

## Commentary

# Clinical Improvement: Commentary on Developing Healthy Physician–Hospital Relationships

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*Central to the success of clinical improvement programs is the degree to which hospitals and physicians can work together to achieve mutually beneficial goals. The purpose of this article is to provide a clear understanding of what is ultimately required for hospitals and physicians to form constructive relationships that deliver greater value to the marketplace. Key words: clinical improvement, multidisciplinary, systems approach, teamwork.*

**C**onflict, confrontation, and crisis characterize the relationship between many hospital administrative and medical staffs despite the fact that managing the delivery of efficient and effective health care requires dedicated teamwork. Unless hospitals and physicians overcome their traditional barriers, neither will prosper in the growing managed care environment that has already given birth to the paradoxical physician-hospital organization (PHO).

Medical staffs and hospital administrators, who function through crisis and conflict, do so for several reasons. First, both groups maintain a traditional skepticism of each other. Second, physicians and managers are different; physicians are doers, reactive deciders requiring immediate gratification, and are independent professionals who advocate patient needs. Hospital managers, on the other hand, are typically planners and delegators who understand delayed gratification and who actively work for the needs of the organization. Thirdly, financial issues gravitate physicians and managers to opposite points; predictably, what monetarily benefits one can be a loss to the other. Each of these factors contributes to a common, often repeated scenario. The hospital has an undesirable clinical or financial outcome such as a high postsurgical complication rate, a prolonged length of stay in a particular diagnosis-related group (DRG), or excessive costs in an ancillary department. Hospital managers are privileged to these facts and, initially, respond by blaming variation in physicians' practice patterns as the cause of these

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clinical-financial anomalies. Conversely, physicians, after learning of the undesirable outcomes, immediately accuse hospital managers of poor support services in areas such as laboratory, radiology, and discharge planning.

These responses on the part of hospital managers and physicians create an aura of defensive obstructionism. The net effect is a revisiting of rotating issues and a thwarting of any significant progress toward improving clinical or financial outcomes.

Part of the truth behind these opposing issues between managers and physicians is that physicians' ordering and prescribing patterns can have an adverse effect on length of stay and costs. Equally, logistical (administrative) problems such as turnaround time on lab tests and X rays, admission and discharge planning, and availability of the operating room contribute to the same excesses. However, the most important truth, which is usually not considered by either of these frustrated groups, is the system itself.

Deming's total quality management research demonstrated that defective products or outcomes were not typically the end product of personnel failures or employee inadequacies, but were the consequence of a failing system. Faulty medical outcomes are usually blamed on physicians or managers, when in reality, the primary culprit is the clinical system. In fact, experience suggests that when a poor clinical outcome occurs, the cause is an aberrant clinical system in 80 percent of the cases.

So rather than the usual adversarial one, a more curative approach to clinical improvement should concentrate on the clinical system and its various process components such as the interaction between:

- Physicians-Pharmacy-Microbiology
- Dietary-Nursing-Physicians
- Nursing-Physical Therapy-Orthopedic Surgery
- Social Services-Physicians-Outpatient Services

A system-focused approach accomplishes several goals: it diffuses the hostile interaction between medical staffs and hospital managers, and interrupts the cyclical argument of blame; it directs attention to the clinical system of specific patient groups; it underscores a multidisciplinary team-oriented direction, thus recruiting and integrating equally important parts including administrative staff, medical staff, ancillary department heads, nurse coordinators/case managers, and social services. And lastly, a system-

focused approach distributes responsibility to all parts of the hospital staff.

So how do hospital managers and medical staffs convert from an adversarial unproductive relationship to one that promotes a team-oriented constructive relationship?

The first step requires the development of mutual goals and objectives in order to channel differences between hospital managers and physicians into a commitment to a system-focused clinical improvement process. This commitment requires the full-faith and endorsement of the Board of Directors (or Trustees) and necessitates that the goals and objectives of the clinical improvement program become incorporated as a mission of the hospital. The development of this mission statement should involve providers from all departments and from all functions of the hospital.

Second, physicians will respond constructively to modification in their ordering and prescribing habits if they derive a clinical benefit. These clinical benefits should be end products of clinical improvement programs, which result in a reduction in lab, radiology, and pharmacy response times, and improvement in discharge planning and prehospital and posthospital services. If a system betters these important processes, then physicians feel supported, they make decisions more quickly, and they begin to participate in the clinical improvement process.

Third, clinical and financial outcomes data must be clinically adjusted for differences in patient severity, intensity, complexity, and risk so that useful information can be shared with members of the medical staff. The information must be reliable, credible, and must be presented in a clear concise format. The goal of information sharing is to establish a foundation of understanding from which physicians and managers can work.

Fourth, designating a physician advisor and recruiting champions from the medical staff across clinical specialties is paramount to integrating physicians into an effective clinical improvement program. These physician leaders aid in the dissolution of the adversarial relationship and aid in reestablishing the medical staff as a leadership group in the improvement process.

Fifth, the creation of a clinical improvement program is a natural result of the first step of establishing

mutual goals and objectives. Quality improvement projects like clinical indicators on antibiotic and oxygen usage, and on foley catheter and I.V. discontinuation, are relatively easy process improvement projects that can positively impact on quality and cost quickly (1–3 months). More long-term clinical improvement programs (3–12 months) such as case management, clinical pathways, and benchmarking programs are most successful when members of the medical staff are fully incorporated in the process. An important point regarding clinical improvement pro-

grams is this: select projects with high potential for success and, once completed, promote the success throughout the hospital staff and the medical staff.

The conversion from conflict and crisis to a constructive relationship between hospital managers and physicians is clearly necessary for mutual success in the increasingly competitive managed care environment. A working partnership between these two professional groups can generate superior clinical outcomes at less cost—simultaneously creating better patient care and greater value to payers and employers.