Which physician is more “aligned” with the hospital? Is it the employed orthopedic surgeon who is working hard and is increasing surgical volumes at the hospital, but who lets everyone know at every opportunity that he will leave at the end of his contract if the hospital does not partner with his physician group to build an outpatient surgery center? Or is it the private orthopedic surgeon who performs most of his outpatient surgeries at a physician-owned center, but who performs all other surgeries at the hospital, takes emergency department call, has participated on numerous committees to enhance quality within the hospital’s operating rooms, and has worked to grow his practice with the needs of the hospital?

Depending on the point of view, one could argue that either physician is more aligned with the hospital. However, one physician is not more aligned with the hospital than the other solely because of the organizational model for the physician-hospital relationship.

Physician-hospital relationships have changed substantially in the past several years—and there will likely be greater structural/economic alignment between hospitals and physicians in the near future. Many significant trends are converging that make structural alignment possible and even necessary, such as economic pressures on both hospitals and physicians, the need to collaborate to improve quality (spurred by pay for performance), etc.

Communication, physician involvement in decision making, and physician leadership development are as critical to strong hospital-physician partnerships as the organizational models for these relationships.

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and the implementation of electronic health records, coupled with demographic shifts, such as looming physician shortages and the lifestyle preferences of newer medical school graduates.

A variety of models for structural and often economic alignment between hospitals and physicians have been introduced that will likely serve as the basis of future models for physician-hospital alignment. Examples include organizational structures, such as physician-advisory councils; economic models, such as joint ventures and employment of physicians by hospitals; and emerging models, such as the anticipated growth of “super groups,” the changing roles of physician-hospital organizations, and the potential for gainsharing. Now more than ever, hospitals, physicians, and payers are positioning themselves for bundled, performance-based payments for care delivery.

Although focus on the development of structural models is critical, one must be mindful that the models in and of themselves do not ensure physician-hospital alignment. Research conducted by Noblis with the American Hospital Association’s Society for Healthcare Strategy and Market Development in 2006 and with the American College of Physician Executives (ACPE) in 2008 suggests that, although structural/economic models are critical elements of physician-hospital partnerships, they are just one aspect of a “menu” of approaches that hospitals should employ to improve physician-hospital alignment and relationships. Other important elements include communication, physician involvement in decision making, and physician leadership development.

**Communication**

Time and again, when asked how to improve relationships, physicians cite communication. In the 2008 ACPE survey, physician executives were asked how they would suggest their colleagues improve physician-hospital relationships. The No. 1 response dealt with improving communication. Two common remarks we hear from physicians are “I don’t know what or why something is happening” and “No one is listening to me.” Two common remarks we hear from hospital administrators are “We have lots of tools for communicating with physicians, like newsletters, e-mails, and meetings” and “We explained that at the medical staff meeting, but the physician wasn’t there or doesn’t listen.”

The disconnect among physicians and hospitals regarding communication comes down to three key points. First, physicians want to be engaged, not talked at, so one-way communication vehicles such as e-mails and newsletters, no matter how good they are, have limited effectiveness. Second, physicians want to be engaged individually, not as part of a group. It is administrators who think of physicians as a “medical staff,” while physicians view themselves as individual practitioners. Third and most important, physicians want to communicate about the care of their patients. Our research indicates that physicians are worried about losing their central position of proving improved health for their patients. As described by a physician interviewed during the ACPE research, “Different types and ages of doctors require different communication methods. Docs want to know how their patients are doing and that they are receiving the best care. Our newsletter published hospital quality indicators to assuage the physicians’ concerns about the type of care their patients receive.” Hospitals that provide substantive and useful information on quality of care and patient satisfaction will enhance physician engagement and support.

Hospitals that provide substantive and useful information on quality of care and patient satisfaction will enhance physician engagement and support.
than others in using them. However, these tools alone do not engage physicians. In our research, the two most effective strategies for improving communication involve individual attention/dialogue with the physician:

> Developing a formal physician relations program, with dedicated staff time to spend with active and referring physicians

> Conducting individual sessions with physicians to identify their concerns

A sustained effort over time is critical to successfully implementing these communication strategies—and administrative turnover can make it quite difficult to sustain these efforts. Dedicated outreach that improves communication would

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**LEADERSHIP STYLES: WHERE DO YOU FIT?**

<table>
<thead>
<tr>
<th>Leadership style</th>
<th>The leader’s modus operandi</th>
<th>The style in a phrase</th>
<th>When the style works best</th>
<th>Overall impact on climate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercive</td>
<td>Demands immediate compliance</td>
<td>“Do what I tell you.”</td>
<td>In a crisis, to kick start a turnaround, or with problem employees</td>
<td>Negative</td>
</tr>
<tr>
<td>Authoritative</td>
<td>Mobilizes people toward a vision</td>
<td>“Come with me”</td>
<td>When changes require a new vision, or when a clear direction is needed</td>
<td>Most strongly positive</td>
</tr>
<tr>
<td>Affiliative</td>
<td>Creates harmony and builds emotional bonds</td>
<td>“People come first.”</td>
<td>To heal rifts in a team or to motivate people during stressful circumstances</td>
<td>Positive</td>
</tr>
<tr>
<td>Democratic</td>
<td>Forges consensus through participation</td>
<td>“What do you think?”</td>
<td>To build buy-in or consensus, or to get input from valuable employees</td>
<td>Positive</td>
</tr>
<tr>
<td>Pacesetting</td>
<td>Sets high standards for performance</td>
<td>“Do as I do, now.”</td>
<td>To get quick results from a highly motivated and competent team</td>
<td>Negative</td>
</tr>
<tr>
<td>Coaching</td>
<td>Develops people for the future</td>
<td>“Try this.”</td>
<td>To help an employee improve performance or develop long-term strengths</td>
<td>Positive</td>
</tr>
</tbody>
</table>

enhance the physician–hospital relationship with both the employed and the private surgeon. In fact, the employed surgeon’s actions could be a signal that he or she doesn’t feel heard, while the private surgeon’s behavior could be a sign that he believes he is being heard.

**Involvement in Decision Making**

Often, physician complaints regarding communication are really expressions of frustration regarding real or perceived lack of input into decision making. In the 2008 ACPE survey, the No. 2 response to our question regarding how to improve physician–hospital relationships was “decision making: involve in leadership activities/development.”

Hospitals have tended to focus on a number of methods for involving physicians in decision making at the “global” level, and our research indicates these methods can be effective tools for improving physician–hospital relationships. Nearly every hospital has multiple physician representation at the board level. During the strategic planning process or at other points, key physicians are invited to participate in planning retreats with board members, other physicians, and members of management to provide input and perspective regarding vision and strategy development. Many hospitals are also developing a vice president of medical affairs position that can be highly effective if filled by the right person.

However, time and again, physicians have expressed that the control they really desire is control over their domain (i.e., involvement in decision making at the “local” level). Our research indicates that the most consistently effective strategy for improving involvement in decision making is allowing physicians to lead the planning and management of clinical service lines or centers of excellence. The ability to have control in decision making is often as compelling to physicians who pursue private ventures or joint ventures with hospitals as is the potential economic benefits of such ventures. It is surprising the frequency with which hospitals still conduct extensive planning and/or make decisions regarding clinical programs or services without significant input from key physicians or those physicians most directly impacted. Emerging models of service line comanagement could enhance physician involvement where it matters most.

There is no doubt that it can be difficult to involve physicians at the governance or local level. Often, physicians have competing interests, and the issue of ultimate control and accountability is a real one. Involvement should be transparent, fair, inclusive, and meaningful.

In our example of the two orthopedic surgeons, the structural models for physician–hospital partnerships do not guarantee involvement in decision making. The employed surgeon’s behaviors are probably an outgrowth of the surgeon’s concerns that he will not ultimately be involved in the decision to develop an ambulatory surgical center—that management will make the call.

**Leadership Development**

The real key to improving physician–hospital relationships now—and even more so in the future—is to focus on physician leadership development. In today’s environment, hospitals often are looking for physician leaders. Physicians themselves tell us they need leadership skills. In some organizations, an adversarial physician–hospital relationship would be preferable to a lack of physician leadership, where staff cannot be moved to action and there are no peers to listen to or to model appropriate behaviors.
In tomorrow’s environment, where we will find physicians who are structurally aligned with their hospitals and who have asked for, and have been given, significant input into clinical decision making, developing a group of physician leaders will become essential. It’s important to note that a structural model alone will not produce leadership. Employment does not guarantee leadership—just attendance. Involvement in decision making does not guarantee leadership—just involvement, as many hospitals and physicians in difficult or failed physician-hospital ventures will point out. A briefing by The Advisory Board Company, *Fostering Physician-Hospital Alignment: An Unchartered Role for Human Resources*, reinforces the need to take the long view and build lasting physician leadership through medical leadership groups, alignment education programs, and outcome-focused personal coaching.

The whole approach to physician leadership needs to adapt and change, with recognition that there are different leadership styles and that hospitals and physicians should focus on leadership training. The criteria for leadership vary by organizational culture, values, and vision, but should include a demonstrated track record or experience and style to ensure competence and organizational fit.

Fred Greenstein, professor of politics at Princeton University and director of Princeton’s Woodrow Wilson School program in leadership studies, provides a template with which to evaluate presidential leadership that may be timely as well as useful for understanding critical success factors for future physician leaders. Analyzing presidential leadership from FDR to Clinton, he articulates a six-factor model:

- Public communication: Effectiveness in communicating with key constituencies
- Organizational capacity: Systematic approach to management, ability to forge a team and get the most out of it, and a proficiency in creating effective system arrangements
- Political skill: Ability to use formal and informal power effectively
- Vision: “Event-making” perspective versus reactive perspective, including the ability to articulate overarching goals for the enterprise
- Cognitive style: Conceptual ability to cut to the strategic heart of problems versus nibbling around the tactical fringes
- Emotional intelligence

Many in the healthcare industry are wary about the lack of investment in developing leadership capabilities in the next generation of physicians.

How ready is your organization to invest in its future physician leaders?

**Leadership Styles**

Hospital administrators and even physicians often look for the “superhero” physician—one who is technically skilled and who everyone can rally around to emerge as the physician leader. This misses the point of the need to develop physician leaders for two reasons: One, there needs to be recognition that conceptions of physician leadership need to change. In the future, technical skill will no longer be solely sufficient to anoint physician leadership. Two, as physicians are grouped in structural models in which they are expected to relate to each other...
and to the hospital more closely, leading within a framework of teamwork and collaboration will become more vital. Just as the physician-patient relationship has changed from a top-down approach to a more collaborative approach, so must leadership styles within the hospital change and adapt.

Daniel Goleman, a noted expert on leadership, writes that there are six leadership styles: the coercive style advocates a “Do as I say” approach; the authoritative style advocates a “Come with me” visionary approach; the affiliative style takes a “People come first” approach; the democratic style takes a “What do you think?” approach; the pacesetting style takes a “Do as I do, now” approach; and the coaching style advocates a “Try this” approach. Goleman not only identified styles, but also quantified their impact on organization climate. Two of the six styles, the coercive style and the pacesetting style, had negative impact on climate. He also found that no one style works in every situation. Good leaders must adapt and use different leadership styles based on the situation.

Our experience suggests physicians stereotypically tend to demonstrate two styles within the hospital setting: Unfortunately, they are the coercive and the pacesetting styles. Clearly, learning and using different approaches to leadership will enhance physician-hospital relationships as well as physicians’ relationships with others (fellow physicians, hospital employees), which are essential now in aligned models and will be even more so in the future. (Note: Hospital leadership/administrators do not get a pass here. Using one style of leadership may produce consistency, but does not yield optimal results.)

Implications for Hospitals
Those who work in hospital finance generally spend time developing models for their organizations and making sure they work from a technical standpoint. However, be mindful that the models that are developed to build hospital-physician partnerships should also enhance communication, decision making, and leadership development as well as provide for contingencies if things do not work as well as they should.

Action steps hospitals should take include:
> Developing and implementing physician alignment plans that describe structural models and other approaches, such as communication vehicles, to improve physician-hospital relationships
> Investing in physician leadership development, as investing in structural alignment will be useless if there are no or few physician leaders capable within the organization

Whatever structural models emerge for facilitating hospital-physician partnerships, those healthcare organizations that can communicate with physicians, integrate physicians into decision making, and develop physician leaders will be most able to adapt and thrive. As one ACPE member says, we must “choose physicians who are well-respected by their colleagues for quality and credibility and provide training to fully develop their leadership skills.”

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Reprinted from the December 2008 issue of hfm.
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