea change" in our healthcare delivery model and many of the long-term ramifications will not become clear for decades. While voices of caution have been raised, the trend toward physician employment is continuing unabated. The imminent retirement of baby-boomer doctors, most of who have spent their entire careers in private practice, will only accelerate the demise of this historic business model. Younger clinicians have shown an overwhelming preference for employment by institutions rather than undertake the difficult demands and risk the uncertain success of running their own small businesses.

Hospitals and health systems have become the employer of choice for physicians in these volatile times for the healthcare industry. Some organizations have embraced the role of physician employer with enthusiasm. Others have done so reluctantly and have only recently begun to undertake the expense and the managerial challenges that come with having doctors on the payroll. Whether organizations have engaged in the employment of medical staff members proactively or reactively, the process rarely proceeds without experiencing some significant difficulties along the way. These challenges can be minor or major. They can put the financial health of a hospital at risk or jeopardize key features of its strategic plan. Employment missteps can leave a legacy of corrosive mistrust between a hospital/health system and its doctors, and threaten both recruitment and retention of clinicians critically needed in a period of growing physician shortages. As competition among hospitals and health systems grows, a successfully deployed physician employment model can be a strong marketplace advantage. Poor execution of physician employment can so damage an organization's stability that it is driven to the shelter provided by a merger or sale. Clearly there is a lot at stake in getting physician employment right.

Once a hospital or health system encompasses physician employment in its strategic plan, it is a key role of management to exercise this tactic effectively. However, boards remain remote from this endeavor at some peril. In the 1990s, a previous era when hospitals employed physicians, many boards were dismayed by the disastrous results physician acquisitions had on their bottom lines, the deteriorated working relationships with doctors that emerged, and the failure of the tactic to strengthen the competitive position of their institutions. Hospital and health system boards should have a keen interest in ensuring that, this time around, employing physicians will yield better results. Furthermore, poor execution of physician employment strategies can result in serious legal liabilities, exclusions from government payment programs such as Medicare, and devastating reputational harm. An organization that employs large numbers of physicians has significantly expanded the oversight burdens borne by the institution's board. In short, the board must not only monitor management's acquisition of physician practices and practitioner employees, but it must ensure that the implementation of this initiative is carried out correctly so that the numerous pitfalls and landmines that litter the way are effectively avoided.

This white paper serves as a guide to board members, physicians, and leaders from hospital and health system management and the medical staff, who wish to learn from the experience of others as they build their medical staff for the decades ahead.

A Brief History of Hospital and Health System Physician Employment

Over most of its history, the private practice of medicine by doctors in the U.S. has been the dominant mode of healthcare delivery.

EVEN BEFORE THE HOSPITAL EMERGED AS A REASONABLY effective locus for care in the late 19th century, there was resistance to the concept of physicians as employees. As a result of the employment of doctors in the late 1800s and early 1900s by corporate employers for the care of their employees, the American Medical Association (AMA) began a strong campaign to block the trend. The idea of prohibiting the corporate practice of medicine (CPOM) originated in 1847 through the AMA's issuance of its Principles of Medical Ethics.[1] The AMA was largely successful in creating new public policy that promoted the independence of doctors from lay control and interference. The rationale was support for integrity of the profession and preservation of physicians' ability to act in the best interests of their patients.

Many states adopted some type of CPOM statutory framework and in others the concept became established through common law or was derived through provisions in the state's medical practice act.[2] The idea that it was improper for hospitals to employ doctors dominated the healthcare landscape for nearly a hundred years. Nevertheless, over time many states have determined that the concerns underlying the "corporate practice of medicine" could be effectively managed through their state's regulatory oversight mechanisms or by the consequences imposed by the legal liability system. Most states have stopped enforcing bans on CPOM and various arrangements for the employment or the direct contracting of physicians have become widespread. Today, even in states that continue to have a strict CPOM prohibition (e.g., California and Texas), there are numerous workaround approaches hospitals and health systems use that make the bans more of a "make work" exercise than an effective tool of public policy.

The first really significant growth in doctor employment by private, non-governmental hospitals began as a result of the managed care initiatives of the late 20th century. In an effort by the government to control cost in the healthcare market, the Health Maintenance Organization Act of 1973 directly promoted the development of HMOs. By the 1990s, many private organizations and employers sponsored HMOs, PPOs, and physician–hospital organizations (PHOs) as part of their managed care efforts to reduce costs and increase profits. Hospitals, worried that patients would be directed away from their facilities by "gatekeeper" doctors participating in managed care programs, began to directly employ primary care physicians. Hospital boards and administrative teams, convinced that the acquisition of physician practices was essential to their future, committed millions of dollars to bring doctors under their direct management. This activity is sometimes referred to as the *first wave* of hospital employment of physicians. (See sidebar below, which illustrates some of the characteristics of this first wave.)

Characteristics of the First Wave of Physician Employment

- Employment largely focused on primary care physicians: family doctors, internists, pediatricians, and ob-gyn practitioners.
- To attract physicians to employment arrangements, hospitals often paid large amounts ("goodwill") for doctors' practices.[3]
- Employed doctors were commonly paid guaranteed salaries that were not tied to productivity or other performance measures.
- Management of newly acquired practices was often undertaken by hospital personnel with little or no experience in the business intricacies of outpatient medical practice.
- Most hospitals had minimal physician leadership in the administrative ranks, and oversight of employed doctors frequently fell to mid-level management personnel.
- Many hospitals tallied annual loses per employed physician exceeding $70,000.

The backlash against managed care and the ebbing of its dominance as a payment model by the late 1990s ended the first wave of hospital/health system employment of doctors. By the turn of the century many hospital CEOs, driven by ongoing financial losses and frayed working relationships with their physician employees, were arranging for the divestment of their recently acquired medical practices. As an experiment in new working

1 See American Medical Association, *Principles of Medical Ethics*, Ch. 3, Article VI, Section 2 (1937).

2 Michael Schaff and Glenn Prives, "The Corporate Practice of Medicine Doctrine: Is It Applicable to Your Client?, *Business Law & Governance,* Vol. 3, Issue 2 (American Health Lawyers Association), May 2010.

3 Goodwill arises when one company acquires another, but pays more than the fair market value of the net assets (total assets–total liabilities). In practice acquisitions it typically refers to income that will be derived from the patients who continue to patronize the practice.

relationships between hospitals and doctors, this first wave was generally seen as a failure.

The 21st century has seen resurgence in the attractiveness of physician employment. The trend was well under way by the middle of the century's first decade and has been accelerating as we approach the mid-point of the millennium's second decade. The drivers of this renewed interest are more complex than those behind the first wave of employment. Early in the second wave, hospitals and health systems began making offers to physicians in those specialties that supported mission-critical service lines. Anxious to secure the availability of hard-to-procure neurosurgeons, cardiothoracic surgeons, and other "high-end" specialists, organizations often converted exclusive contracts to employment arrangements. These specialists were generally hospital-based and happy to lock in their historically high rates of compensation.

An organization that employs large numbers of physicians has significantly expanded the oversight burdens borne by the institution's board. The board must not only monitor management's acquisition of physician practices and practitioner employees, but it must ensure that the implementation of this initiative is carried out correctly so that the numerous pitfalls and landmines that litter the way are effectively avoided.

The second wave of employment has also been fed by the increasingly tenuous position of private medical practice. The combination of rising overhead costs (e.g., to implement expensive electronic health records or EHRs) and declining reimbursement has caused a near implosion of the small business model of physician practice in large swaths of the country. Physicians in distressed practices began to request employment from their local hospital or system. While almost all medical practices have labored to succeed in recent times, there have been some idiosyncratic reimbursement decisions that have affected specialties differentially. For example, in 2004 Medicare cut back dramatically on its payment to private cardiology offices for lucrative ancillary testing that was a traditional linchpin in practice finances. All across the country, thousands of cardiologists determined they would be better off going forward as hospital employees and they swelled the ranks of hospital-employed doctors. According to the American College of Cardiology, the fraction of cardiologists employed by hospitals rose to 35 percent in 2012, up from 11 percent just five years earlier.

Meanwhile, a new generation of freshly minted medical residency graduates has been making clear its strong preference for hospital/health system employment over private practice. Many private practices have found it extremely difficult to expand or recruit needed replacement physicians because young doctors largely shun these opportunities. According to a recent article in *The New York Times*, in 2013 "…64 percent of job offers filled through Merritt Hawkins, one of the nation's leading physician placement firms, involved hospital employment, compared to only 11 percent in 2004. The firm anticipates a rise to 75 percent in the next two years."[4] Young physicians, often carrying large debt from college and medical school tuition payments, are attracted to hospitals for their greater financial stability. These physicians also prefer to join large organizations where they believe it will be easier to balance home and work priorities, find part-time practice opportunities, and have reduced on-call obligations.[5]

Another demographic driver of this shift to employing physicians is that baby-boom doctors comprise the largest generational cohort of physicians and the private practice model of medicine has dominated their professional lives. Today, approximately one-third of physicians are 55 years of age and older and 40 percent are 50 and older. More than a third of practicing physicians are expected to retire in the next 10 years. As these doctors leave the workforce, the younger physicians that replace them in communities all across the country will not have the same affinity

4 Elisabeth Rosenthal, "Apprehensive, Many Doctors Shift to Jobs with Salaries," *The New York Times,* February 13, 2014.

5 For some additional perspective, see Jackson Healthcare, *Filling the Void,* 2013 Physician Outlook & Practice Trends, 2013. Available at www.jacksonhealthcare.com/media/191888/2013physiciantrends-void_ebk0513.pdf.

for private practice. Hospitals and health systems that want to meet their future medical staff manpower needs will have to offer employment options that appeal to this younger cohort of practitioners.[6]

There are some critics who believe that this second wave of physician employment will recede, as did the first wave two decades earlier. There is little evidence to support this prognostication. Efforts to resuscitate private practice medicine are largely confined to tactics that work around the dominant health insurance paradigms of the day. Examples include concierge medicine (accessible largely to upper-income patients), house call only practices (viable because they have little overhead), and experiments in direct reimbursement primary care (where patients pay a subscription fee and no insurance is collected). Meanwhile, further economic threats to private practice continue to lurk on the horizon, including CMS efforts to remove exceptions in the Stark laws allowing "in-office" ancillary testing and the ever-present likelihood that insurers will cut back payments on highly reimbursed procedures that sustain the incomes of many specialists.

Current surveys suggest that hospital-employed doctors are generally happy with such arrangements. In March 2014, the Web site Medscape released data from the *Medscape Employed Physician Report 2014*.[7] This survey suggests that nearly two-thirds of employed physicians are likely to recommend employment to their colleagues over private practice. Furthermore, a majority believes that patient care is better in the employed setting and that as employed doctors they enjoy a work/life balance that is superior to their experience in private practice.

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In the decades ahead, it is patently clear that most hospitals and systems will have significant numbers of employed doctors. Most will retain a hybrid medical staff of private and employed physicians. This means that hospital and health system boards and leaders will have to understand the realities and pitfalls of physician employment and manage the recruitment and retention processes successfully. The remainder of this white paper is directed at helping in those efforts.

6 Current data on the number of physicians employed by hospitals is hard to come by. The AMA has reported approximately three in 10 physicians are hospital employees based on 2012 data (see C.K. Kane and D.W. Emmons, *Policy Research Perspectives: New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment,* American Medical Association, 2013).

7 Leslie Kane, M.A., *Employed Doctors Report: Are They Better Off?,* Medscape, March 11, 2014. Available at www.medscape.com/features/slideshow/public/employed-doctors#1.

Common Missteps in Employing Physicians (and Other Practitioners)

1. Hiring the Wrong Practitioners

One of the most important decisions to be made by hospitals and health systems seeking to employ physicians is determining which doctors to hire. Previous sections of this white paper have articulated the reasons organizations seek to engage doctors through employment, including the need to grow or secure a mission-critical service line, in response to a request for employment from an important hospital referral source, or to fill gaps in the medical staff manpower plan. Unfortunately, many organizations spend too little time considering whom *not* to employ. These institutions underestimate the destructive impact a physician can have who is a wrong fit for the needs of the hospital or its collective group of employed doctors. Before a practice is acquired or a physician offered employment, healthcare leaders should investigate whether the practitioner(s) have been solid citizens of the medical community. Are they productive? Do they manifest values that are compatible with those of the institution? Are they mature and self-confident enough to adjust to the loss of control they will experience as an employee? Is their practice area important enough to the organization's strategic direction to warrant the expenditure of energy and resources necessary to acquire it? Are the practitioner(s) compatible with the currently employed cohort of doctors?

Characteristics of Physicians Who May Be Poor Candidates for Employment

- Those with a history of vocal antagonism toward the organization and its leadership, automatically oppose change, and are not supportive of the organization's long-term goals
- Practitioners with a history of disruptive behavior or unprofessional conduct as members of a medical staff
- Doctors who are recognized as poor team players and who are constantly critical of perceived limits on their autonomy as clinicians
- Clinicians whose historical practice patterns do not comport with current demands for high-quality, cost-effective, patient-centered care
- Individuals whose sole motivation for employment appears to be lucrative financial guarantees from the organization (especially if they are pushing for a long-term contract that locks in compensation that skirts acceptable fair market valuations)
- Practitioners who do not have the confidence of their colleagues

Why do organizations hire doctors they know to be poor fits? The answer to this question varies from organization to organization. Many institutions feel desperate to fill physician needs as the recruitment of practitioners becomes increasingly difficult. Growing shortages of both primary care doctors and specialists are threatening the ability of hospitals all across the nation to meet the needs of their communities. Leaders at these facilities may believe that they are better off employing a sub-optimal practitioner than having no one at all in an unfilled position. In other cases hospital recruiters are judged by how many bodies they get on board rather than the quality of the practitioners. Motivated by the strong trend toward physician employment and perhaps by competition from other institutions for a diminishing pool of available doctors, those responsible for identifying and employing doctors may find it inconvenient to dwell on the theoretical future problems their recruits may manifest.

Some organizations may take on potentially problematic practitioners as a result of political pressure exacted by the candidate himself or by others in the community who ally themselves with the applicant. Such a candidate may be a long-standing member of the medical community with a loyal patient following; she may be a major source of referrals to other practitioners on the medical staff; he may be friends with members of the board; or practitioner threats to accept employment by a competitor may be seen as unacceptable. Under these circumstances, a management team may override its better judgment and make an offer of employment, knowing there are downsides. The destructive consequences of such decisions are frequently underestimated.

What are the downsides to hiring the "wrong" physicians? When such physicians have a history of combativeness and antagonism with hospital or medical staff leaders, this behavior often worsens under employment. Excessive amounts of leadership time may be consumed in struggles with such practitioners—time better deployed to the enormous challenges of improving quality in a cost-effective manner. Similarly, if there are quality or competency concerns regarding the employed physician, inordinate time may be invested in monitoring and attempting to redress this situation. Classic "disruptive" conduct undermines staff morale and can lead to nurse turnover while posing difficulties for ongoing recruitment. Such behavior has been directly linked to poorer care and an increased threat to patient safety. Such behavior can also lead to lawsuits from aggrieved staff members, patients, and even colleagues. If colleagues become targets of disruptive behavior, physician turnover may increase and future recruitment efforts may be impaired. As prevailing

reimbursement models move to place hospitals and health systems at greater financial risk, these problematic clinicians may weaken performance results and lead to diminished institutional payments. Finally, these doctors can be a serious threat to the efforts of organizations and their associated employed physician group practices to build strong collegial cultures of excellence. This last issue may have the most damaging effect of all upon the future success of the organization. Future institutional survival under evolving healthcare business models and in the face of increasing competition may hinge on a hospital's ability to powerfully engage its physicians in the delivery of superior results. When the "wrong" doctors are employed, that engagement is retarded and the ability to build a culture that can sustain great outcomes is constantly eroded.

2. Offering the Wrong Deals for Employment

When an organization identifies a physician it wishes to employ, or when a practitioner requests such employment, a first step is due diligence to ensure such employment will serve the interests of the institution. For appropriate candidates, the next step is to work out the contractual arrangements of employment. In the wave of physician employment seen during the 1990s, many hospitals made contracting mistakes that are being recapitulated today. The "wrong" deal made with the "right" physician can wreak considerable damage on both parties. This section enumerates some of the common missteps that have characterized both the first and second waves of hospital employment of doctors.

Legal Concerns Regarding Employment Arrangements

In our highly litigious healthcare environment, any contracts between doctors and hospitals are fraught with risk. Especially for non-profit hospital entities, it should be axiomatic that financial reimbursement to a doctor should not exceed fair market value.[8] Doctors who do not come to hospital/health system employment from private practice ownership typically expect compensation that is pegged to regional or national benchmarks. This generally poses no problem from a legal perspective. However, many physicians converting from private practice to employment have unrealistic expectations regarding compensation. Most recognize that today it is unusual for organizations to pay for goodwill. Hard assets need to be purchased (if at all) at fair market value, and receivables should be left with the practice owners or purchased at a discounted rate that compensates for the cost of collection and bad debt. Physicians may have unrealistic fantasies

about what their practices are worth and may make demands that are excessive. This may be especially so if they feel they have leverage over the organization and its management because they have historically been important players in the medical community. In these circumstances it is important for hospital/health system representatives to provide education on market trends and legal realities so that physicians do not feel insulted when they are not compensated for the intangible value they perceive in their practice.

Any offer that is an outlier when compared to normative benchmarks should be vetted by a valuation firm to justify its worth. There are numerous examples of organizations overpaying in physician employment arrangements that have led to government lawsuits. Such legal actions can jeopardize the tax-exempt status of the organization and can subject it to penalties under the Stark and various federal and state fraud and abuse laws.[9] Excessive hospital payments to doctors can be viewed by the IRS as "private inurement" to individuals[10] or as a disguised method of illegal payment for referrals. Both doctors and their employers can be hurt when deals are found to fall outside legally acceptable parameters.[11]

One recent example of these legal shoals is the tentative settlement of $85 million made by Halifax Health in Daytona Beach,

8 Fair market value is a business valuation concept that has significant implications for transactions involving healthcare providers. The definition of fair market value for general business valuation purposes is considered the price at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms-length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts. Nearly every healthcare business transaction must be based on some measure of fair market value. Setting a transaction at fair market value attempts to ensure the price paid will be comparable to that which would typically be paid by unaffiliated third parties.

9 To comply with Stark law and the anti-kickback statute, compensation paid to physicians by hospitals must be generally consistent with fair market value and not take into consideration the value or volume of referrals an employed physician may bring to the hospital or the hospital's affiliates. Specifically, a hospital may not base any part of a physician's compensation on the expected value of business the physician will refer to the hospital.

10 Private inurement is "likely to arise where the financial benefit represents a transfer of the organization's financial resources to an individual solely by virtue of the individual's relationship with the organization, and without regard to accomplishing exempt purposes." (See IRS GCM 38459, July 31, 1980.)

11 Health law governing transactions between hospitals and physicians is complex and implicates numerous statutes, regulations, and regulatory bodies. A good resource in this area is *Fundamentals of Health Law,* published by the American Health Lawyers Association.

Florida.[12] As of March 2014, the hospital had reached a preliminary deal to resolve a whistleblower allegation of Stark law violations. The case was brought by a woman whom, six years earlier, had been the hospital's physician services director. At that time she was reported to have alerted the chief compliance officer and other hospital executives that the hospital's payments to some of its employed physicians looked illegal. In particular, she argued that hospital payments to employed specialists were at above-market rates and included bonuses meant to incent the referral of Medicare patients and the delivery of unnecessary care. When the agreements were not modified, she filed a whistleblower lawsuit. The federal government joined the suit, saying the whistleblower had provided clear evidence that long-time leaders at the hospital had overpaid neurologists and oncologists. The hospital litigated the case all the way through jury selection before agreeing to pay $85 million (a sum more than eight times the hospital's annual operating margin). As this white paper goes to print a second trial on related matters is still set to proceed with millions of additional dollars potentially at risk. The hospital has also entered into a five-year corporate integrity agreement with the U.S. Office of Inspector General requiring the hospital to retain an independent legal reviewer to monitor its provider agreements and which mandates an independent compliance expert assist the board with its compliance oversight obligations (see **Exhibit 1**).

Another example is that of Tuomey Healthcare System in South Carolina. In October 2013, the system was ordered to pay a $237 million judgment for violating the federal False Claims Act.[13] The judgment followed a May 2013 jury verdict that found Tuomey violated the Stark law and False Claims Act through improper arrangements with 19 specialist physicians. These specialists entered into part-time employment contracts with Tuomey, which was worried about loss of revenue to a freestanding ambulatory surgical center. The federal government alleged the agreements paid physicians in excess of fair market value as a result of fluctuating base salaries, productivity bonuses, and incentive bonuses that paid the physicians, on average, 31 percent more than their total net collections. The U.S. argued that these payments varied with, and took into account, the volume or value of the physician's referrals and the jury agreed. The jury also found that the Stark law violations resulted in submission of false claims to Medicare.

In the wake of cases such as these, it is important for hospital and health system executives to remember that employing physicians does not eliminate concerns about Stark violations. This statute does have an exception for "bona fide employment" under which money paid to doctors is not considered compensation subject to the Stark law, as long as doctors receive no more than fair market value for the services and the payments don't vary with the volume or value of the services done at the hospital. At Halifax, employed oncologists received incentive bonuses that varied with volume and the U.S. District Judge found the arrangement fell outside the bona fide employment exception. A similar finding drove the judgment in the Tuomey case. Even when hospitals have vetted their compensation arrangements with legal

Exhibit 1: Amendment to Medical Oncology Employment Agreement

AMENDMENT TO
MEDICAL ONCOLOGY EMPLOYMENT AGREEMENT

THIS AMENDMENT to Medical Oncology Employment Agreement is entered into by and between HALIFAX STAFFING, INC., hereinafter referred to as the "Company" and BOON CHEW, M.D., hereinafter referred to as "Employee."

The Medical Oncology Employment Agreement between the parties is hereby amended as follows:

1. Section 3.C is amended to read as follows:

Beginning with the fiscal year ending September 30, 2005, an equitable portion of an Incentive Compensation pool which is equal to 15% of the operating margin for the Medical Oncology program as defined by the financial statements produced by the Finance Department on a quarterly basis. The amount of the incentive compensation distributed to the Employee shall be determined by the Medical Oncology Practice Management Group. This compensation shall be paid annually according to the operating margin for the fiscal year. Payment will be made on or before March 15 of the following year in order to provide a 90-day period of collections. The Company shall make best efforts to achieve a reasonable collection rate in light of community needs, patient mix, and relevant health care reform efforts.

12 *United States of America ex rel. Baklid-Kunz v. Halifax Hosp. Med. Ctr.*, et al. No. 6:09-cv-1002-ORL-31GAP-TBS, Document 590, filed March 10, 2014.

13 *United States of America ex rel. Michael K. Drakeford, M.D. v. Tuomey Healthcare System, Inc.,* U.S. Court of Appeals for Fourth Circuit.

counsel, as was done in both the Halifax and Tuomey cases, the government and courts may rule against their conclusions and find liability.

Other Concerns Regarding Employment Contracts

Regardless of the legal pitfalls of a wrongly constructed employment deal, there are other significant downsides. Many hospitals have found that legal compensation at the top end of acceptable fair market value may be an unsustainable proposition. Payer reimbursement for hospital and physician work is under constant downward pressure. If an organization's financial situation deteriorates, its contractual commitments to high physician compensation can be a danger to its stability. When funds are in hand, agreeing to a handsome compensation package in order to secure employment of a strongly targeted physician may seem like a real coup. Too often, however, a year or two down the road the carrying costs of such a contract can be a lodestone around the organization's proverbial neck. At that point, efforts to reform the contract are likely to be contentious and may lead the impacted physician to defect from the organization or fight it in the courts.

Trust is a critical ingredient to lubricate effective partnership between a hospital and its medical staff. Many pundits note that strong trust and collaboration between doctors and the organization is the sine qua non of long-term organizational success.

A related mistake is the issuance of long-term contracts, especially if they contain income guarantees. Healthcare today is in a state of constant evolution and rapid transformation. In the 20th century, five- and 10-year contracts made sense because change was a slower process. Organizations that offer such long-term contracts today lock themselves into provisions that may turn out to be inappropriate or damaging in a very short window of time. Of course, one reason doctors seek employment is to reduce uncertainty in tumultuous times. They crave the security they believe a large organization can provide and that small private practices can no longer deliver. They want contracts that provide "guarantees" and clear commitment to a certain future state of affairs. Nevertheless, both parties to such contracts are better served if they recognize that change and uncertainty are now constants in the world of healthcare. Prudent and sustainable contracts are those that are written with this real world in mind. It is for these reasons that most organizations today offer contracts that are of limited duration, typically one to three years in length.

In recent years, many organizations have felt the need to go back and negotiate or demand new terms for the unwise or unsustainable employment contracts they consummated with physicians. This is never an easy undertaking and the consequences of "re-trenching" established deals are often significant. Most damaging of such consequences is the potential loss of trust between doctors and the organization. Trust is a critical ingredient to lubricate effective partnership between a hospital and its medical staff. Many pundits note that strong trust and collaboration between doctors and the organization is the sine qua non of long-term organizational success. The constructive engagement of physicians is almost impossible in an environment characterized by mistrust and resentment. However, these are precisely the emotions that are triggered by an organization's efforts to change previously agreed-to contract terms. Doctors perceive the organization retreating from its commitments and sometimes accuse administrators of deploying "bait and switch" tactics. A large percentage of the practitioner community may believe the organization made lucrative offers to lure physicians into employment with the intention to renege on its commitments all along. Those aggrieved physicians subject to contract renegotiation often work to promote such perceptions and fan flames of discontent among their peers.

Another consequence of contract revision is the potential for legal action by one or more doctors to block such efforts. The legal assertion is typically breach of contract or some other claim based on employment law. It is never healthy for an organization to be in litigation with members of its own medical staff, and the financial costs may be substantial. Such legal battles often generate publicity in the press and the organization may feel forced to refrain from public comment or be seen as combative with a local doctor with a faithful following.

Other downsides to contract reformation include creation of long-term morale problems within the physician community and the migration of employed physicians to other institutions. Even if the contract terms preclude an employed physician's defection to a direct competitor, a doctor's departure from the medical staff can have a negative financial impact. This impact has been calculated to exceed $1 million by some recruitment firms when they look at hard recruitment costs, the opportunity costs if the position had remained filled, new doctor orientation expenses, and the period it takes a new physician on staff to "ramp up" business.

Potential Consequences of Reforming Ill-Advised Provisions in Physician Employment Contracts

- Loss of physician trust in the organization and its leaders
- Litigation based on breach of contract claims
- Defections to other medical staffs by disgruntled employees
- Long-term morale problems that undermine critical hospital–physician collaboration and partnership

3. Failure to Set Expectations and Describe Features of the Employment Relationship

There is often a large disconnect between physician expectations of employment and management's assumptions about how the employment relationship will work. This can be a major problem when an organization employs physicians from local private

practices. In some cases hospitals foster false expectations by vaguely suggesting to doctors being recruited that major changes in their practice circumstances are not anticipated. The table is set for future contention when a hospital recruiter makes offhand comments such as, "I see no reason you shouldn't be able to maintain your historic referral patterns…" or "the hospital has no interest interfering with your current office personnel arrangements…." Since the individuals recruiting doctors and finalizing contractual arrangements usually have no responsibilities for the subsequent management of these employed physicians, it is understandable that they might not appreciate how such vague assurances can cause future controversy. Hospitals and health systems set themselves up for future battles with employed physicians when they do not preemptively address the organization's expectations of such doctors before all parties agree to the employment arrangement.

Organizations that manage physician employment well have carefully thought through the important messages they want to give doctors who are considering employment. Hospital/system or physician leaders have frank conversations with potential employment candidates in which they lay out performance expectations, enumerate the organization's chains of command and authority, describe anticipated limitations on professional autonomy, articulate the organizational mission/vision/values, and so forth. These conversations should be reinforced through strong orientations and onboarding efforts for new employees. However, it is critically important that physicians appreciate these expectations *before* they sign on for employment.

Over many years working with hospitals/health systems and their employed physicians, we have identified numerous areas where the identification of issues up front would have minimized subsequent controversy and unhappiness. The following is a partial list of commonly articulated organizational expectations regarding working relationships with employed practitioners.

Examples of Hospital/System Expectations of Employed Practitioners

The organization will need to tie future physician compensation to the fiscal realities of the organization, just as required in the private practice of medicine. The organization seeks to pay physicians fairly and competitively but in a manner that is sustainable and consistent with the financial wherewithal of the institution. (*This expectation is meant to make clear that compensation can be revisited as circumstances warrant and that current payment amounts are not written in stone for the long haul.)*

The compensation methodologies under which employed physicians are paid will need to evolve over time as reimbursement models continue to migrate from fee-for-service to value-based and capitated reimbursement approaches and the industry increasingly focuses on population health management. *(Many organizations find they have adopted suboptimal compensation models but discover physicians resistant to changing the arrangements they negotiated or agreed to when they were first employed.)*

Employed practitioners are expected to embrace new technology deployed by the organization, including any EHR the institution adopts. *(Many organizations have encountered considerable physician resistance to changing from the computerized record or practice management system utilized in their former private practice, or resistance to convert from paper to electronic medical records.)*

The organization may need to consolidate clinical practices, change practice locations, modify practice personnel or staffing ratios, transfer some business functions from historic practice locations to a central office, or make other administrative changes in order to ensure the efficient and effective management of employed physician practices. *(Physicians from local private practices who become hospital employees often develop false assumptions that nothing will have to change. They see subsequent efforts to streamline or rationalize elements of the larger employed group practice as threats to their personal autonomy.)*

The on-call obligations of employed physicians will be fluid in nature to accommodate unanticipated changes in physician availability to cover the ED. Initial call arrangements are not guarantees of maximum call requirements. *(It is important for organizations to be clear that they will rely on their professionals to meet their legal and moral obligations to the community to provide appropriate and timely emergency care. Changes in staffing may require adjustments in call arrangements from time to time.)*

The organization expects employed practitioners to support one another and the organization through referrals whenever clinically appropriate and consistent with any legal proscriptions. *(Many organizations have found themselves struggling with employed practitioners who insist they will continue to engage in their historic referral patterns even when this sends business to competitors, undermines effective coordination of care and clinical integration, and/or is contrary to concepts of patient-centered care.)*

In order to achieve maximum reimbursement, the organization may remove ancillary services from the office of an employed physician. *(If this is an expectation, it is an important one to articulate if entering into a compensation arrangement with a physician where revenue from ancillary services contributes to that practitioner's take-home pay.)*

The practices of employed physicians will maintain practitioner hours that support ready access by patients. Doctor availability

for patient care hours will be established through formal practice management arrangements in consultation with the affected practitioner. *(Practitioners used to having complete control over their schedules often balk when they lose power to cancel clinical sessions on short notice, can no longer arrange for "golf days" when the weather suddenly proves conducive, or decide to close the office for "holidays" not formally recognized by the organization.)*

Establishing a Working Relationship Up Front

It is important to set and communicate clear expectations regarding the working relationship between the organization and its employed practitioners. Examples of such expectations include:

- The need of the institution to tie compensation amounts to the fiscal realities of the organization (just like in private practice)
- The likelihood that current compensation methodologies will evolve over time as reimbursement models change
- The need for employed practitioners to embrace new technology, including any EHR the institution adopts
- The possible need to consolidate acquired practices, change practice locations, modify office personnel or staffing ratios, or transfer some business functions to a central office
- The fluid nature of call obligations, which may change depending on manpower availability and institutional need
- The expectation that practitioner office-hour obligations cannot be arbitrarily changed by doctors on short notice and must be scheduled in a manner that promotes open access for patients
- The possibility that an employed practitioner may need to change historical referral patterns
- The possible requirement of an acquired practice to transfer ancillary services to the hospital enterprise
- The possibility of requiring an acquired practice and some employed physicians to move to provider-based billing

Finally, it is important for the organization to be uniform in the expectations it establishes. When some doctors are offered "deals" that do not apply to other colleagues, distrust and anger may be sown among the cohort of employed practitioners. For example, allowing some doctors to keep their office managers and not others is sure to seem unfair unless a business rationale can be provided. Similarly, exempting some doctors from a requirement to adopt a particular EHR may undermine a hospital's efforts to gain widespread cooperation for any number of important initiatives.

4. Failure to Apply a Uniform and Thoughtful Compensation Model

Many organizations have gone about recruiting doctors to employment by offering each candidate whatever deals will get the contract signed. This can result in dozens of different arrangements under which an organization's employed doctors are compensated different amounts for similar work commitments. Such a state of affairs has several drawbacks. First of all, some doctors will feel mistreated and assume a colleague is getting more money because that doctor exercised undue political clout in contract negotiations, or some type of "under the table" deal has been consummated. Most physicians have an acute sense of fairness that is violated by such perceptions. These feelings become the breeding ground for physician mistrust of management with all of its undesirable consequences. In addition, when the time comes to renew contracts, physicians who feel they got the short end of the stick in the first round may be unreasonably demanding in the next negotiations. Furthermore, if an organization later tries to bring more uniformity to its physician compensation arrangements (e.g., benchmarking all pay to regional norms), those who were initially paid at higher rates almost always push back at efforts to reduce their compensation. Being treated fairly is clearly in the eye of the beholder.

Even when organizations have been fairly uniform in their contract terms and pay scales, many are using compensation models that have failed in the past. The most damaging may be straightforward salary guarantees that are not tied to practitioner productivity. In the first wave of physician employment in the 1990s this was the typical model for compensation. Not surprisingly, most hospitals experienced a subsequent drop-off in physician productivity. It became quite common to see physicians regard salary guarantees as an opportunity to adopt more reasonable lifestyles and work/life balance. Some organizations that did not engage in physician employment during that period have recapitulated the mistake of salary guarantees in recent times. Physicians understandably push for the security of such guarantees and some organizations have succumbed to this pressure in their anxiety to secure physicians on the payroll. Most go on to regret these commitments and find it necessary to abandon them after some time.

There is no single "best practice" when it comes to physician compensation models. Careful thought must be given to how physician payment goals can be met while providing motivation for desirable practitioner behavior. Under the continuing dominance of a fee-for-service payment system, most hospitals have found it prudent to tie compensation to physician productivity. Varied methodologies can address this need and each has its strengths and weaknesses. For example, some institutions compensate doctors on a "revenue minus expenses" model. Such an approach motivates doctors to maximize revenue and keep expenses down. However, doctors often have little direct control over many expenses and may become frustrated when held accountable for a portion of hospital overhead and costs imposed by management. A more common productivity model is based on work relative value units (wRVUs). This approach is usually regarded as the fairest and is generally well received by doctors. However, it provides no incentives for clinicians to keep down expenses that actually are in their control.

Of course, today's prevalent compensation models based on productivity will become increasingly dysfunctional as fee-for-service is replaced by various value-based reimbursement schemes. Already we see many organizations adding to current compensation models various "bonuses" or incentives meant to

drive physician attention towards goals for quality, patient satisfaction, or cost savings. As payers place hospitals and their employed physician groups at increased financial risk for specified results, further changes in compensation approaches will have to be contemplated.

There is no single "best practice" when it comes to physician compensation models. Careful thought must be given to how physician payment goals can be met while providing motivation for desirable practitioner behavior.

A "best practice" undertaken by many organizations is the creation of a physician compensation advisory panel. The purpose of this group is to study various compensation methodologies and make recommendations to management on models for local implementation. This group can provide legitimacy in the eyes of employed physicians to management's imposition of particular approaches to practitioner pay. As the reimbursement world alters its payment methodologies, this study group can explore appropriate ways to modify the compensation model and provide clear rationale for its evolution. This will facilitate the ability of the hospital to be nimble in adjusting compensation models to changing fiscal realities.

The panel can serve other purposes as well. When management believes an exception should be made to allow a physician's compensation to vary from the generally applied methodology, this advisory group can weigh in with an appropriate endorsement. In this way, it does not appear that management conducted an underhanded deal with the practitioner. For example, if a newly employed doctor is asked to staff a brand new office in order to build market share in a geographically remote part of the hospital's service area, the prevailing wRVU compensation model might prove inadequate. The advisory group could endorse a one- or two-year salary guarantee to allow the new doctor a sufficient grace period to achieve reasonable patient volumes. This advisory body can also be helpful in the selection of metrics that will drive bonuses or other incentives in the compensation scheme. This process will give these metrics legitimacy in the eyes of the employed physicians whose pay will be impacted.

Physician compensation advisory committees usually meet three or four times a year. Many have adopted a charter to explicate their purpose and guide their activities.[14] When this tactic is utilized, it is important that all parties understand that it is purely advisory. Actual compensation arrangements with physicians will be negotiated and offered by management, under the oversight of the board or a board compensation committee.

5. Failure to Deploy an Appropriate Administrative Infrastructure to Adequately Manage Employed Physician Practices

The first wave of physician employment accompanying the rise of managed care during the 1990s included mostly primary care doctors practicing in the outpatient setting. Hospitals during that period were loath to create additional bureaucracy to manage the activities of these practices and attempted to do so using traditional hospital departments and staff. As hospital losses on these practices piled up, it quickly became apparent that administrative personnel really had little expertise or facility with the complexities of outpatient practice management. Employed physicians became increasingly frustrated as they watched hospitals struggle to manage their practices adequately and a perception that administrators were generally "incompetent" became widespread in the medical community. Hospital board members were often appalled at the mounting losses their institutions were absorbing as practice acquisitions grew. Many hospitals eventually abandoned the effort and divested themselves of physician practices, much to the relief of the exasperated primary care doctors who had run them previously.

The second wave of physician employment is now upon us and many organizations are still trying to run outpatient medical practices without investing in the right administrative infrastructure and expertise. This second wave of employment involves *both* specialty and primary care offices and once again creates a demand for highly skilled management personnel who have experience and a proven track record in the management of physician office practices. It is critically important that boards and management teams understand that the advantages of physician employment must be carefully leveraged and sustained by an appropriate and sophisticated infrastructure to manage doctors' practices effectively.

How do successful organizations accomplish this? Many recruit high-level managers from existing large physician group practices. Others outsource some of this work to entities with proven track records in physician practice billing, personnel

14 A sample charter for a physician compensation advisory panel is available from the author at TSagin@SaginHealthcare.com.

management, office operations, and/or contracting. The organizations that get in trouble are often those that attempt to save money by running their newly expanded physician practice enterprise with personnel and departments that comprise the existing hospital infrastructure. More often than not, this proves to be a "penny wise, pound foolish" decision. Over time the balance sheet losses on employed practices mount due to inefficient management and poor collections, physician frustration with management grows and corrodes any meaningful hospital–physician partnership, and physician retention and recruitment suffers. These hospitals frequently fail not only to grasp the tremendous differences between hospital and physician office practice management, but they also underestimate the leadership needed to drive physicians to make the operational changes necessary to integrate their practices into the larger organization.

6. Treating Physicians like an "Employee"

Physicians have an enormous emotional investment in their perception of themselves as professionals. After enduring years of demanding education and training, it is this perspective that drives doctors to work arduous hours, take on daunting patient challenges, maintain cutting-edge clinical skills, keep current with fast-changing medical knowledge, and strive to be highly regarded by peers and the public. Organizations that undermine these perceptions and attributes do so at their peril. When doctors are treated as just another employee, they lose initiative and accrue resentment. Hospital and health system administrators inadvertently set this tone when they make statements such as, "Now that the doctors work for us we can make them conform to our expectations regarding…" medical records completion/call coverage/clinical documentation or any of a multitude of other expectations. They also propagate a diminished sense of physician importance when they take actions that unnecessarily erode physician autonomy and participation in decision making.

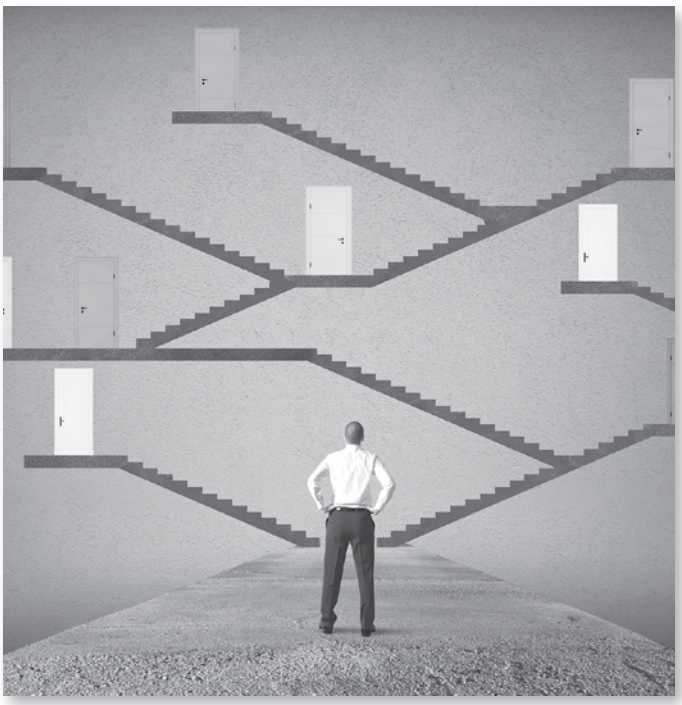
Loss of autonomy is the biggest adjustment for experienced physicians to make when moving from private practice to employment. Such autonomy has long been critical to the respected professional and it is deeply engrained in physician culture. In most institutions, doctors typically have a long list of grievances that reflected an injured sense of autonomy. For example, most employed physicians are frustrated when they have little or no say over personnel decisions regarding their office support staff. They may feel the same way when they have minimal input into their office schedules or significant office policies. There is no question that medicine is moving away from the traditional physician autonomy that granted wide latitude to physicians to practice in the manner he or she chose. In the evolving models of clinical practice, physicians will work in clinically integrated teams and share decision making with both the team and patients. Individual autonomy will be increasingly subordinated to team-based application of algorithms and best practices, and adherence monitored. Nevertheless, organizations would be well served to preserve and nurture physician autonomy where it is appropriate and will yield positive results.

In many hospitals, a major complaint of employed physicians and a significant source of diminished morale is "being bossed around by less-educated administrators." These middle managers often handle their insecurities over rapid healthcare change by bullying physicians and engaging in other passive-aggressive behavior. This occurrence is not simply a figment of overly sensitive physician imaginations—it is a very real phenomenon and occurs particularly in institutions that don't do an adequate job of conveying to staff why physicians are being given greater leadership roles as hospitals and systems partner with them to meet new demands. To these managers, physicians have always been a problem to manage. While the senior leadership teams may cumulatively spend weeks of time at retreats and meetings discussing the merits of enhanced physician leadership, middle managers typically are not well oriented to this brave new world. They resent the change in their roles vis-à-vis physicians and often work subtly to push physicians back into their traditional roles. When senior hospital administrators allow this to happen, physicians see themselves being "managed" like any other employee and quickly become disengaged.

Hospitals and health systems engage in numerous strategies to combat physicians' sense of diminishment as employees. Other sections of this white paper discuss strategies to build constructive new cultures around employed physicians, strengthening their autonomy through the development of group practice models, and augmenting traditional physician leadership roles. Many organizations also commit significant effort to educating their middle management on the rationales for new models of partnership with doctors. The upside is that when doctors feel appropriately respected, they show greater openness to new models of teamwork, collaboration, and integration, and pine less for "the good old days" of complete physician autonomy.

7. Allowing Employed Physicians to Take an Apathetic Attitude toward the Activities of the "Organized Medical Staff"

Physician interest in the activities of the traditional organized medical staff has been waning for decades. The responsibilities of this entity, largely focused on credentialing and peer review, seem ever more remote from the day-to-day challenges facing doctors. Indeed, in many communities it has become increasingly difficult to entice new faces into the rotating leadership roles of the organized medical staff. Young physicians in particular, such as those who prefer employment, find the burden of medical staff leadership a generally undesirable option. They tend to avoid volunteering for medical staff committees, are often absent from the medical staff's department and general meetings, and pay negligible attention to overall medical staff affairs.



Healthcare executives, often frustrated by physician non-engagement in required medical staff responsibilities, sometimes believe that employing doctors will solve this problem. Physicians in private practice may avoid medical staff work because it requires time away from those activities that generate income. Healthcare administrators reason that employment solves this problem because employment job descriptions can include the expectation that doctors will contribute to medical staff work. However, these administrators may forget that employed doctors are typically paid on productivity models (e.g., wRVUs) and will therefore find that their take home pay is reduced if they spend time engaged in medical staff work. Thus, employed practitioners tend to be just as resistant to losing income in this manner as their private-practice brethren.

These circumstances lead to a particular danger for organizations moving rapidly to employ doctors. As the pool of employed physicians disinterested in the medical staff grows, non-employed doctors who are unhappy with current healthcare trends may capture control of medical staff affairs. From this pulpit they may battle against the inevitable changes transforming the healthcare environment and their hospital. Such disenchanted doctors may oppose further development of an employed physician group, move to block integration efforts they perceive as attacks on their professional autonomy, "circle the wagons" around problematic colleagues whose behavior is disruptive or whose clinical quality is lacking, and advance a contentious "us versus them" mentality towards their employed colleagues. They may use medical staff leadership positions to perpetuate attacks on management, and these fusillades can become a consuming challenge for the board to which these leaders are directly accountable. This sad and unproductive scenario is playing out currently in numerous hospitals across the country.

The message to thoughtful healthcare leaders is to encourage and facilitate the participation of employed physicians in medical staff activities and leadership. Where it seems prudent, incentives for such work can be built into compensation models. As employed physicians become more numerous, they should be encouraged to vote in medical staff elections to ensure they are represented in this crucial organizational entity. Initiatives in leadership education can also help prepare employed physicians to see the value in taking on medical staff roles and to undertake them with sufficient skill to earn the trust of their colleagues across the medical community. Medical staff leadership should represent everyone in the practitioner community as it hones its focus on its primary responsibilities to advance quality medical care and patient safety.

There is a corollary caveat regarding leadership roles outside of the organized medical staff. Most medical staffs today are hybrid in nature, comprised of both employed physicians and those who continue to run their own private practices. Healthcare leaders often seek to "enfranchise" members of their staffs who remain in private practice by offering them significant leadership roles as medical directors, service line chiefs, or appointed department chairs. Administrators may believe such placements will attenuate the fears of private doctors as employment of their colleagues grows. These efforts to engage this pool of physicians can be positive if the individuals selected for these roles are good choices. However, it is usually a mistake when organizations place doctors in these positions who have been resistant to the hospital's efforts at increased integration, clinical redesign, team building, enhanced use of non-physician practitioners, or other change initiatives. When doctors are placed in these roles largely as an attempt to placate their opposition rather than for the benefit of their leadership skills, the organization inevitably suffers.

Healthcare leaders should facilitate the participation of employed physicians in medical staff activities and leadership. Employed physicians should be encouraged to vote in medical staff elections to ensure they are represented in this crucial organizational entity. Initiatives in leadership education can also help prepare employed physicians to see the value in taking on medical staff roles.

8. Underestimating the Organization's Need to Recruit and Retain Primary Care Physicians

The first wave of physician employment was largely focused on acquisition of primary care practices. The second wave of employment began with a focus on the recruitment or retention of specialty physicians in mission-critical, high-revenue generating service lines. This often involved the employment of neurosurgeons or cardiothoracic surgeons. When the government began cutting back on the reimbursement of cardiologists

in private practice, hospitals and health systems stepped up quickly to secure these vital practitioners through employment arrangements. In recent years, many organizations have become employers of large numbers of specialists and have belatedly come to realize that they need to ensure a reliable referral base to keep these practitioners busy. This realization has been bolstered by recognition that the healthcare world is becoming rapidly less hospital-centric and more outpatient-focused. There is increasing talk of population health management requiring a strong primary care base. Patient-centered medical homes run by these same primary care doctors are increasingly seen as the foundation of effective "accountable care" initiatives.

Tertiary and quaternary hospitals will always need to employ large numbers of specialists to ensure they have a full spectrum of services to offer the populations they serve. As hospitals consolidate more and more into systems, smaller institutions in particular should recognize the critical necessity of securing (mainly through employment) a committed cohort of primary care doctors. While these institutions can exist without specialists who are becoming more fungible within hospital systems, they cannot serve their local communities without essential primary care doctors. Many smaller hospitals would be better served in their physician employment efforts by focusing the vast majority of their recruitment time and resources on this latter group.

9. Reluctance to Share Financial Information with Employed Physicians

Most management teams share some financial data with employed physicians. This is especially true if these doctors are organized into a multispecialty group practice with designated leaders. Unfortunately, the data shared often amounts to a spreadsheet or balance statement limited to demonstrating the significant losses the organization is suffering because of its employment of physicians. This information is usually delivered as stated or implied criticism of these physicians for being inadequately productive and a burden on the organization.

Financial information shared in this manner and limited in scope to physician finances rather than disclosure of comprehensive hospital data has several undesirable consequences. First, it erodes the working relationship between the organization and its employed doctors. Doctors feel demeaned by constantly being told they lose money for the organization. Distrust is also engendered because physicians are certainly cognizant that they are employed precisely because they bring value, not because they are destructive of the hospital's success. They are not ignorant of the essential downstream revenue they create for the institution. The savvy among these physicians also realize their practices are often "taxed" with a portion of expensive hospital overhead and, on the revenue side, they receive no credit for the ancillary revenue that supports a typical medical practice. Employed physicians quickly come to believe that the financial picture shared with them is a disingenuous game to manipulate their understanding of the overall fiscal realities of the institution.

When employed physicians have clear leaders, they should be involved in designing the financial reports that are shared with their colleagues. Since these doctors have interests that are fully aligned with the hospital, a complete financial picture of the institution should be shared. In this way, employed doctors are more likely to contribute to the economic success of the organization and to step up and take ownership of difficult financial challenges. When they have trust in the economic information being shared by management, they are also more likely to keep their own compensation demands realistic in light of the institution's financial status.

10. Emphasizing Recruitment to the Neglect of Retention

Hospitals and health systems across the country have been busy soliciting doctors for employment and responding to physician requests for employment. Commensurate effort is rarely being

made to retain doctors once they come on board. A robust physician retention program should be part of every healthcare organization's culture. Turnover in physicians is expensive in multiple ways, including direct recruitment costs, lost opportunity costs while positions remain vacant, potential negative impact on quality of care if inadequate staffing results, and sometimes damage to morale within the practitioner community. The growing nationwide shortage of physicians will make filling vacated positions increasingly hard to accomplish in a timely manner or at all. The effort to replace a departing physician can consume significant resources and time from leaders whose attention could be better devoted elsewhere.[15]

More and more organizations are coming to recognize that a culture that fosters retention and job satisfaction is a tremendous recruiting tool. What kind of steps do leaders take to create a satisfying environment for their employed doctors? Many begin with sophisticated orientation and onboarding efforts. To assure that new physicians don't feel neglected and are settling in successfully, these activities are followed up with one-on-one meetings that can occur after one month, three months, six months, and then annually. Some organizations have set up workforce committees to focus on physician satisfaction in the organization and ensure there is a responsive "ear to the ground" so they can promptly address issues that aggravate their practitioners. These committees often become adept at recognizing signs that a physician is approaching "burn-out" and can intervene before the departure of such a physician is imminent.[16] Other hospitals focus on meeting the economic needs of their doctors by judicious use of bonuses, forms of ED call pay, assistance with retirement planning, and so forth. It is most critical to maintain effective and ongoing two-way communication with employed physicians through both formal and informal structures.

Common Physician Employment Missteps

- Hiring the wrong practitioners
- Offering the wrong deal
- Failure to preemptively set and communicate expectations of employed physicians and describe critical features of the employment relationship
- Failure to adequately consider various compensation models and involve employed physicians (through representatives) in the ongoing study, design, and revision of the compensation model
- Deploying an inadequate administrative infrastructure to manage practices of employed doctors
- Treating physicians like "employees"
- Allowing employed physicians to remain aloof from the activities of the organized medical staff
- Underestimating the organization's need to recruit and retain primary care physicians
- Reluctance of hospitals to share comprehensive financial information transparently with employed physicians
- Emphasizing recruitment of physicians to the neglect of retention efforts
- Failure to organize employed physicians into a single multispecialty group practice
- Inadequate investment in leadership development
- Insufficient clarification of leadership responsibilities and accountabilities leading to role confusion between employed and non-employed physician leaders
- Failure to design a mechanism by which the board can assess whether its physician employment strategy is returning value to the organization

15 According to data put out by the market research firm SK&A, the rate at which physicians leave one location for another has varied with changes in the marketplace, with the move rate over 18 percent in 2008 and around 11 percent in 2011. See Emily Berry, "Fewer Physicians Move, a Sign of Career Caution," *American Medical News,* June 6, 2011. Available at www.ama-assn.org/amednews/2011/06/06/bisc0606.htm.

16 Some insight on the stresses driving physicians to leave a practice can be gleaned from: Phillip Miller, Louis Goodman, and Tim Norbeck, *In Their Own Words: 12,000 Physicians Reveal Their Thoughts on Medical Practice in America,* Morgan James Publishing, February 2010.

Best Practices for Employing Physicians

The trend toward hospital/health system employment of physicians represents a permanent change in the landscape of 21st century healthcare. While there are a few contrarians who predict a reversal in the demise of private practice, it is very clear that upcoming generations of physicians have a strong preference for employment by large, stable institutions.

ONE OF THE DEFINING FEATURES OF SUCCESSFUL HOSPITALS and health systems in a highly competitive environment will be their ability to carry out physician employment well. Those who stumble in this effort will find it hard to recruit and retain doctors in a marketplace where physicians are highly mobile and in short supply.

What gives a hospital a competitive edge when it comes to employing physicians? Some competitive elements may not be under managerial control, such as geographic location or overall institutional size. On the tactical front, it certainly helps if an organization takes steps to avoid the hiring mistakes described above. More important, however, is a strategic game plan to make the hospital or health system a rewarding professional home that makes these institutions destinations of choice for doctors and other critical clinicians. Such strategic plans typically emphasize two critical and complementary approaches. The first is the organization of employed doctors into highly effective multispecialty group practices. A second important activity is to engage these physicians in a thoughtful leadership structure for the hospital or health system that is not simply "jury-rigged" around historic leadership roles. These two practices regarding physician employment are described further below.

Formation of an Employed Multispecialty Group Practice[17]

Highly organized physician group practices have a strong history of exceptional performance in the U.S. Prestigious medical groups can be found throughout the country and many have built notable reputations for high-quality, efficiently delivered, and integrated care.[18] Policy analysts frequently laud these groups as ideal foundations upon which to build highly coordinated delivery systems, capable of managing care across the continuum for communities and defined populations of patients.[19] This attitude reflects a growing recognition that durable hospitals and health systems are becoming less reliant on fixed "bricks and mortar" and will rely ever more heavily on the talent pool of professionals they can attract and retain.

Many organizations acquire private practices and employ their associated physicians while making little effort to forge them into a unified entity. The professional community in these institutions changes little when physicians remain separated in their historic practice siloes. The physicians in these practices may now receive a W-2 but little else is altered—even the official name on the office door often remains the same. As long as this historic organization of individual practices continues and balkanization prevails, it is a significant challenge for healthcare leaders to advance efforts to redesign and integrate care, rationalize services and create new efficiencies, and manage collective physician performance. When hospital managers push change on these doctors the latter complain about loss of autonomy and opine they are being treated like an "employee." Hospital administrators become increasingly frustrated and boards begin to question the decision to employ physicians in significant numbers. These circumstances make it difficult for the organization to be nimble and flexible in the face of constant change on all sides. If this picture sounds familiar to some readers, it is "déjà vu" all over again for those who lived through the first wave of physician employment in the 1990s.

In the 21st century, hospital boards should insist on a different strategic pathway for hospital-employed physicians. Organizing these doctors into a semi-autonomous, multispecialty group practice that is largely self-governed allows practitioners to maintain a sense of ownership over their professional lives. Such groups develop value structures that emphasize involvement, peer leadership, and decision making with the best interests of the entire

17 A comprehensive discussion of this topic can be found in: Eric Lister and Todd Sagin, *Creating the Hospital Group Practice: The Advantages of Employing or Affiliating with Physicians,* Health Administration Press, 2009.

18 Examples of such medical groups include: Cleveland Clinic (Ohio), Mayo Clinic (Minnesota), Ochsner Clinic (Louisiana), Geisinger Health System (Pennsylvania), Scott and White Clinic (Texas), Permanente Medical Group (California), Gundersen Clinic (Wisconsin, Minnesota), Guthrie Clinic (Pennsylvania and New York), Lahey Clinic (Massachusetts).

19 Don Seymour, "A Rational Approach to Physician Integration," *BoardRoom Press,* Vol. 23, No. 6, The Governance Institute, December 2012; Michael Porter and Thomas Lee, "The Strategy That Will Fix Health Care," *Harvard Business Review,* October 2013.

organization in mind. When such groups motivate their members, support strong work ethics, and couple these attributes with sophisticated business operations, the foundation for success is locked in. Within such groups a culture of teamwork and collaboration can be fostered and pride in excellence nurtured. The group becomes a stimulating and rewarding professional home for doctors that encourages member participation, is responsive to their needs, and receptive to their ideas for clinical improvement.

It is important that the goal of employing physicians is not seen as simply filling hospital beds. This is an outdated approach that is increasingly incompatible with emerging new reimbursement models.

One of the most destructive features of modern medical practice is the isolation in which so many doctors practice. Most private practices are solo or small and doctors rarely have time for anything except terse interactions with colleagues. Participation in traditional medical staff affairs has eroded steadily over recent decades and doctors spend less time in the hospital and more in the relative isolation of a private office. Mutual forms of support and professional stimulation have dwindled and even formerly communal events like continuing medical education are increasingly online activities. The relative isolation of physicians leads many to feel powerless to impact the dramatic changes taking place around them, and internalized frustration sometimes manifests as anger towards the hospital, colleagues, or even patients. The potential of a significant group practice to create a real sense of community is not a panacea for these concerns, but it is a powerful countermeasure. The better a group practice is at creating a sense of community, the more successful it becomes at attracting new members and retaining current practitioners. Physicians are more likely to talk positively about their experiences and strengthen the organization's reputation. Furthermore, doctors who feel empowered by their colleagues are more likely to put forth creative ideas to boost financial performance and raise the bar for quality. This task of creating strong group practice culture is much harder than most hospitals realize and they devote too little effort to shepherd this process. As will be discussed briefly below, it requires strong leadership, the adoption of best practices in communication and compensation, sustained support of essential resources, and often considerable coaching and mentoring.

When a decision to form employed doctors into a group is first considered, some organizations deliberate the desirability of separating their practitioners into two organized practices: a specialty practice and a separate primary care practice. While this approach can be made to work, it is not generally advisable. Maintaining separate groups perpetuates a historic fracture between the activity of specialists and their colleagues in primary care that is counterproductive in efforts to redesign health services across the care continuum. In addition, as these two cohorts of employed practitioners jockey for influence and resources within the larger organization, a whole new layer of unproductive politics is inevitably engendered. For similar reasons, where previously contracted groups are converted to employment (e.g., hospitalists, emergency room physicians, anesthesiologists, pathologists, and/or radiologists), these physicians should be folded into the larger multispecialty group practice. This can sometimes prove problematic if these specialty practices have historically been self-managed and if their numbers dominate those of the group practice in its early formation. Nevertheless, the organization is usually well-served by having a goal of a single multispecialty practice, and this vision should be shared with all employed physicians, even if implementation is delayed to allow the hiring of a critical mass of practitioners.

One critical question organizations that are forming a group practice of employed doctors must address is where the group fits on the corporate organizational chart. A related question is whether the group practice will function as an operational division of the hospital or whether it will be incorporated as a wholly owned subsidiary of the hospital or health system. How an organization answers these questions depends on numerous considerations including tax consequences, liability concerns, laws regulating the corporate practice of medicine, and institutional politics. Regardless of the group practice's legal status (incorporated or non-incorporated), most institutions create a direct reporting relationship from the group to the senior executive management of the hospital or health system. In addition, it is common for the chair of the group practice board or executive committee to be a member or regular invitee to the parent organization's board of directors. In establishing the group practice's reporting relationships it is important to avoid giving employed doctors the impression they have been hired to fill hospital beds and sustain the historic "bricks and mortar" edifices of the parent organization. The organizational and reporting relationships should make clear that employed physicians are valued as true *partners* in shaping a strong, sustainable, 21st century health system. Many health systems place their employed group practice on their organization charts just below the board and senior

executive team and on the same level as system hospitals and other corporate subsidiaries. This positioning communicates the importance the hospital/health system places on the group practice and its leadership role in the larger organization.

Advantages of Organizing Employed Physicians into a Multispecialty Group Practice

A group practice model for employed physicians:

- Provides a vehicle to allow physicians retention of significant autonomy over their professional lives
- Facilitates efforts to redesign and integrate care through increased collaboration and coordination of clinical activity
- Creates a sense of professional community that counterbalances the growing practice isolation of physicians
- Drives innovation when groups have strong internal leadership coupled with financial stability, control over a broad range of resources, and a history of teamwork and collaboration
- Liberates hospital/system administrators from the time-consuming and contentious tasks of managing employed physicians directly
- Is an attractive model for recruiting and retaining clinical practitioners
- Can promote development of a culture of excellence, teamwork, and patient-centered care
- Provides a structure by which the hospital or system board can hold physicians collectively accountable for desired results

For boards that have sanctioned the employment of physicians, considerable anxiety can be generated as the costs of this strategy mount. Board concern is often exacerbated when the success of this approach is monitored chiefly by looking at the magnitude of "losses" being attributed to physician employment. When a hospital or system employs a significant number of doctors and promotes their organization into a functional multispecialty practice, there are multiple measures of success that it should consider. While economic performance is important, it is also valuable to follow indicators to evaluate the development of group cohesion and sophistication. What do such hallmarks of group practice success look like? Some examples include:

- The establishment of a physician-driven and led governance structure. (This can be a formal board if the group is incorporated, or a high-level executive committee for those groups that aren't incorporated. In either case this body should function to establish group practice vision, values, goals, leadership positions, and overall operational structures, and to endorse critical policies and clinical processes.)
- The group practice has its own management team that comprises different individuals than those managing the hospital/system.
- There is a unitary management infrastructure that supports all specialties and practice locations staffed by the group practice.
- Physicians maintain referrals largely within the group to the degree group practice size and diversity permits.
- The group practice promulgates standardized approaches to common clinical problems.
- The physicians in the group practice are paid commensurate with a common compensation methodology in whose design group practice leaders participate.
- The group promotes a common culture by setting and communicating clear expectations for its members. Strong orientation programs, mentoring of new practice members, and the monitoring and coaching of outlier practitioners facilitate this effort. A sign of group maturity is its ability to reject applicants who do not share its vision or its decision to terminate membership to individuals who are a poor cultural fit.
- Group members are able to manage difficult disputes among themselves by relying on internal leadership rather than calling on the assistance of senior hospital management or the board.
- The group maintains its accountability to the hospital or health system board through clear and effective leadership structures and processes.

The effort to move employed physicians into a sophisticated group practice is a complex undertaking and beyond the scope of this white paper.[20] However, success in creating a cohesive employed group can dramatically change the nature of an institution by strengthening hospital operations, facilitating use of health system resources across the full continuum of care, and providing physicians an increasing role in health system leadership.

Fostering Physician Leadership for Employed Physician Groups and Rationalizing Physician Leadership across the Hospital or Health System

Group Practice Leadership

Today most hospitals recognize how critical physician leadership is to their future success. This is important for group practices because physicians often balk at non-physician management.[21] However, leadership from physicians who are not skilled in their roles can create groups that are stubbornly ineffective or that can quickly spiral down to dissolution.

Until recently, the history of physician leadership in hospitals has been disappointing. Medical staff leaders traditionally received little training for their roles and key positions turned

20 For a complete discussion, see Lister and Sagin, 2009.

21 For a good description of the culture that makes physicians resistant to non-physician managers, engenders suspicion of collective decisions, and leads them to assume that traditional business algorithms are irrelevant to their clinical work, see Joseph S. Bujak, M.D., *Inside the Physician Mind: Finding Common Ground with Doctors*, Health Administration Press, 2008.

over every year or two. By definition, such leadership was amateur and it was the rare medical staff leader who was the beneficiary of any formal leadership education. In recent years, hospitals and health systems have found good return in sending newly elected medical leaders to "just in time" training as they take up their positions. This education is usually circumscribed in scope, focusing on important medical staff duties such as credentialing, peer review, and meeting management.

Physician leaders guiding multispecialty group practices need a much broader set of management skills than their colleagues in medical staff offices. Many of these are generic skills common to significant leadership roles in any setting (for example, the ability to communicate effectively, manage teams, understand strategic business planning, cope with conflict, understand the basics of personnel management, and facility with business finance). In addition, group practice leaders need to be knowledgeable about areas specific to contemporary medical practice. Examples include clinical workflow design, advancement of a culture of safety and excellence, the reduction of clinical variance through use of practice guidelines, use of health information technology, best practices in physician compensation, promotion of patient-centered medical services, techniques in population health management, and skills in the coaching and mentoring of clinical peers. In addition, some physician leaders of an employed group practice will need to acquire knowledge and skill regarding organizational governance and the important responsibilities of a legal fiduciary.

As health systems evolve and become less hospital-centric, employed group practices will become increasingly important as the driver of organizational success.

Acquisition of such skills requires careful planning since most employed physicians are paid based on productivity and therefore incented to focus on clinical work rather than leadership education. In planning an employed group practice, healthcare leaders should consider the creation of specific incentives to support the management education of physician leaders. These could be stipends for the time spent in approved educational activities, bonuses built into a compensation model, the creation of wRVUs assigned to leadership education and activities, continuing education credits for classroom work, or other tactics.

Many organizations across the nation are in the process of establishing various forms of "leadership academies" to train expanding cohorts of current and future physician leaders. These efforts range from relatively simple (e.g., an annual one- or two-day workshop) to elaborate efforts that have thoughtful curriculums taught in monthly classes that may advance over several years through progressively more complex topics. Every hospital or health system with a significant employed practice group should invest in a reasonably sophisticated leadership development program. Ideally this program should include not only didactic classroom instruction but also provide for on-the-job coaching and mentoring.

Once an employed medical group reaches an adequate size, it becomes imperative for the practice to have its own medical director. This individual provides critical infrastructure to the group. The duties of group practice medical director should not be considered "back pocket" work for an existing hospital or system vice president of medical affairs (VPMA) or chief medical officer (CMO). Neither of these executives is likely to have the time necessary to carry out this role adequately.[22] Depending on the size and structure of the employed group practice, various additional physician leadership roles typically need to be created. Hospital boards and management should not short-change the development of physician leadership roles. In the 20th century it was not uncommon to see hospitals with voluntary medical staffs of hundreds of physicians but only a single physician executive employed to manage them—typically a VPMA. Additional leadership positions were voluntary medical staff roles, often unpaid and constantly rotated among community doctors. It is no wonder efforts to improve quality, patient safety, and cost effectiveness languished in those years. Today, boards must ensure there are engaged and energized physicians demonstrably driving ever better results for the organization. An investment in adequate physician leadership is essential for such outcomes.

It is also important for the board and management team to commit to true partnership with physician leaders. In many institutions this partnership is captured by the declaration that the organization will be "physician led and professionally managed." This concept recognizes that great results can be achieved when physicians combine their medical expertise with the managerial skills of their administrative colleagues in a true dyad partnership. In too many hospitals, administrators still take decisions made in executive suites to physicians for their "input" just prior to implementation. Physicians quickly recognize they are not considered essential partners in strategic planning and critical decision making. When physician leaders are at the table from the very start of such efforts, their contributions will be more meaningful and their engagement more complete. Institutions that treat physician leaders in this way retain and attract the best doctors and make the greatest headway in creating productive change.

Rationalizing Physician Leadership across a Hospital or Health System[23]

Changes in the 21st century business model of medicine have spawned numerous new physician leadership roles in hospitals and health systems. This growth frequently occurs without careful planning, such that organizations may find themselves with leaders who have conflicting roles, unclear accountabilities, duplicative responsibilities, and even competing constituencies. Through most of the 20th century, hospital-based physician

22 For a more complete description of the medical director's responsibilities and reporting relationships, Lister and Sagin, 2009.

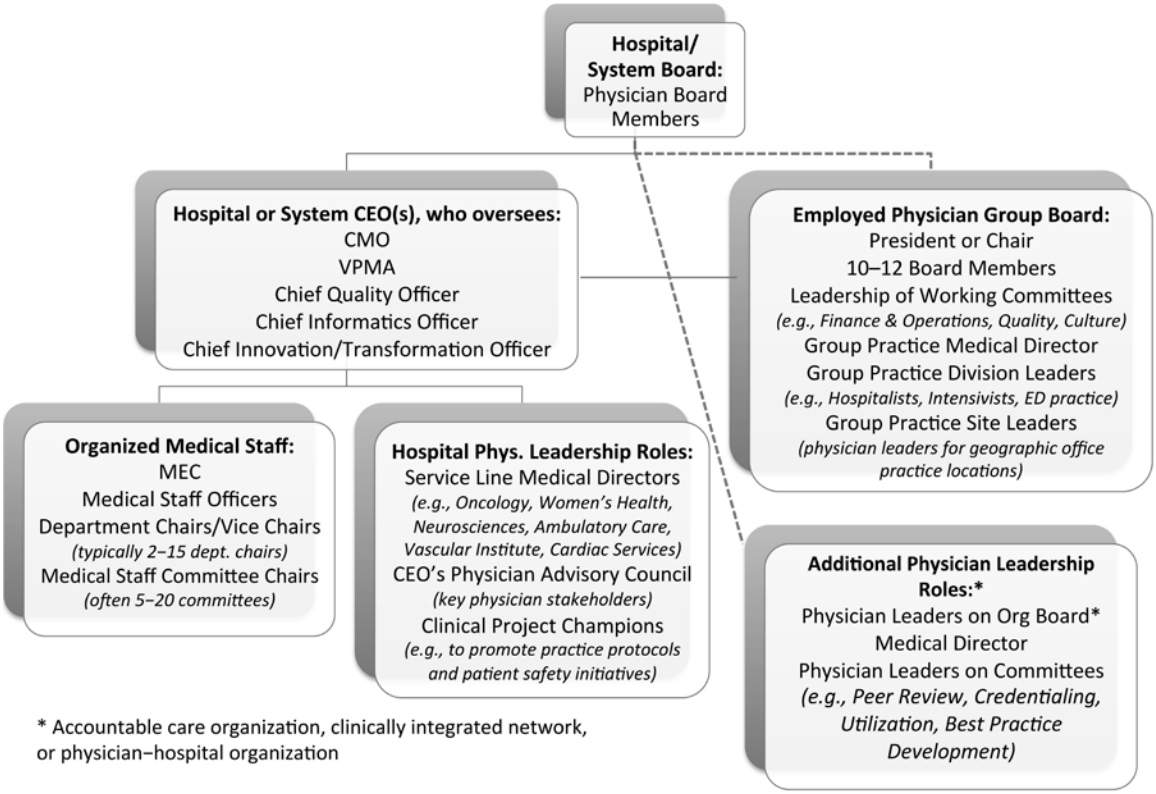
23 See Todd Sagin, "Restructuring Physician Leadership in Evolving Health Systems," *BoardRoom Press,* Vol. 24, No. 1, The Governance Institute, February 2014.

leadership usually consisted of those positions created by the medical staff bylaws: officers, department chairs, and committee chairs. In some organizations the medical staff bureaucracy has run amok with dozens of departments, clinical divisions, and an extensive number of working committees. In recent times, organizations have seen a need for more professional leadership and often added physician executives to their management teams. These can range from the traditional VPMA to positions for doctors such as CMO, chief quality officer, chief medical informatics officer, chief innovation officer, chief integration officer, and so forth. Hospitals and health systems that have followed the popular practice of organizing clinical service lines typically hire a clinical service chief to manage critical aspects of this activity. Many institutions are organizing ACOs with their own requirements for physician leadership. Others are revitalizing dormant physician–hospital organizations (PHOs) or establishing clinically integrated networks (CINs) that in turn create additional physician leadership roles.

Organizations with significant ranks of employed physicians that are organized into multispecialty group practices create a need for doctors to take up both governance and management roles. A typical such practice may have numerous board seats, one or more medical directors, several working committees each with a chair, and a cadre of geographic or specialty oriented practice leaders. Even when an organization has chosen not to organize its employed doctors, it may still find a need for leaders of employed or private hospitalist groups and other hospital-based practitioners such as intensivists, emergency room doctors, anesthesiologists, radiologists, and others.

The proliferation of roles for doctors in leadership may strain the ranks of available candidates in many communities. It is important to fill physician leadership positions with individuals who are prepared to do the jobs well. This means doctors who have had some leadership training and experience, who have interests fully aligned with the organization, command the respect of their colleagues, and hold some passion for tasks they will be asked to undertake. To avoid filling positions with poor candidates it is prudent for hospitals to consider whether the plethora of new roles can be reduced into a smaller and more effective set of positions. Downsizing this leadership bureaucracy and rationalizing roles can be politically sensitive and require careful facilitation. There is no single template for an effective physician leadership structure and each hospital should plan in accordance with its size, complexity, and available physician leadership talent. In recent years, many organizations have undertaken retreats to redesign physician leadership roles and structures in their health systems. (**Exhibit 2** provides a visual depiction of the growing variety of physician leadership positions and how they might be structured in a given organization.)

Exhibit 2: An Expanding Constellation of Physician Leaders



Conclusion

The transformation of healthcare delivery continues to progress at a rapid pace in all corners of the country. One of its distinguishing features will be increased hospital and health system employment of physicians and the diminishing role of private practice medicine in most communities.

THE HISTORIC TRACK RECORD OF HOSPITAL EMPLOYMENT OF doctors is a checkered one. Done poorly, a legacy of doctor–hospital mistrust and disappointment can last for decades. When done well, powerful organizations have emerged that have demonstrated a strengthened ability to improve the quality and safety of patient care. In many cases their alignment with physicians has also enabled these institutions to provide more cost-effective services. They have often grown into health systems notable for innovation, flexibility, and highly regarded patient-centered initiatives.

Hospital and health system boards should closely monitor the effectiveness of its strategies for engaging physicians successfully. Getting employment right requires careful execution and implementation at numerous places in the process. Offers should be extended judiciously to appropriate candidates. Institutions seasoned in the employment enterprise can be recognized by their willingness to turn down employment requests from physicians who are not compatible with the practice culture the hospital and its doctors are cultivating.

When offers are extended they should be generally consistent with standardized agreements offered to all applicants. Before a contract is signed significant discussion should take place laying out the expectations of employed physicians and the mutual understanding of how the relationship will proceed. Strong orientation and onboarding efforts go a long way to facilitating physician satisfaction, and monitoring satisfaction can be done through periodic meetings with practitioners to address mutual concerns and detect early signs of physician "burn-out." The compensation models under which employed practitioners are paid should be reviewed regularly to ensure they represent current best practices and are promoting desired results.

Organizations with significant numbers of employed physicians should structure them into a single multispecialty group practice that is granted considerable autonomy in the governance and management of its professional affairs. As health systems evolve and become less hospital-centric, this group practice will become increasingly important as the driver of organizational success. It is important that the goal of employing physicians is not seen as simply filling hospital beds. This is an outdated approach that is increasingly incompatible with emerging new reimbursement models. A hospital's employed physician group practice can be a potent force for delivering care in a manner that is fully responsive to these emerging value-based reimbursement paradigms.

Good results from employed physicians can't be accomplished without good leadership, and boards should insist on robust physician leadership development programs and thoughtful succession planning. They may also have to mediate retrenchment of historic physician leadership positions to avoid unnecessary conflict and confusion among old and new leadership roles.

As we approach the middle of this century's second decade, hospitals and physicians are joined at the hip as never before. Increasingly that conjoined doctor will be an employee. When board members, senior administrators, and employed physicians are smoothly operating partners, they are well positioned for any changes the remaining decades of this century present.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