the eye of the beholder: A Qualitative Study of Mutual Obligations and Areas of Ambiguity in the Hospital-Physician Relationship

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Running head: Physician-Hospital Exchange

Abstract

Hospitals and physicians have been working together for years in providing specialized health services. However, Hospital-Physician Relationships are considered lukewarm at best. We build on psychological contract theory to develop an in-depth understanding of how physicians (N=15) and hospital executives (N=15) in Belgium experience and interpret obligations in their working relationship. Our analysis yielded a rich understanding of mutual obligations and areas of ambiguity. Two major themes emerged from the analysis. A distinction should be made between administrative obligations (adequate support and responsive decision making) and professional obligations (clinical excellence and physician autonomy). Two areas of ambiguity could be identified reflecting both dimensions. An economic trade-off exists in the day-to-day interaction and therefore views on how the way care should be organized differ. In addition, the extent to which medical decisions should take into account the corresponding impact on hospital finance varies.

Key words: health care administration, health care professionals, hermeneutics, lived experience, relationships

Introduction

Hospitals and physicians have been working together for years in providing specialized health services. In general, physicians provide the medical care while the hospitals provide the resources by which the care can be managed and delivered (Schramko, 2007). In this working relationship the physician acts as a professional, independent decision maker who has considerable control over the resources of the hospital. Their relationship was historically labelled as a 'workshop model' in which both parties worked relatively independent of each other, maximizing the professional autonomy of the physician (Pauly & Redisch, 1973; Harris, Hicks & Kelly, 1992). However, hospital financing has evolved from a retrospective, cost-based reimbursement to a prospective financing system (Jegers, Kesteloot, De Graeve, & Gilles, 2002). This has led to unaligned incentives: hospitals are stimulated to provide cost-effective care but also have to persuade and educate physicians whose fee-for-service incentives remain for the most part the same (Burns & Muller, 2008). As a result, these conflicting financial incentives between physicians and hospitals are often cited as a major obstacle to effective collaboration (Mark, Evans, Schur, & Guterman, 1998; Goldsmith, 2007) and a set of long-standing practices characterized by medicine's dominance and physician autonomy are challenged (Castellani & Wear, 2000). Consequently it has been argued that Hospital-Physician Relationships (HPRs) moved from a symbiotic relationship to competitive interdependence (Burns, Anderson, & Shortell, 1990; Berenson, Ginsburg, & May, 2007). In this challenging environment hospital executives have been struggling to build effective hospital-physician relationships (Smith, Reid, & Piland, 1990; von Knorring, de Rijk, & Alexanderson, 2010) which have been pointed out as a critical determinant of organizational success (Kaissi, 2005).

The process of building effective relationships with the medical staff has been described as physician-hospital integration. Three approaches to achieve greater integration can be distinguished (Burns & Muller, 2008). The first approach is rooted in economic literature in which alignment is realized by financial means (economic integration). The second represents a sociological perspective, emphasizing the cooperative nature of the relationship (noneconomic integration). The third concentrates on the clinical dimension, the coordination of patient care (clinical integration). Since it can be argued that noneconomic integration lies at the very basis of physician alignment, building the needed trust and laying the foundation for alignment of financial incentives (Trybou, Gemmel, & Annemans, 2011)

and integrated care delivery (Gillies, Shortell, Anderson, Mitchell, & Morgan, 1993), we focus on the non-economic approach. This is considered to be a means to realize increased cooperation and refers to hospitals' efforts to make their facilities more attractive and accessible, their operations more efficient and convenient, their decision-making processes more participative and responsive and their staffing better trained (Burns & Muller, 2008). Moreover, these efforts emphasize the needed cooperative behaviour in the symbiotic relationship with the hospital and recognize physicians' professional career needs to build, maintain and expand their practices (Shortell et al., 2001). It aims at making the hospital more attractive for physicians by improving the hospital's working environment and addressing physicians' related concerns (Berenson, Bodenheimer, & Pham, 2006).

Our analysis of the transcribed interviews builds on psychological contract theory and yields a rich understanding of how physicians and hospital executives interpret and experience mutual obligations and areas of ambiguity. There has been a plethora of research on psychological contracts in the last 20 years inside and outside the healthcare sector. This research has led to a large body of empirical research that demonstrated the explanatory power of the psychological contract to a variety of work-related attitudinal and behavioural outcomes (Conway & Briner, 2005). The psychological contract consists of the individual's belief regarding terms and conditions of the exchange agreement between the individual and his or her organization. It refers to the way the working relationship is interpreted, understood and enacted by individuals at the interface between themselves and their organization. Key issues include the belief that explicit and implicit promises have been made and a consideration offered in exchange for it, binding the parties to some set of reciprocal obligations (Rousseau, 1989). It has been shown repeatedly and consistently that individuals seek to enter and maintain a fair and balanced exchange relationship with the organization they work at, described as the norm of reciprocity (Cropanzo & Mitchell, 2005). This norm is based on the belief that organizational members tend to reciprocate beneficial treatment they receive with positive work-related behaviour and tend to reciprocate detrimental treatment they receive with negative work-related behaviour (Blau, 1964; Gouldner, 1960). In this respect, the management of the psychological contract may have important implications on hospitals' ability to motivate and align highly skilled physicians. We use the concept of the psychological contract as our dominant theoretical framework to examine the hospital-physician relationship. The aim of this study is to understand how

physicians and hospital managers experience mutual obligations and areas of ambiguity within their working relationship.

Methods

We developed a robust understanding of the lived experience of the psychological contract between physicians and the hospital they practice at through the qualitative analysis of data obtained from transcribed interviews. Using a qualitative approach, our analysis focuses on the understanding of how physicians and hospital executives interpret and experience mutual obligations and areas of ambiguity in their psychological contract. Previous research has generally focused on capturing the organizations' obligations to the individual, thereby neglecting the measurement of the individuals' obligations and failing to study adequately the content and mutual character of psychological contracts. Following Winter and Jackson (2006), to capture both the hospital and physician perspectives of the psychological contract, managers were treated as agents of the organization and are in a position to convey promises or future commitments to physicians as actions of the organization itself (Kotter, 1973). This approach is consistent with Rousseau's (1995) viewpoint that organizations become party to psychological contracts as principals who directly express their own terms or through agents who represent them.

Data collection

This study builds further on the data collected in chapter 4. In addition, interviews were performed at a third Belgian hospital. In accordance to qualitative research methodology, the hospital choice was based on the principle of variation. Specifically, the selected hospitals varied in size (350 – 850 beds) and ownership type (public or private). Because our research focuses on self-employed physicians, all hospitals were not-for-profit hospitals with an independent, self-employed medical staff. We conducted interviews with both physicians and members of the executive committee. Within the executive committee the Chief Executive Officer, Chief Financial Officer, Medical director and Chief Nursing Officer were chosen because of the difference in responsibilities within the hospitals and the difference in their day-to-day interaction with the medical staff. In addition, because of the central role of the medical board in the structured negotiation between the medical staff and the hospital

board, the president of the medical board was also interviewed. The different specialties were chosen based on differences in operational linkages with the hospital (i.e. the use of the operating theatre and supporting personnel) and differences in their remuneration and associated incentives (medical fees). Within each hospital we conducted an interview with a paediatrician, geriatrician, cardiologist, orthopaedist and a general surgeon. All interviews were performed by the first author lasting between 30 and 60 minutes. The 30 interviews satisfied the number necessary to reach data saturation for this study.

Data analysis

Following the studies of von Knorring and colleagues (2010) and Jones and Sambrook (2010) the data analysis was based on the constant comparison method (Holloway & Wheeler, 2009). An initial set of categories for coding the data based on the described definition of noneconomic physician-hospital integration (Burns & Muller, 2008) was used. Interview questions were of an open-ended, semi-structured nature designed to allow participants to address issues which they believed to be most significant. The final question provided an opportunity to compare the perceived obligations between executives and physicians. During the interviews probing questions were used to ensure the participant's experiences were grounded in concrete situations to increase the validity of the interview.

All interviews were transcribed in full and analysis began whilst the data were still being collected. This provided the possibility to explore in further detail each theme that emerged in later interviews. The transcripts were read repeatedly, initial open data exploration was followed by identification of concepts and their relationships. Interview transcripts were scrutinized by the first author and categories were applied to the data. Thereafter, the content of the statements (meaning units) was condensed and changes to the categories were made according to what the data revealed (Miles, 1979). Table 1 provides an example of the coding procedure. The issues were explored thematically. The findings that are the subject of this paper relate to the interconnected themes listed in table 2. Finally, the results were read by all co-authors to discuss the reproduction and interpretation of the analysis.

In the results section, identified codes and themes of the statements are illustrated by direct quotations from the interviews. All quotes presented here were translated from Dutch. The quotes can be related to a specific type of interviewee by identification letters: (MD) if the

interviewee is a physician and (CO) if the interviewee is a member of the executive committee.

Insert table 1 about here

Findings

We asked study participants about their beliefs about the hospital-physician relationship and their perceptions of the obligations that exist within this relationship. Although physicians operate as independent practitioners with a distinctive revenue stream, they need organizational support that enables them to practice medicine. This confirms the suggestion that in the case of the psychological contract of physicians, It has been suggested that the perceived obligations are shaped by professional and administrative work ideologies (Bunderson, 2001).. Both ideologies are relevant in understanding how physicians relate to the hospital they practice at. In other words, physicians interact with the hospital both as professional and as organizational member. As professional, they assume and ascribe particular roles (a set of perceived rights and obligations) to the organization that are consistent with the institution and ideology of professional work. As organizational members, they assume and ascribe particular roles to the organization that are consistent with the institution and ideology of the administrative organization. Table 2 summarizes some of the key differences between professional and administrative work ideologies.

Insert table 2 about here

Our qualitative findings demonstrate that hospitals' obligations typically consist of issues related to organizing and planning the hospital care. Different obligations related to supporting physicians in building and maintaining their practice can be identified. A

distinction can be drawn between administrative obligations (adequate support and responsive decision making processes) and professional obligations (clinical excellence and physician autonomous medical decision making). In addition, within these main themes several sub-themes emerged. These findings are discussed in the following paragraphs. The results are presented through the use of the participants' words. Table 3 provides an overview.

Insert table 2 about here

Beliefs about effective hospital-physician relationships

The interviews started with a direct question that inquired about beliefs of what an optimal, effective hospital-physician relationship consists of. In addition to their responses to this question, respondents mentioned the characteristics of “a good relationship (MD 4 & CO 12)” also in response to other questions during the interview. The vast majority of the respondents reported that “an open, constructive relationship (CO 8)” and “mutual respect, communication and trust (MD 12)” are foundation building features that are indispensable to realize effective relationships and ultimately crucial to improve hospital performance. Related to this, one physician reported “understanding the viewpoint of physicians (MD 8)” and another participant stressed the importance of “taking into account the interests of the other party (CO 3)” as prerequisites to constructive cooperation. The belief that interests of the hospital and the medical staff are not fully aligned is illustrated by these comments.

Adequate support

This theme describes the interviewees' experiences of obligations related to providing adequate support to physicians. Physicians rely on hospital resources to deliver medical care. The way supporting processes are organized has an influence on their day-to-day activities. Related to this obligation, three subthemes emerged from the interviews. Participants stressed the importance of an adequate number and competent supportive

staff, talented and skilled physicians-colleagues and efficient and convenient operations that enhance physicians' efficiency.

An adequate number and competent supportive staff. Hospitals deliver integrated secondary care. Whereas the care is coordinated by physicians, a lot of supporting staff with specific expertise and experience is invoked. Nurses are responsible for the bedside nursing care (i.e. wound care and the administration of drugs), technicians assist them in performing medical procedures (i.e. imaging, interventional and surgical procedures) and other professionals like physiotherapists and pharmacists provide other specific care. As one respondent reported:

An adequate number of nurses to monitor my patients is a basic requirement to realize high quality care. This is equally important at night. Next to the staffing level, their competence is of the utmost importance (MD 5).

However, physicians are ultimately responsible for the quality and coordination of the delivered care. A physician clarified this aspect as follows:

It is a well-known fact that a lot of errors are made for instance with the administration of drugs. As a physician, I'm legally responsible for the care to my patient. However, I can't monitor the patient care 24 hours a day. To realize high-quality care I need competent supporting staff that can be relied on (MD 12).

Providing adequate as well as competent supportive staff can therefore be considered as an important obligation of the hospital and a key concern of physicians. This was confirmed by the hospital executives as a key obligation of the hospital.

Talented and skilled physicians-colleagues. The medical field is characterized by specialization and interdisciplinary dialogue between different specialties is increasingly important. Attracting competent physicians that contribute to the realization of high quality care is an important obligation of the hospital. Besides providing adequate supporting staff, it is also important for physicians that the hospital attracts and retains competent physician-colleagues. As two physicians put it:

Practicing medicine is increasingly complex and patient care has evolved from a mono- to multidisciplinary model ... given the shortage of certain specialties, cooperation with other, competent specialists is a major concern (MD 2).

An important referral pattern within the hospital exists, this generates additional patient care for colleagues with other (sub)specialties (MD 7).

Hospital executives did acknowledge this obligation in the hospital-physician relationship and indicated this as “a shared responsibility (CO 3 and CO 12)”. Moreover, the medical board and groups of physicians (the associations) play a dominant role in attracting physicians. This finding illustrates that felt obligations by physicians are not solely shaped by the hospital but are also cocreated by the medical staff (hospital management *with* physicians).

Efficient and convenient operations. A majority of the respondents believe that assuring efficient and convenient operations to physicians is one of the primary obligations of the hospital. As one physician commented:

The way the care is organized has a direct impact on my personal efficiency. When I need to wait for results or needed support, I’m losing valuable time, time that can be spent to patient care (MD 9).

Related to this, respondents stressed the financial importance of well-organized operations from a physician perspective. As an independent practitioner with a distinctive revenue stream they are responsible for generating their own income. Efficient operations limit the opportunity cost of time spent away from their own practice and maximize the time available for remunerated patient care. A physician clarified that “considering the fee-for-service payment system of medical fees, the way the care is organized has also important financial implications (MD 1)”.

Hospital Executives acknowledge that efficiency and convenient operations are important to physicians since “the physicians act as independent caregivers generating their own income [professional fees] (CO 6)”. However, executives accentuate this aspect as import area of

ambiguity since in the “day-to-day interaction between both parties an economic trade-off exists (CO 11)”. The way the care is organized may be very efficient for the physician but from a hospital perspective it can be inefficient and even wasteful. An executive pinpointed:

Modern hospital care is characterized by multidisciplinary. Physicians appeal to a lot of supporting staff (i.e. nurses). Whereas it can be considered efficient to delegate certain tasks to a nurse from a physician practice perspective, from a hospital perspective this might be inefficient and increase labour costs. Similarly, when nurses regularly have to wait for a delayed physician (i.e. to begin the medical round at the nursing ward) hospital costs increase (CO 1).

Participative and responsive decision making

Physician involvement in hospital decision-making processes could be identified as a central theme in the interviews. Physicians frequently stressed the importance of decisions made by executives to their own day-to-day practice. They need hospital resources, managed by hospital executives, to deliver medical care. Accordingly physicians expect participative and responsive decision-making processes. Specifically, resource allocation and budgeting decisions were perceived as indispensable to develop their medical practice and clinical field further. Likewise, respondents believe that participative and responsive decision making processes are crucial to the individual medical staff members:

The core business of the hospital is to deliver medical care. Therefore, besides the patients, physicians are the most important stakeholders of the hospital. The medical field is complex and is highly specialized, consequently clinically related choices can only be made in close cooperation with the medical staff (MD 9).

Justice and equal treatment of physician(group)s were expressed as a central concern by the interviewed physicians. The participants asserted that fairness of the procedures used in hospital decision making is an important aspect. Additionally, the explanation provided to physicians, which conveys information about why procedures were used in a certain way or

why decision outcomes were distributed in a certain fashion, is considered an obligation of hospital management. This was acknowledged by the interviewed executives:

We inform our physicians about the important management decisions made in the hospital . . . since they are our professional partners in delivering care they have the right to have information when significant decisions are made . . . this also raises their level of commitment to the hospital (CO 8).

While different committees that defend the interests of the medical staff as a whole are present in the hospital, participative and responsive decision making processes are also important at the level of individual medical staff members: A physician clarified:

The composition of these committees is often determined by elections. At first sight, this seems fair but it is important to realize that the medical staff is not a homogenous group and is composed of different groups of specialties with different needs. Consequently, the specialties that are greater in number are elected and the smaller specialties like paediatrics are strongly underrepresented (MD 11).

Professional obligations

Clinical excellence. At first sight hospital and the medical staff members have clearly the same objective: the improvement of the health of individuals by providing excellent hospital care. Since the medical professional plays a central role in realizing high quality care, it is not surprising that the interviewees perceive “excellent medical care (CO 3)” and “meeting the high standards of clinical practice (MD 6)” as the primary obligations of the medical staff members. Respondents clarified that the “essence of the working relationship lies in the clinical contribution of the MD (CO 9)” and stressed that “the medical expertise, competence and skills of physicians are of the utmost importance (MD 3)”. Therefore, the clinical contribution of physicians to the secondary care delivered in the hospital lies at the heart of the hospital-physician relationship and is considered to be the primary professional obligation by both physicians and hospital executives.

Physician autonomous medical decision making. Physicians enjoy a monopoly in several major decision areas (i.e. admit and discharge patients, the decision to perform a certain procedure). In the past, this professional autonomy was reinforced by the financing system by which physicians were paid on a fee-for-service basis and hospitals were paid on the basis of costs incurred. As such, the financial incentives were aligned. However, the financial relationship between hospitals and physicians has changed. Hospitals have evolved from a physician workshop to accountable organizations, charged with the development of internal organizations where quality and cost effectiveness go hand in hand. Hospitals bear the associated financial risk of DRG-payment systems (and sometimes pay for quality initiatives) creating a greater need for managing the delivery of care. Consequently physician autonomy has eroded in recent years. In the interviews, the safeguarding of physician autonomy was expressed as a central concern and primary obligation of hospital management by a vast majority of the interviewed physicians. Two respondents commented:

Medical decision making, for instance the choice of an implant, is purely a medical matter. Hospital management has no business with those decisions and I must be able to make this choice independently. Physician autonomy has to be respected (MD 5).

As physicians we can interact and cooperate with for instance the development of clinical pathways and efficient admission and discharge policies, however we have to draw the line between interactive delivery and purely medical decisions made between patient and physician (MD 15).

However executives stressed the different financial incentives induced by the payment framework characterized by a dual split in payment (in which physicians and hospital have separate revenue streams). During the interviews it became clear that hospitals, confronted with a prospective payment system, have to persuade physicians to adjust their medical behaviour while their fee-for-service incentives remain largely the same. Prospective payment systems create “a greater need for managing the delivery of care (CO 5)”. This introduces considerable financial risk on an organizational level and potential conflict of

interest into the triangular relationship hospital-physician-patient. There is clearly a tension between the need for independent medical decision making, focusing on the individual patient interest and the adversarial payment system of hospitals that concentrates on an aggregated level (i.e. the mean length of stay). In response to these financial incentives installed by the payment system, hospital management responds by the use of a variety of techniques intended to reduce the cost of secondary care (i.e. length of stay) and improve the quality of care (i.e. clinical pharmacy). Guidelines, formularies, profiling and financial agreements are used and force physicians to consider not only the needs of the individual patient but also those of the hospital. While the improvement of the health of his or her individual patients is still the primary responsibility of the physician, this is no longer his or her exclusive responsibility. Modern health care delivery forces physicians to consider not only the needs of the patient but also those of the hospital:

Of course our physicians need to take into account the financial impact their medical decisions have on the hospital. Modern care delivery is characterized by budgetary constraints and hospitals are held accountable for the assigned public means. Pharmaceutical prescriptions, length of stay and performed technical examinations have an important influence on the hospital bottom line [hospital financial performance]. This economic reality should be taken into account by physicians to realize cost-effective, sustainable hospital care (CO 2).

Discussion

Internationally, physician-hospital integration has emerged in response to increased pressures to improve quality and cost-effectiveness of hospital care delivery. However, while previous research has focused almost exclusively on the contractual arrangements between both hospital and physician we have shown that physician-hospital integration encompasses more than just strengthening the economic ties between both. Using the theoretical lens of psychological contract theory, our findings draw attention to the importance of noneconomic integration. Moreover, the majority of the participants in our study stressed the importance of an open, constructive relationship characterized by respect, communication and mutual understanding. Trust emerged as a foundation-building

characteristic of the hospital physician relationship. This finding is supported by the large body of evidence that consistently found trust as an outcome of cooperative behavior (Zhao, Wayne, Glibkowski, & Bravo, 2007) and a key element of effective work relationships between hospital managers and physicians (Succi, Lee, & Alexander, 1998).

The results of our study have some important implications. Firstly, it is clear that the policy-framework has a great influence on the working relationship between executives and physicians. More specifically, the dual split in payment and the alignment of incentives poses serious challenges to the hospital-physician relationship (Goldsmith, 2007; Berenson et al., 2007). This conflict of interest challenges physician autonomy and tends to fuel conflicts. Therefore, it is perceived as an obstacle to effective collaboration between hospital and the medical staff and a more integrated policy view on hospital financing is highly needed.

Secondly, hospital executives should recognize the critical need to develop and maintain effective hospital-physician relationships in order to realize cost-effective care delivery. Research rooted in social exchange has shown that individuals seek to enter and maintain a fair and balanced exchange relationship with the organization they work at (Cropanzo & Mitchell, 2005). This principle is based on the belief that physicians tend to reciprocate beneficial (or detrimental) treatment they receive with positive (or negative) work-related attitudes and behaviour (Blau, 1964; Gouldner, 1960). In this respect, the management of hospital-physician relationships can be considered to be highly important. Our interviews have shown that participative and responsive decision making is a key concern of physicians. These findings are consistent with the large body of evidence focusing on organizational justice (Colquit, Conlon, Wesson, Porter, & Ng, 2001). Moreover, it has been shown that responsive and participatory decision making processes enhance trusting relationships with executives and enables effective work relationships (Succi et al., 1998). Furthermore, taking into consideration and weighing the interests (of the hospital vs. self-employed physician) was described as a difficult balancing act that characterizes the physician-hospital working relationship. Involving physicians in hospital decision making can increase their fiduciary responsibility and exposure to tough decisions, both of which are likely to increase physician sensitivity to hospital performance (Smith et al., 1990). In addition, our findings raise a number of important questions for future research. One important avenue for future research is to focus on the importance of social exchange and reciprocity in the hospital-physician relationship. Moreover, physician response to perceptions that the hospital is not

fulfilling its obligations (psychological contract breach) would be insightful. Specifically, the sensitivity to unmet professional obligations compared to unmet administrative obligations can be considered interesting (Buderson, Lofstrom, & Van De Ven, 2000; Burderson, 2001). Furthermore, given recent efforts to reform the financing and delivery of health care, the degree to which the perceived medical autonomy by physicians is preserved can be valuable information (Spyridonidis & Calnan, 2011). Our research demonstrates the usefulness of the concepts of reciprocity and the psychological contract in understanding and improving hospital-physician relationships. This analysis should assist hospital executives and physicians in building cooperative relationships needed to improve the quality and cost-effectiveness of hospital care delivery. We hope that this study and any further work which arises from it will inform and challenge current debate.

Conclusion

Our analysis of the transcribed interviews yielded a rich understanding of how physicians and hospital executives interpret and experience mutual obligations and areas of ambiguity in their psychological contract. We found that a distinction should be made between administrative obligations (adequate support and responsive decision making) and professional obligations (clinical excellence and physician autonomy). Executives should recognize the critical need to develop and maintain effective hospital-physician relationships in order to realize cost-effective care delivery. The policy framework in which hospitals and physicians operate has a great influence on the working relationship between physicians and executives. The dual split in payment and alignment of incentives is frequently perceived as an obstacle to effective collaboration. Two areas of ambiguity could be identified reflecting both dimensions. On the one hand a trade-off exists in the day-to-day interaction of self-employed physicians with the hospital. Therefore, the interpretation of executives and medical staff members about the way the care should be organized differs. On the other hand, in contrast to the prospective hospital financing system, physicians are mainly remunerated by fee-for-service. The extent to which physicians should take into account the impact their medical decisions have on the hospitals' financial performance varies between executives and physicians.

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