Physician's Responsibility in Change

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AS WE GATHER I am impressed, challenged, and gratified by the diversity of professional niches in the field of surgery represented by our group. It has been to me one of the most important aspects of our gatherings and discussions over the years. It has given each of us an appreciation for one another's problems, whether we are full- or part-time faculty in a public or private hospital, in a small town, a metropolitan area, or even a for-profit or not-for-profit hospital setting. Until recently, we have all had a significant and close relationship with one or more hospitals. With the emergence of free-standing ambulatory surgical and diagnostic centers this is changing for some. The majority of the general, thoracic, vascular, colorectal, and pediatric surgeons will continue to have a major interrelationship with one or more hospitals. There will be an ever increasing number of regulations under which we will operate, greater severity of illness of patients we care for in the hospital, more pressures of capital requirements with ever increasing desire for advanced technology, increasing hospital/hospital competition, more physician/hospital and physician/physician competition all coupled with revolutionary changes in reimbursement.

Historically, the hospital/physician relationship has been at best independent, at worst adversarial. Legislation, liability, patient expectations, capital requirements, the business community, cost of care, and reimbursement have changed that. No longer can there be a hostile or even contrary conjunction between us and the institution in which we choose to practice, but rather there must be an alliance, lacking selfish motives, and an interaction which we both see as a means to an end, an end which we have continued to pursue, namely, high quality care for the patients whose custody has been placed in our hands.

With this as a basis, I would like to talk about hospital/physician relationships, specific areas of relationships, and physician responsibility in meeting these challenges. I anticipate these thoughts to be dynamic and revolutionary and hope we have the capability to adapt to the changes that we will be involved in over the next decade and beyond.

William Baker told us a year ago that managed care may lead to decreased quality of care.[1,2] I see decreased quality of care as a major threat.

There will be continued pressures to reduce the rate of increase in cost of medical care, to enhance productivity, and to control utilization while improving access and quality. This will require a joint effort between hospitals and physicians. This shall, therefore, require a change in that historic relationship. Hospitals and physician leaders must take the initiative as, in fact, some have.

This initiative will take on a broader scope as we look toward the development of the community health care system. This is happening as the hospital moves from the traditional role as provider of acute inpatient care to the leadership role as the provider of full range personal health care services available on a cost effective basis.[3] The elements of the community health care system will include traditional acute inpatient care, ambulatory care network, extended care, home health care, an alternative finance system, and prevention and education functions.[4] This will require physician leadership and significant physician/hospital collaboration.

I am going to present a scenario of what should

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happen, some questions we must ask ourselves, and finally, a statement of responsibility we have as practicing physicians and teachers of young surgeons.

Hospitals must and will declare acceptance of physician involvement in basic functions of the institution. This includes finance, strategic planning, resource planning, mission effectiveness, and board and management evaluation. There are other areas that will be mentioned later. Given the history of hospital governance and management, physician involvement in itself will present a big change and conceivably a major threat to many involved. In fact, in several states, statutes specifically forbid physician participation in public hospitals in the areas we are discussing. As policy decisions are made in these areas, physician expertise has to be present to assure high quality of patient care, without which we all fail. Medical technology and medical ethics, coupled with an aging population, will present hospital management and governance with provoking questions that will require physician expertise to help resolve.

A second requirement in this projection is that physicians must be able to accept the responsibility of involvement in the dynamics of change, a concept not easily grasped by many. Most of us would like to have a pretty good lifestyle for ourselves and family, avoid confrontations which endanger our feeling of security, have a substantial degree of clinical autonomy, and provide good surgical care for our patients; in fact, that is fine, but there is more. No group of individuals are better qualified to meet the needs of the community health care system in planning, finance, technology, and ethical decisions than physicians.

Today, hospitals hire patient advocates. Let us not forget that physicians have always been patient advocates and they are still today. With that goes the responsibility for the health care dollar. No group is a more logical choice for that custody than physicians, but it will not be easy. The proper stewardship is part drudgery, part disappointment, and part frustration but can be very satisfying, for we continue to hold high quality of care as our goal.

The question of physician aptitude for these leadership roles must be asked. Historically, physicians have held ceremonial or very departmentalized positions in management and governance. They have often been rightly perceived as against change, and reactive rather than proactive, especially in meeting legislative and regulatory issues. This includes issues of private practice as well as of the hospital. It seems worthwhile to delineate a few specific areas where I see us, as physicians, accepting leadership responsibilities in our relationship with hospitals. It is apparent that some of these areas have had isolated physician leadership for years. One example is alternative finance and delivery systems. Other leadership examples include joint ventures between hospitals and physicians, governance, graduate medical education, clinical service development, fiduciary responsibility of the institution, and quality analysis, including information gathering. The physician must remain clinical captain of the ship in the care of the patient.

I submit that as physicians, we bring a different and supportive personality to management and governance functions. We have the acquired base of knowledge of the specifics of the institution or system from which to work. Physicians have considerable experience in unofficial effectiveness and generally, when involved, can get things done. This is partly a response to our need for instant gratification which we, as surgeons, possess in abundance and which must not be an overriding philosophy in management. However, I think some of that feeling in decision-making keeps dynamic our responses to a constant barrage of challenges in health care.

Let us not forget our clinical life has been one of numerous decisions and the need to communicate these decisions to our colleagues and our patients. There can be no lack of these communication skills in modern hospital management. Physicians in leadership roles bring a natural concern for the patient, the patient's access to care, and to the quality of that care. I would hope that this includes the special consciousness for the plight of the poor and almost 40 million uninsured people in our society. The responsible care of these people will be a tremendous challenge for health care leaders, as well as all members of society. Communication to all involved will be an important building block in the structure by which we accomplish this.

Because of clinical experiences, while we like instant gratification, physicians are patient and will persevere when called upon. We also develop a comfort with adversity that many managers do not have. Credibility with Medical Staff, because of common experiences and common needs, is an important part of the supportive personality the physician brings to the leadership role.

Next, I would like to address the question, why should we as physicians become involved? No group has the ability to see the broad picture of the community health care system as clearly as physicians. We see it as a patient in the system, as a physician delivering care, and as an employer in the community. As managed health care becomes a reality in virtually all locales, this perspective will place the physician in a unique circumstance for viewing the spectrum of health care. With it goes potential authority which can be exercised proactively if appropriate posturing has been attained.

If physicians do not maintain decision-making authority, that authority will be lost, and if lost, will be very difficult to regain. Less than a decade ago, ninety per cent of the health care dollar was physician directed. In

1987, it decreased to seventy per cent and the decline is continuing. I do not believe the trend is in the best interest of the patient. We see corporate America increasingly directing the amount of money spent. We do not curtail this by ignoring it. I believe businesses of this country want physicians to control the increase in health costs, but they have not seen significant evidence of that happening, and thus, have assumed the challenge themselves. More often than not, it has brought business into conflict with physicians and hospitals. It is physician leaders that will resolve the conflicts and stabilize the environment. No group is better prepared to make crucial decisions than physicians, because of their training and experience.

The government has regulations that we are obligated to follow, but we can affect government involvement with dedicated physicians in leadership roles, especially if we can find ourselves in harmony with corporate America. We must strive to find our common ground and work together. There is no question again that the primary goal must remain high quality of care and we must work with the business community to avoid cost containment overkill.

The community health care system is fragmented at best; our energy must go toward bringing those pieces together into a working module which accomplishes the goals we have set.

Finally, I see us, as practicing physicians and teachers of young surgeons, having another responsibility. We need to convey to them this leadership role. Their perception of practice is based on a role model, usually out of their past, that has very little relationship to the environment in which they soon will be commencing their life's work. Residents need to be coached on what to look for in a locale in which they are seeking practice opportunities, such as fee-splitting custom, outreach clinics and itinerant surgery, privileging of non-certified surgeons on the hospital staff, involvement with HMOs, PPOs, IPAs, and the differences, referral patterns, response of hospitals to physicians, competition between hospitals and physicians, hospital-owned physician practices and a host of other things. We also need to tell them how to market themselves ethically and give them a foundation in the business aspects of office management. It is far more important today than in the past to begin with the same knowledge of business because of large personal education debts, increased costs of starting a practice, and a smaller financial margin with which to work.

I believe education of the resident concerning the responsibility of leadership is critical to the future of health care and to the physician's role in its management. That educational responsibility lies with us all. The vast amount of information and technical skills that we must impart to those young people who will join us and follow leaves little time for my charge, yet I believe we must find the time and must find the people to inform them if we ourselves do not feel comfortable doing it. This is not to declare that all will be leaders, but some will. Those who choose not to deviate from clinical duties must accept leadership from those who lead, recognize the importance of that task, and acknowledge it. Thomas Huxley said, "Perhaps the most valuable result of all education is the ability to make yourself do the thing you have to do, when it ought to be done, whether you like it or not, it is the first lesson that ought to be learned, and however early a man's training begins, it is probably the last lesson that he learns thoroughly."

Because of our training, our preference for clinical activity, patient contact, research interest, and feelings about medical and surgical practice, we may find it distasteful to spend valuable time accepting non-clinical leadership responsibilities.

I think this charge does not have to be unpleasant and leadership must be acknowledged and met; not everyone will be leaders. I would like to quote John H. Glenn; "People are afraid of the future, of the unknown. If man faces up to it and takes the dare of the future, he can have some control over his destiny. That's an exciting idea to me, better than waiting with everybody else to see what's going to happen." It is an exciting idea to me also. We must not underestimate the importance of physician involvement in the decisions to be made in health care during the remainder of this century. There will be tremendous changes; there will be good decisions and bad, but we as physicians must be knowledgeable and committed to being a part of those decisions.

I want to thank members of the Midwest Surgical Association for the honor and privilege of serving as your President for this year. It is humbling that a surgeon from a small town in Iowa would be your choice, but I shall always remember this opportunity and appreciate it sincerely.

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