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Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations

"Ms. Gosfield's excellent paper makes the vital connection between physician involvement in medical decision-making and high quality patient care. She clearly establishes that physician leadership is critical to halt the erosion of professionalism in our volatile health care environment."
------*E. Ratcliffe Anderson, Jr., MD, Executive Vice President, American Medical Association*

To Ms. Gosfield regarding Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organization, *"you have unified extremely important insights into a critically important concept, certainly describing and presenting them in an excellent fashion."*
------Alfred S. Buck, MD, Executive Vice President, Division of Measurement and Research, Joint Commission on Accreditation of Healthcare Organizations

"Physicians play a central role not only as leaders in the American health care system, but as major influences in the lives of most Americans. Ms. Gosfield has eloquently described the vital contributions physicians are poised to make, and the responsibilities they must confront, as we move forward into a new era of accountability in health care."
------*Cary Sennett, MD, PhD, Executive Vice President, National Committee for Quality Assurance*

"Gosfield's Quality and Clinical Culture*… provides a direct, clear and detailed linkage between the highly valued, scientifically grounded caring physicians' role and the emerging accountable organizations that are changing health care in this country. Her grasp of the core elements of the physician's clinical culture goes beyond idealism and nostalgia to real understanding. Gosfield's command of the new demands of accountable healthcare, its organizations, and its existence in the marketplace provide the grounding for a new synthesis that recognizes the uniquely personal character of the clinical culture."*
------John M. Ludden, MD, Senior Vice President for Medical Affairs, Harvard Pilgrim Health Care

"Ms. Gosfield's paper is thought provoking. The ideas expressed are very appropriate for today's health care environment. They make me think about how medicine ought to be practiced."
------*George J. Isham, MD, Medical Director and Chief Health Officer, HealthPartners*

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Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations

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Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations

by Alice G. Gosfield, JD.*

Over the last twenty-five years the special contribution of physicians to the quality of hospital care through an organized medical staff has been recognized in accreditation standards, hospital licensing rules, and Medicare conditions of participation. Today, however, the primacy of the hospital as the physician's significant other in providing medical services to his or her patient is evolving. In addition, the role of the organized medical staff has been called into question by some. Many of the changes vary by geographic location. In some places, hospitals are expanding into far broader delivery systems. In other settings they are being supplanted by other entities as the critical delivery vehicle to which the physician relates in providing services to a patient.

With the advent of new payment techniques, consolidation throughout the industry and new organizational instruments like managed care organizations ("MCOs"), integrated delivery systems ("IDSs") and physician practice management companies ("PPMCs") to support and provide health care services, there has been an overall corporatization of what was previously predominantly part of the charitable sector of the American economy. As this white paper describes further, these changes have raised questions about the accountability of health care organizations for the outcomes and quality of care provided through and by them. In this paper, an accountable health care organization is one which has explicitly focused on its clinical culture as supportive of appropriate quality for which such an organization is willing to be evaluated, compared and held responsible. For reasons which are set forth more fully below, against the altered backdrop of the American health care delivery and financing system, it is time to reconsider the role and functions of physicians and medical staffs in accountable health care organizations, generally.

This paper examines the new context within which concern for quality has come to the fore. It considers the critical role that physicians have to play within the system and addresses those areas to which their expertise ought to be directed. Some essential values and principles for relating to physicians effectively to foster a quality focused clinical culture for accountable health care organizations are presented. To fulfill the potential considered here physicians will have to confront some significant challenges within organizations and among themselves, some of which reflect the ways in which physicians have sometimes undermined their own effectiveness in the past. These issues are presented at least initially. Finally, this white paper presents why the entities to which they relate will want to include physicians in a reinvigorated role in the new order.

This document is directed at two audiences -- the physicians whose involvement in accountable health care organizations is so important, as well as the organizations to which they relate. For both groups this paper is intended to instigate a willingness to consider a new approach to physician integration into the real business of health care. To do so will require recognition that the time is particularly ripe to grapple with these concerns in a new way which can speak to the needs not only of the participants in this dialogue, but more importantly to the needs of the patients whose care is the reason for all health care businesses.

* The author is the Chairman of the Board of the National Committee for Quality Assurance (NCQA). The opinions expressed here are her own and should not be attributed to nor imputed to the NCQA in any way whatsoever.

This paper is not a proposal for a specific organizational model. It does not provide a particular schematic of committees, rules and legal structures. This paper addresses the issues about which physicians and accountable health care organizations ought devote concerted energies at collaboration, and provides the foundation for a dialogue -- through articulated operating principles and values -- that can make a difference in crafting a better approach in some settings to physician-organizational relationships. It also posits some new challenges for which solutions will arise from engaging in the process described here. This discussion is intended to stimulate local reactions and will likely generate some additional conceptual work as well.

I. The New Context

As health care becomes almost 20% of the gross national product, anxiety about increasing costs and expenditures has become a central, driving force in the purchasing, payment, and delivery of health care services. The advent of "managed care" -- a term which encompasses a wide variety of techniques, compensation systems, and corporate structures -- has been the predominant reordering of the last ten years. With an increased emphasis on cost control has come a related emphasis on more businesslike approaches to organizing health care delivery. While this new mindset has, on one hand, imported from the manufacturing industries principles of efficiency, competition, and product lines, it has also, on the other hand, led to the introduction of continuous quality improvement and customer satisfaction as key management initiatives. These dual tensions have been at the center of societal disquiet about the new developments: cost containment achieved through business principles may undermine assurance of quality health care and disrupt pivotal physician patient relationships.

Overview of Changes

A variety of forces both manifest and contribute to the new business order: (1) changed financial incentives are intended to generate altered health care service utilization; (2) a plethora of new forms of business entities are now involved in providing the platform from which health care services are provided; (3) anti-managed care laws around the country confront perceived inequities and dangers from some of these developments; and (4) there is increasing demand for data about health care performance.

Insurance products in the form of health maintenance organizations, point of service plans, preferred provider organizations and exclusive provider organizations, have emanated from traditional indemnity insurers as well as start up managed care companies. With these new creations, insurance techniques have been interjected into new payment systems that combine health care delivery and insurance functions. Actuarial principles of financial risk assumption have been imposed contractually on providers through new financial incentives to contain costs — from primary care capitation for an individual physician to percent of premium payments for integrated delivery systems.

These initiatives have been directed at "aligning the incentives" of the delivery system away from traditional fee-for-service, pay-as-you-go reimbursement to techniques which put providers at risk for financial loss for unchecked ordering and provision of health care services. While the logical reaction to fee-for-service incentives is to provide more services, many of the new payment systems motivate more parsimonious utilization, with increased financial risk for ineffective management. In response, new aggregations of providers into ever larger entities have been typical throughout the country. Much of this movement is to allow the assumption of even more financial risk at the provider level.

Integrated delivery systems coalesce around academic medical centers or tertiary care hospitals bringing together multiple hospitals, employed and independent physicians, alliances of various types and other contractual relationships to create a single provider network. On a more limited scale, hospitals and their physicians form new ventures (physician hospital organizations ("PHOs")) to offer one-stop shopping to purchasers. Physicians in private offices form independent practice associations ("IPAs") through which they seek to contract with managed care payors. Physician practice management companies buy the

business assets of physician practices and introduce entrepreneurial management techniques to the prior cottage industry of solo practitioner and small group medical practices.

In addition to the delivery system evolutions, a whole substructure of related businesses that influence clinical behavior has emerged. Stand alone utilization review companies contract their services to managed care organizations and others to review and recommend the medical necessity and appropriateness of services ordered for and provided to patients. Pharmaceutical companies and disease management vendors influence prescribing patterns and introduce proactive clinical management techniques for disease states such as diabetes, asthma, and high risk pregnancy. Clinical practice guideline and software companies provide proprietary and intellectual property upon which clinical decisions are made.

Nationwide some of these entities have remained home-grown and some tax exempt, but more and more, these new ventures have developed as for-profit companies. As a result there are many more health care sector entrants into the public markets. Some have become very large publicly traded national enterprises. Everywhere, the new requirement to generate shareholder value in the for-profit health care sector is more significant today than ever before. While all of these developments have undeniably slowed the rate of health care cost inflation, they have also come to stimulate legitimate questions about the quality of and accountability for the clinical health care services that can be provided within this context of new values.

Concern for Quality and Accountability

The American public has demonstrated much apprehension about the extent to which quality is compromised in the new setting. This anxiety is taking many forms.[1] One of the most significant phenomena, from coast to coast, has been the enactment of so-called "anti-managed care laws" either in state legislatures or by regulation. These promulgations cover widely ranging matters. Many of these laws touch directly on the clinical content of the care provided pursuant to the new approaches. Mandating the option for a 48-hour post-partum stay, restricting one-day mastectomies, requiring disclosure of financial incentives for physicians and of the utilization review criteria used by payors, and specifying that only a state licensed physician may make utilization review judgments on a case-by-case basis all focus on the clinical legitimacy of decisions made in response to new incentives. Outlawing "gag" clauses is intended to lift barriers to doctor-patient communication so that patients have a full understanding of their clinical options. Mandating permitted self-referral to ob-gyns is aimed at improved access to clinical care. Prohibition of physician indemnification of an MCO is intended to prevent MCOs from contractually avoiding responsibility for the clinical consequences of their management activities, thereby impliedly making them more accountable for the results of their medical management programs. All are a clear confirmation of the link between management of care and traditional clinical decision-making.

Other public policy initiatives also reflect this undeniable expression of societal concern for quality and clinical content of care. Legislatively required public reporting of quality performance data at the hospital level (notably in Pennsylvania and New York and now including Texas) and, even with respect to individual surgeons, is intended to shed light on the quality of care.[2] Major purchasers offer only those HMOs which are accredited by bodies which evaluate the capacity of managed care entities to monitor clinical quality and seek opportunities to improve care.[3] Coalitions of business purchasers require that managed care entities report their performance on a range of specified quality measures (HEDIS).[4] The federal government regulates directly the quality of services provided by the managed care organizations who seek federal dollars available to pay for care for federally financed populations, in Medicare, Medicaid, CHAMPUS and other programs.[5] The fraud and abuse laws are increasingly used to punish quality failures.[6] The Presidential Commission on Patients' Rights is not only a reflection of anxiety about individual choice but also about the extent to which business values will predominate in

circumstances where sensitive clinical decisions are made. The very title of the final report – "Quality First: Better Health Care for All Americans" – and the substantive content go well beyond a consumer Bill of Rights to an explicit agenda for quality improvement.

Criticism of the rising business culture of health care and its effect on health care delivery can be found in two ancillary developments as well:

1. Throughout the country, local governments are removing charitable tax exemptions from hospitals because they compete directly with for-profit entities in the communities in which they operate. These communities believe that hospitals who have heeded the siren call to businesslike management are no longer entitled to special recognition for their charitable mission which is seen to have eroded.

2. Although weak in some states, in others State Boards of Medical Examiners and the courts have upheld or reaffirmed their prohibition on the corporate practice of medicine. This longstanding principle in a number of jurisdictions is predicated on the idea that physician licensure is a public policy recognition of the physician's special body of knowledge which ought be brought to bear for the benefit of individual patients without undue influence by unlicensed individuals. Consequently, in a corporate practice of medicine state, such as Pennsylvania, by law physicians are not permitted to be employed directly by an entity other than a professional corporation controlled by other licensed professionals. Since the hallmark of an employment relationship is that the employer directs and controls the manner in which the employee fulfills the duties of the relationship, even today corporate practice of medicine states have reasserted the need for the essential independence of medical judgment.

Caselaw on Liability

While legislative and policy actions reflect a desire to safeguard elements of quality, the courts have increasingly moved to hold corporate entities, HMOs and other MCOs directly liable for bad clinical outcomes experienced by their subscribers.[7] Certain aspects of the new context have led more immediately to this position. The fact that the MCO selects a restricted network of clinicians and limits the subscribers' ability to obtain services from anyone else has been a significant issue. More recently the courts have noted an ongoing responsibility of these entities to monitor the quality of care provided by their selected providers. Although some MCOs have attempted to avoid any direct responsibility for the changed behavior they intentionally generate, the courts have repeatedly bound those organizations more closely in legal terms to the clinical effects of their programmatic strategies.
In cases examining the ability of these new entities to terminate their relationships with physicians without cause the courts have begun to note the broad import of the new arrangements:

> The public has a substantial interest in the relationship between health maintenance organizations and their preferred provider physicians…This relationship is perhaps the most important factor in linking a particular physician with a particular patient. As [the plaintiff] correctly notes, the termination of his relationship with [the HMO] affects more than just his own interest…We conclude that the public interest and fundamental fairness demand that a health maintenance organization's decision to terminate its relationship with a particular physician provider must comport with the covenant of good faith and fair dealing and may not be made for a reason that is contrary to public policy…[8]

Although as a result of the ERISA laws the courts have less often imposed liability for utilization management decisions, increasingly they are unwilling to lay all responsibility for the consequences of the industrial revolution described above at the feet of the physicians. Case law develops exceedingly slowly. In the meantime, market forces are changing traditional notions of quality to encompass a broader view, both of quality and of health care, itself.

New Dimensions of Quality

Traditionally the concept of health care quality has been firmly grounded in what happens clinically to individual patients. Today, however, the concept of quality has taken on the additional connotation of overall outcomes for populations assigned to a care system or paid for by a specific payor. Still further, in an environment in which access to providers is restricted, service becomes very important. Customer satisfaction, therefore, has become a major measure of the quality of service provided by each element of the new food chain. Whether patients in a restricted network actually have meaningful access to the professionals assigned to provide them care has become a new quality dimension. Whether those professionals who are in the network in fact are available on a timely basis is evaluated today. Telephone response times and physician communication styles have also been identified as quality-relevant. The concept of "health care" itself is now shifting to put more weight on prevention, wellness, and early detection – a major departure from its historical boundaries.

While much in the traditional hospital medical staff setting has concerned desperately ill patients receiving expert care in highly technical environments, another change in the system is the advent of real consumerism -- the activist involvement of consumers in seeking out alternative care, gathering information from widely variant sources about their options, confronting traditional notions of professional control by physicians, and wending back and forth between more and less traditional providers of health care. With the rapidly expanding information about health available on the internet and in the lay press, physicians throughout the country are facing a new dynamic in their relationships with their sick patients, with those who are referred to by some as the "worried well" and even with those who are not sick but are managing lifestyle issues. These changes represent still further challenges for physicians in the new context. As all of these new dimensions are added, however, some anxiety over a loss of focus on technical quality in clinical care delivery is resurfacing.

While the added new dimensions of quality and health care are ripening, technical quality remains a core concern. Technical quality is a judgment as to the right treatment or process for the patient's clinical condition; whether services were provided correctly and appropriately; whether there were opportunities for process improvement; and how improvement might be achieved. The many ways in which technical quality is assured and supported, or neglected and undermined, defines the clinical culture of a health care organization.

Complexities

The complexities in this environment are profound. Influences on clinical culture are many.[9] The variety of actors who affect a clinical outcome for a specific patient are myriad. In addition to the multiplicity of business entities which, through financial incentives, medical management programs, utilization review and payment techniques directly influence clinical services, there are also new types of clinicians that interact with patients --- from nurse practitioners and physician assistants to occupational therapists and certified registered nurse anesthetists, for example. The sheer varieties of clinicians at work in today's health care environment is dizzying.

The numbers and types of business entities that focus on discrete and highly specialized industry niches have also multiplied and compounded. We see entire sectors of the industry which did not exist twenty years ago: home infusion companies, proprietary ambulance companies, free-standing cancer centers, mobile lithotripsy providers, free-standing psychiatric hospitals, and rehabilitation centers. All interact with physicians, patients, and other elements of the system in ways that can affect clinical outcomes. As each of these clinicians and providers gains a foothold in the delivery process, they assert varying claims to mold policy on matters reflecting their specific sphere of influence.

The constituencies and stakeholders involved in making judgments and choices within this expanding universe is equally staggering: Employers and those who purchase care must evaluate the bona fides of those who would seek to be selected to insure and/or provide services. Sensitive health care decisions are made in an ever more competitive context for those who would seek to do business with the purchasers. The providers seek to position themselves to be selected by those with the dollars who will assure their future. Government shapes quality in a major way through (a) direct regulation, (b) payment systems when it is the financier of care, and (c) in its own selections as a sizable employer. Above all, the patients and potential patients of the system are vitally concerned about how care is provided and what will happen to them as a result. Throughout, physicians stand in a unique status with respect to the rest of the industry.

II. What Is Different About Physicians?

Physicians now find themselves in a dramatically reconfigured environment within which they engage in their principal role. This role has been considered and expounded upon by many, but among the most elegant descriptions of what physicians do which distinguishes them from the other actors on the current scene as well as throughout history has been articulated by James L. Reinertsen, M.D.

> [Physicians] transform information into meaningful explanations of the present, predictions of the future, and changed futures, mainly for individual patients and sometimes for whole populations.[10]

This explanation has been adopted and re-characterized by another commentator as follows:

> [T]he fundamental nature of the transaction that takes place between physician and patient, as complex, multifaceted, and enigmatic as it is, can be captured in just three questions that people seek answers to when they are sick: ...[P]eople basically look to their physicians to (1) explain nature: "What is happening to me?"; (2) predict nature's future: "What is going to happen to me?" and (3) alter nature's future for the better: "What can be done to improve what happens to me?"[11]

As Reinertsen says,

> We take information about health and transform it to a higher order of information, not just as an intellectual exercise, but to satisfy the three fundamental needs of explanation, prediction and change. We can do other things in the course of our day, but all are secondary to this primary task.[10]

By bringing to bear a specialized body of knowledge, combined with learned medical judgment and appreciation of the individual patient's specific needs, physicians perform a function which even the law recognizes as unique. Throughout the country physicians are accorded a legal status distinct from other practitioners: physicians are plenary licensed. They are authorized to perform the functions which other practitioners may also perform, (whether podiatrists, optometrists, physical therapists, nurses or psychologists, for example) and more. Not only is the legally recognized scope of their practice the broadest of any clinicians, but they are also authorized and expected to exercise the responsibility to direct others to perform functions defined by the physician as necessary.

Physicians can now be found fulfilling this legally and societally sanctioned exceptional role in a wide variety of settings including independent practice, as employed by large groups or systems, or within corporate business structures. No matter where, however, physicians as a group tend to draw on an essential set of values which reflect their training in and experience with their singular role. An understanding of these values is central to an appreciation of what physicians bring to bear on the basic

issues of quality and clinical accountability. It is these values which represent the core differences physicians can offer, the public craves, and accountable health care organizations ought draw on to solidify their credibility.

The Core Physician Values

Accountability and Liability

Above all, in the doctor-patient relationship, a physician has a legal, ethical and clinical responsibility to the individual patient who presents for clinical care. This responsibility is paramount. Today, physicians feel that this primary commitment is being altered since physicians in groups may be assigned some accountability for outcomes for populations as well as for appropriate resource consumption. In the one-on-one doctor-patient relationship, though, the physician stands in a fiduciary relationship with his or her patient, holding that individual's needs as the touchstone of the decisions to be made between them. This level of responsibility to the patient is momentous for the physician. Identification by the physician with the patient's needs is so strongly embedded in the relationship that it produces the often seen phenomenon of the physician becoming the advocate for his patient in traversing the complex roadways of the current health care system.

The legal liability imposed on physicians for failing in the exercise of this sacred responsibility is clear. In many states the scope of the physician's responsibility is recognized in the doctrine of the "captain of the ship", meaning that since the physician orders the services that are provided pursuant to his orders, then the physician himself can be held liable for the negligence of others operating pursuant to his orders -- on his watch, so to speak. This liability focuses physicians intensely on compliance with the legally recognized, traditional standard of care in treating patients. Although this standard may be impliedly changing given some of the contractual obligations physicians are assuming in managed care contexts, the law has not altered its evaluation of the standard of care.

Against this legal and ethical background, one of the rarely discussed but very powerful aspects of the physician mindset stems from the searing nature of the experiences physicians undergo in training and later – namely, the power of life and death. The physician's behavior in relationship to the patient is highly charged with the potential to prolong life or to end it. Most physicians are keenly aware of this power and they are changed as a result of its impact on them. It colors their views of others with whom they interact in managing patients. It drives many of their decisions. Physicians recognize their own imperfections and the risk of making mistakes when they make critical judgments in the moment, often based upon imperfect information. Most physicians carry with them always the memories of those cases where they fear they erred or caused harm.

There is an unspoken bond among physicians who have shared this experience and a very real sense of distance from those who may have a medical degree but have not felt the profound impact of this awesome accountability. As physicians exercise their clinical judgment and fulfill their special role, this appreciation is always with them. In subtle and not so subtle ways this common history among physicians influences not only their relationships with their patients but also their interactions with others who can affect the outcomes of care. In some ways the interplay of individual fiduciary responsibility and legal liability generates and sustains the fierce autonomy demonstrated and sought after by many physicians.

Scientific Evidence and Dynamism

The keystone of medical training is science and the scientific method that requires proof of the validity of a teaching to be adopted by the student. So, evidence-based teachings, often reflecting empirical observation and consensus judgments, have long been the foundation of medical learning. This reliance on science is also part of what distinguishes physicians from other types of clinicians. As Reinertsen has observed:

> I think the distinction between the practitioners of so-called alternative medicine -- chiropractors, homeopaths, naturopaths, and others -- and those of us who claim our grounding in science is that the alternative practitioners are often very skilled at meeting the first two needs -- explanation and prognosis -- but they don't often actually change the future for their patients -- at least not for those with meningitis, or insulin-dependent diabetes, or comminuted fractures of the tibia and fibula or infarction of two feet of their small bowel. . . .
>
> For this is the real miracle that science brought to medicine. . .To truly alter the future, the doctor must have an effective craft – one worth knowing, not just a sham – and must use that craft with wisdom.[10]

The renewal of and commitment to a science base is a long tradition, although one which has experienced a very significant resurgence in the new era of "evidence-based medicine". Michael Millenson has documented the relative youth of the new movement to standardized care and data-based judgments.[12] Cohen has also observed:

> The standards of evidence are happily becoming more rigorous as we become more concerned about the effectiveness of what we do and as we become armed with more authoritative information on the outcomes of our choices. All physicians...can improve the outlook for their patients by ensuring that their practices are evidence based.[11]

Whether from randomized controlled clinical trials, empirical observation or expert consensus as its source, career-long knowledge renewal has become a hallmark of good medical practice. Continuing medical education is now so much a part of the tradition of medicine that in many states it is a condition of continued physician licensure; that is, state legislatures regard this as so fundamental to the practice of medicine that they will not permit physicians to keep practicing if they do not constantly self-educate.

This requirement also reflects another aspect of medicine based on science – namely its dynamism. Knowledge changes. Science teaches new approaches. Invention adds to the treatment armamentarium. The volume of information now available to inform physicians, even when restricted only to the peer-reviewed literature, is unprecedented. The use of new information in continued learning is aimed at another bedrock of medical practice – continued improvement in clinical care based on knowledge of what works. Good physicians draw from long-known information and combine with it the new knowledge produced in the never-ending pursuit of improved care.

Collegiality

Their educational experience also socializes physicians to a collegial style of interaction. In treating the patient they draw often on the intellectual capital of their medical colleagues. They must do so as multiple specialists interact on the patient's behalf. This intellectual interdependency is cultivated from their earliest academic experiences and continues for physicians in practice throughout the country. Physicians learn from their initial exposure to the discipline that a spirit of collegiality improves the care of the patient by seeking out multiple perspectives and experiences. This position has been renewed in discussions of the clinical benefits of group practice.[10]

Group learning is a predominant style of continuing education for all physicians regardless of practice setting, with grand rounds a prominent example of this approach. Here, physicians come together to share their perceptions of and reactions to the management of a specific patient or of a general clinical problem. The model is intended to generate discussion in an open forum from which all learn from the interactions. The group foundation for this type of interaction can be seen as somewhat paradoxical given the intense emphasis on individual autonomy which also characterizes physician behavior in other realms.

For the purposes of this paper, the importance of collegiality to physicians has a variety of consequences: They are relatively uncomfortable – at least by comparison with attorneys and businesspeople – with adversarial processes and styles of interaction.[13] The grand rounds model does not mandate arrival at a definitive conclusion. The approach produces a fairly fluid consensus style of decision-making, which is frequently seen by non-physicians as unbusinesslike, inefficient and dilatory.

On the other hand, this desire for collegiality stimulates a preference for group processes for decision-making. Although physicians are not typical team-players in the spirit of corporate traditions, they do identify with other physicians and often choose group mechanisms to express their objectives when they feel themselves positioned separately from other stakeholders with whom they interact. Although there is significant variation in the manifestations of physician collegiality within healthcare organizations and among individual physicians, collegiality forges a physician desire to find intellectual support in a group context even while acting in fulfillment of the recognition of ultimate individual responsibility for the patient. Drawing from collegiality exercised for the good of the patient, at its best the physicians' emphasis on collegiality can strengthen the ability to engender common vision and purpose directed at mutually agreed upon goals.

Due Process

Given these core clinical values, then, it is not surprising that in a non-clinical vein, physicians hold fast to traditions of due process when their own careers or activities are under review. For physicians, due process is the scientific method for determining the validity of the hypothesis at issue. Since judgment regarding physician competence has been a fundamental activity of organized medical staffs, consideration of this tenet is significant in reviewing those physician values that are important to accountable health care organizations.

Typically, where a hospital makes a case against a physician for corrective action or termination of privileges , the Medical Executive Committee or another body, makes a recommendation. This, in essence, becomes the scientific hypothesis – e.g. clinical privileges should be curtailed for a specific reason. The fair hearing provides the opportunity to test the validity of the hypothesis (like repetitive experimentation in the scientific method) in the crucible of cross-examination. By challenging the evidence and the basis for the judgment to see how it withstands intense scrutiny, due process is aimed at refining and assuring a better, more equitable outcome, because the ultimate decision will be based on the quality of the evidence and its capacity to stand up to concerted review. Although the exercise is not particularly efficient nor crisp, it does mirror the basic values physicians are taught in deciding a course of clinical action. While many physicians argue the equities of due process ("It is more fair.") in fact, much of what offends them when they are confronted with termination without cause provisions in a managed care contract, for example, is the absence of a testing mechanism with respect to the quality of the evidence upon which the harsh judgment rests.

This discussion has focused on only four primary domains around which physician values cluster. There are many other observations to be made about what sets physicians apart. But the matters addressed here critically define what physicians are, as those attributes are directly relevant to quality. These values are shared by physicians across practice settings, specialty training and age cohorts. Still, there are differences among physicians which are also relevant to their roles in accountable health care organizations. Typically these more refined distinctions are called into play with respect to the representative capacity of one physician in relationship to others. Because of the practical issues in drawing on physicians for their singular contribution to health care organizations, an appreciation of some of these differentiations is also important.

<u>Cultural Differences Among Physicians</u>

As alluded to above, perhaps what physicians feel most separates them from others in health care is their intimacy with the power of life and death, which remains an active factor for some throughout their careers and with others is experienced only in training. This separation is so meaningful to physicians that they consider those physicians who have never had significant clinical responsibilities outside of training to fail as peers of those who are actively engaged in clinical practice. Even among physicians who have had significant clinical responsibilities for substantial portions of their careers, but no longer do, other actively practicing physicians will consider them apart. This scale ranges from active clinical practice, to once having had clinical responsibilities, to those who have never really been tested in this way and therefore offer only a theoretical contribution – appropriate in some contexts as representative of physicians, but not really capable of speaking for physicians generally.

Among practicing physicians, the most traditional distinctions, so real as to be the subject of stereotype and humor, are those based on specialty training. Today, the lines between primary care (typically family medicine, pediatrics, general internal medicine and sometimes obstetrics and gynecology, or geriatrics) and specialty care are bolder than in the past, in part based on the new model of the primary care gatekeeper and primary care capitation. Since, in managed care, patients often access the rest of the system through a primary care physician, these practitioners become the customers of the specialists as well, in some settings. Specialists – by definition – have a more narrow, in depth focus on a particular clinical discipline. Primary care is more generalized.

Since much of academic medical training has been oriented around highly specialized activities, the resurgence of primary care into the forefront of the health care world represents a major change for the primary physicians as well as the specialists. And, there have always been distinctions among specialties– between the more surgical, procedurally based specialties on one hand and the more cognitive, diagnostic specialties on the other. Among physicians these differences are seen as more than just theoretical nuance and are often called into question in debates on representation. Among speciality categories, different clinical orientations reflect even more refined distinctions in practitioner behavior. Orthopedists often analyze and solve problems differently from internists, just as the internists are distinguished from neurologists, and so on. These differences can contribute to an enriched decision-making process when they are marshaled for the greater good; but they can also undermine efforts for a broader perspective.

Today, physicians also draw lines between those who are independent and those who are employed by another entity. Although many physicians have, through mergers and acquisitions, formed larger practice entities than were typical several years ago, many physicians distinguish between those who are employed by an institution or a very large group and those who are still seen as entrepreneurs. Moreover, in the physician activities within health care organizations, whether one is employed by the institution around which he is engaged with others in common cause is increasingly a point of comparison, particularly with respect to his representative capacities.

An ancillary issue to questions of loyalty and to whom the physician owes a primary allegiance also arises today more than before: Is the physician a volunteer or paid? Elected, volunteer department chairs in a community hospital, for example, are seen as having different loyalties from those chairs who are paid a stipend for their service as chair or are employed directly by the facility for those functions.

Finally, in this consideration, distinctions between leaders and those who are led are also at issue in addressing the roles of physicians. The extent to which physician leaders fulfill those functions both as representative of their constituencies as well as in the exercise of trusted independent judgment is sometimes a point of contention among physicians. Sometimes physicians hew to their specialty values although their constituency wants them to take a broader view. By the same token, however, sometimes physician leaders who act in the furtherance of the larger good of the group are taken to task for abandoning a more narrow representative function. Whatever these refined cultural differences, though,

they really have meaning mostly within a context in which physicians have a significant role to play in general. To what that role ought be directed is the principal consideration of this white paper.

III. The Continuum of Involvement

Against the background of an evolving health care system which is increasingly dominated by business considerations, the unique common values of physicians for the clinical content of care and particularly as it affects an individual patient, are not only unassailable, but as demonstrated in anti-managed care laws, essential to the American public's view of an acceptable health care system. Although the many different types of organizations and institutions at work in the health care world will stake out their strategic positions in a variety of ways, those health care organizations which would seek to assure their potential customers – purchasers and patients – that they can effectively provide good quality clinical care, cannot do so without seeking to incorporate meaningfully the special contributions that physicians have to make with respect to the most critical issues at work in health care.

Those issues parse out across a continuum of potential physician involvement. The taxonomy set forth here clusters around four degrees of physician input: (1) There are some matters which are imbued so clearly with clinical significance as to create an **imperative** for substantial, meaningful, directive physician involvement in their undertaking in order to safeguard the very values which physicians typify. (2) There are closely related issues which support the imperatives of clinical culture for which physician involvement would be **important** to a health care organization which seeks to be accountable for the clinical implications of its work. (3) Of lesser priority are matters in which it would be **useful** to incorporate physician perspectives. (4) Lastly, there are a range of activities which are part of health care delivery and payment about which physicians have no particular expertise or claim of legitimate influence and therefore, their involvement is discretionary and **not a priority**.

This elucidation is inherently somewhat artificial. The interconnectedness among and between activities and operational units in a well functioning organization are far greater than this analytical construct would imply. Still further, the continuum described here may in reality be more of a spectrum where the gradations are far less distinct and blur especially between the imperative and important issues. At the boundaries of this analysis it is clear that only a surgeon would hold the scalpel in an operation and that a physician most likely would not produce tax reports about a health care business. Within the parameters defined here, though, the role of physicians can be contributory in unexpected ways, illustrated by the following story: A health system planned a marketing campaign. The proposed newspaper advertisement prepared by the public relations department showed the image of a physician looking at an x-ray which was upside down. The mistake was only discovered by a physician who participated in a marketing discussion.

The extent to which any organization chooses to involve physicians along this continuum can be seen as a reflection of the value placed on the quality and clinical culture that entity chooses to create and project. In some ways, an understanding of how physicians are or are not utilized on those issues could be a measure of the accountability for clinical culture of that organization.

The process of developing the desired extent of physician involvement may also reflect a parallel continuum. For example, in some settings, where a well organized group merges into a larger system, the physicians will have experienced the full continuum of involvement in their own group and will then find themselves starting over again in the new organization. In other places, the range of involvement from imperative to not a priority, may represent evolutionary stages with gradual introduction of increasingly broader and deeper physician integration.

This section of the paper elucidates the types of issues which are included under each rubric of the physician involvement continuum. This taxonomy is neither immutable nor exclusive. It is an attempt to

begin to articulate an explicit understanding which is frequently missing from the debates on these subjects. The functionalities addressed under each heading are a first attempt. They are intended to be refined and refocused as each accountable organization defines its own mission and strategic goals.

Imperative

Whether in a hospital medical staff, the workings of an integrated delivery system, the operations of an HMO, or the affiliation with new partners by a PPMC, the first clinically significant judgment to be made is the selection of the physicians who will be included in the relevant network of participants. Although credentialing – determining whether applicants have the relevant recognitions in the form of licensure, clinical privileges at other facilities or contracts with other MCOs – has absorbed much system energy over the years, the process of gathering the information upon which that judgment can be made is now seen as essentially administrative and capable of performance by credentials verification organizations.

The actual selection of the physicians, though, and judgment as to whether they are competent to perform specified activities in the exercise of clinical privileges or contractual obligations is one of the most essential decisions an accountable health care organization can make. The process is one that does not stop with initial selection. It sometimes entails active recruitment of a specifically needed clinician. But of equal significance to fulfill a tradition of constant knowledge renewal and continuous quality vigilance, selection also necessarily entails on-going monitoring and evaluation of actual performance of the selected pool of clinicians over time. Where problems are found, this process, if accountable, requires education and corrective action for improvement and termination of those members of the network who cannot meet the ever changing performance standard which maintenance of clinical skills and knowledge requires.

These judgments were traditionally designated as peer review, for implementation only by physicians acting through the traditional organized medical staff. The process of selection and evaluation of physicians has evolved today to the point where there are others who can contribute to this undertaking as well, in gathering and analyzing data about applicants and those in the network, for example. But in the last analysis, the technical evaluations which are essential to the judgment as to whether a physician is competent to perform certain functions or demonstrates high quality performance can best be made by others with a fulsome understanding of the requirements of the task. Those others are usually physician peers.

Of paramount significance in the new arrangements which limit resource consumption and utilization of health care services is the basic judgment of what patients need for treatment of specific conditions. Review programs have the capacity to limit access to services or pay only for some services at a specific point in the disease process as opposed to other options. Those medical management programs, therefore, influence access to and utilization of clinical services and encompass extremely sensitive technical clinical judgments. They mandate, therefore, significant physician involvement both in their design and in on-going involvement in the application of policy decisions to individual cases. The importance of this activity in managed care and insurance programs has been demonstrated in the vastly increased regulation of the process of utilization review in many states throughout the country.[14] The involvement of physicians in the design and operation of these programs, along with others, is indispensable to a clinically legitimate program.

A related aspect of many of the new programs is the use of incentives – financial and otherwise – to motivate clinician behavior. Many of these systems have been designed and implemented with relatively little physician input. As a result, physicians chafe at their operations which have little clinical rationale or validity. Techniques of medical management which are designed to influence clinical behavior cry out for meaningful physician involvement in their design and implementation. Whether they will produce a program that denies patients access to medically necessary services or whether they can be refined so as

to motivate sharply focused appropriate resource consumption is part of the operations of the new system around which physician input is imperative.

A major trend in the new environment is an emphasis on standardization of care, away from unexplained variation in clinical treatment. To manage care effectively, many institutions and organizations are seeking to adopt clinical practice guidelines, protocols or pathways, to define those processes which are considered appropriate for treating patients for specific conditions.[15] These guidelines are beginning to drive the clinical culture of many health care organizations. They are used in the moment of delivering care as the basis for doctor-patient communication in selecting treatment options. They are used to profile practitioners as part of on-going monitoring to benchmark excellent performers from whom other physicians can learn and to focus attention on those who need education and corrective action. Guidelines can form the basis for negotiation of payment rates and as the foundation to construct physician incentive programs. Of critical importance – as if those uses were not enough – guidelines can be translated directly into tools for quality review and improvement.[16]

The selection and development of both clinical practice guidelines and the medical review criteria to be drawn from them are pivotal choices around which physician values must be brought to bear in the accountable health care organization. Analysis of data based upon assessment of performance in compliance with or deviation from established guidelines is a major determinant of clinical culture. Above all, the decisions that will be based upon the data reflecting implementation of guidelines are where the rubber hits the road -- these are the standards of quality for each organization. Since guidelines may be the basis for enhanced or diminished payment rates, maintenance or exclusion from a network, or major quality improvement initiatives, their impact in clinical terms will be significant. The importance of guidelines-based undertakings to staking out a clinical culture cannot be overstated. Embedding clinical premises into administrative processes and linking administrative mechanisms to clinical processes are also increasingly consequential for effective operation in a clinically motivated accountable organization. All of these clinically based processes, therefore, are an aspect of health care delivery that tracks unquestionably to the imperative end of the physician involvement continuum.

Finally, two aspects of the operation of an accountable health care organization relate to a more intense systemic focus on clinical improvement. Continuous quality improvement has become firmly rooted in the health care culture in this country, although the extent to which organizations and physicians actively embrace its precepts in practical terms is quite variable. In addition, attention has recently been targeted at the extent to which medical mistakes undermine health care quality in many hospitals, institutions and organizations.[17] Accountable health care organizations are deeply involved in activities which seek to identify opportunities to improve and then take actions to make a difference for the better. These activities are also imbued with technical clinical significance and therefore call for physician involvement. Continuous quality improvement and mistake avoidance are so overwhelmingly charged with a need to incorporate physician values and safeguard clinical quality as to mandate substantive, meaningful involvement of physicians in their design and execution. In contrast however, there are a range of other activities which either support these imperative functions or determine the context within which they can proceed.

Important

Many of the activities designated in this second category as important for physician involvement are the infrastructure upon which the imperative activities rest. These important undertakings then, are not the primary responsibility of physicians, but need physician involvement if they are not to undermine the imperatives.

So critical to an effective clinical culture as to rise virtually to an imperative is the role of information systems in an accountable health care organization. None of the management systems which can assure a

safe and quality-focused culture can be defined or improved, nor can care be managed effectively in clinical terms without information systems which are appropriate to the tasks at hand. Of even greater practical significance may be whether the information systems can actually be used by those who must interact with them. Many health care organizations have either succeeded or foundered on their information systems. Whether the information systems that support clinical culture are useable by physicians and whether the information these systems produce is credible and understandable by those who are expected to be persuaded and informed by the data are essential predicates for an accountable, manageable entity. Physician involvement here for those aspects of the system that will feed them and those whom they would direct is of major significance.

In payor contract negotiations one of the most momentous issues is the payment rate. Whether the rate proposed will support appropriate care for the applicable population ought to matter to any accountable health care organization. The actual analysis of the numbers is not the special purview of physicians, but consideration of the clinical implications of the negotiated rate is a matter which will determine – as it is intended to – the actual clinical content of care to be delivered. Consequently, physicians should be at the table in a meaningful way when these issues are decided.

Risk management vitally affects physicians and should involve them in a significant way, since physicians influence so much of what others within the organization will do clinically. Today, concepts of risk management go well beyond malpractice avoidance, but where risk management involves pure clinical mistake avoidance and management of issues where things have gone awry, the design of systems and involvement of physicians in support of these activities will be essential to their successful implementation.

Three aspects of management of the business of an accountable health care organization also are not primarily the responsibility of physicians, but have profound implications for the activities to which they do direct their attention: (1) strategic planning: what business will be in and how will we engage in it?; (2) budgeting – will the resources allocated support the goals to be accomplished? (3) manpower planning -- do we have the right constellation of practitioners and others to accomplish the tasks we have set for ourselves? These activities all draw first on the expertise of others in the system, but an accountable health care organization understands that the activities of the physicians are so fundamental to their business that they cannot engage in a worthwhile planning process for any of these three aspects of their business life without physician input. Once the planning process is completed, the same analysis is relevant to the on-going management judgments which will define the boundaries of what the clinical culture of the organization can achieve.

Useful

Activities around which it is useful to involve physicians from time to time or in more limited ways are those which can influence the imperative and important undertakings but they are not primarily directed at quality or clinical culture issues. Payor contract negotiation that does not entail whether the rate can support quality is important. The topics at issue in a payor contract are diverse. Although administrative requirements to which physicians are to adhere and an understanding of their appeal rights and responsibilities within the many management programs created by a managed care entity do legitimately involve aspects of care about which physicians will care – and they should – other matters such as coordination of benefits, term and termination and choice of law provisions are of relatively little import to the clinical quality focus of physicians.

Billing systems that draw on physician documentation or require direct physician input reflect the clinical decision-making of physicians and, in the current context, often form part of the basis for data analysis. So, whether these systems can be handled effectively by physicians and whether they speak in terms

which will in fact gather the information sought are questions around which physician contribution can make a difference.

Within an accountable health care organization, financial and administrative reporting will provide information that may be of interest to physicians and can provide them with a more complete understanding of their relationship to the overall enterprise. This understanding can enhance the entity's operation generally, but only in limited ways will it influence the clinical culture.

All health care organizations are involved in marketing their services in one way or another. They make claims about performance; they make claims about efficiency and cost savings. Much of what they say is puffery. Other pronouncements merely restate what others have said ("We have ranked consistently in the top 5 hospitals in the metro area in our five year survival rates for breast cancer as reported by the Community Inquirer newspaper"). Physicians do not have any special claim on participation in those activities. On the other hand, where the physicians are the subject of the relevant marketing activities, they will want involvement to assure the validity of what is said. In addition, an accountable health care organization will seek their support and therefore some involvement in that activity.

Finally, as customer satisfaction has become a measure of quality and external data reporting becomes a more significant activity, where the data to be reported will implicate physicians and, therefore, the accountable health care organization seeks the application of their energies and initiatives to improved performance, involvement of physicians in understanding what is reported, how, and conclusions to be drawn from data will be key.

Not a Priority

There are many basic activities in the operation of health care organizations around which physician involvement is not a priority. Human resources and materials management influence the setting within which physicians work, but are not particular objects of their expertise. Marketing and public relations generally, claims payment management, housekeeping and the retail businesses (e.g. gift shop, restaurants) are also examples of such operational areas.

IV. Principles of Physician Involvement

The fundamental need to involve physicians in specific strategic areas of the operation of accountable health care organizations has been observed by those studying issues of integration and transformation of the health care delivery system. "It is simply not possible to achieve any measurable level of clinical integration for patients without a close relationship of physicians with an organized delivery system."[18] This recognition is increasingly implemented through formal incorporation of physicians into the governance of forward looking health care systems.[19] In order to get the real value of physician involvement interwoven into the fabric of the accountable health care organization culture, taking into account the attributes and values of physicians, certain operating principles will be critical.

Above all, to make any process or structure work, the physicians will have to participate at the table with real power to influence the outcome of the process where it counts – namely, as appropriate to the activities where they matter, along the physician involvement continuum outlined above, from imperative to useful involvement. Zuckerman et al[20] describe the need for those with power to truly be willing to share it if these initiatives are to be meaningful and effective. Although there is no question that physicians no longer have an exclusive claim to affect these issues, their sphere of influence must be given meaning through structure and process that reflect the importance of their contribution to each specific function. This approach has not been found in the typical hospital medical staff experience which in some communities has been relatively inconsequential; in others has been adversarial; and in still others has relegated physician input to one of mere advice. The current public policy environment is

so apprehensive of the loss of physician values in the burgeoning business culture of health care that explicit consideration of the role of physician values in accountable organizations demands a commensurate, careful elaboration of the extent of their authority and involvement on specific topics.

To make the participation work, multiple commentators have observed that there must be mutual trust between the physicians and other relevant constituencies, prime among them the governing board of the accountable organization. At the same time, (as described more fully below) the process will have to foster trust among the relevant physician actors as well. Hallmarks of a worthwhile process and structure are open, frequent, and candid communication among the relevant actors. If the processes where the real decisions are made take place in the corporate boardroom from which physicians are excluded, they will feel the truth of their situation, that they have been marginalized. Although trust is generally earned in the doing of the activity, recognition by the relevant parties, at the outset, of the need for integrity and credibility of dialogue is essential. This means that both the physicians and those with whom they collaborate must do what they say they will do consistently over time. In addition, the importance of the sharing of data cannot be overemphasized. Physicians by their training are called on to evaluate raw data. Consequently they are mistrustful of interpretations of data when they are not provided with the underlying basis for the conclusions or recommendations presented.

If physician involvement is to work over time, the visibility of the physicians in the critical processes will enhance the undertaking. Sidebar, informal cloak room/cafeteria dialogues do not accomplish this purpose. To gain the support and trust of the physician constituencies which are so crucial to the strategic goals of an accountable health care organization, the physicians must know and have evidence of the value placed on their involvement. Recognition of how the physician need for collegiality fosters a group-based mechanism as the platform for their contribution will also matter in creating productive physician input.

As due process is a primary tenet of the physician culture, implementation of physician involvement through fair and equitable procedures with rules that all parties have agreed to in advance can go a long way towards supporting a cooperative partnership.

In many organizations, steps to involve physicians in the ways described here will represent a radical departure from the past. For the physicians themselves, they will be asked to draw on skills for which they have not been academically trained. An accountable health care organization will acknowledge and support physician education necessary for physician involvement to be effective.

In a recent consideration of the role of physicians in successfully integrated health care enterprises, Zuckerman et al. have drawn on the eight “i’s” of successful strategic partnerships:

1. The partnership must be strategically important to the participants.

2. It should be viewed as an investment requiring resources and time.

3. The partnership must be based in mutual interdependence. A key concept acknowledging that the future for physicians and hospitals/systems is intertwined, and that together they can accomplish what neither could do alone.

4. Each partner must display individual excellence.

5. There must be real integration of purpose and activity.

6. Open, frequent, and candid exchange of information is central to effective collaboration.

7. The partnership must be institutionalized.

8. The interchange among the partners must be based on integrity, on relationships based on trust, commitment, good faith, and honesty in dealing with one another.[20]

While these observations have been made primarily around the activities of integrated delivery systems, the fundamental principles come from industry generally and are useful in other models of health care organizations as well.

V. The Rationale for an Organized Formal Process to Include Physicians

To incorporate the values of physicians (II (1)) in a workable manner, utilizing the principles which are important for strategic partnerships (IV), one is led inevitably to contemplate the utility of an organized formal process/structure to accomplish these goals. Given the diversity among physicians (see II (2), above), and the need for trustworthy, visible processes of physician involvement, it is essential to provide an orderly mechanism for physician collaboration.

Organized Process

In the traditional hospital-medical staff the medical staff bylaws have performed the role of outlining the rules of engagement among the parties. In many jurisdictions, the bylaws are considered a contract between the corporate board and the members of the medical staff. In the same way that the law of contracts requires a meeting of the minds, exchange of consideration between the parties, and a clear articulation of the purposes of the relationship, some formal enunciation of the nature of the involvement of the physicians in those content areas where they will be more actively engaged as well as their responsibilities in assuming accountability as described here would be fundamental to the principles of effective integration.

Some document elaborating the principles of interaction and structure of their implementation -- whether in bylaws, principles of operation, memoranda of understanding or some differently designated policy -- can serve several functions in fulfillment of the creation and implementation of a strong, quality oriented clinical culture[21]: (1) The process of adoption clarifies the understandings of the actors and assures a common vision for both the nature of the enterprise and the methods by which its strategic goals will be accomplished; (2) Articulation of the relevant spheres of influence along the continuum of involvement mitigates the risk of unnecessary and counter-productive conflicts over role definitions. (3) Formal adoption of a series of principles speaks to the relevant internal constituencies -- including non-physicians -- who will have concerns about the scope, purposes and accountabilities of physicians in the organization's operations. (4) A document solidifies the visibility of physician engagement that enhances the credibility of the process as well as the commitment of the organization to its selected clinical culture. (5) The document can speak to external stakeholders as a manifestation of the seriousness of the value context adopted. In the absence of a formalized structure, the risk of too many voices and the wrong voices in the dialogue will increase. In addition to clarifying the expectations of the parties, an organized mechanism can provide a pathway for more effective communication.

Through a formal process and/or structure, there is a place for an accountable health care organization to itself lodge the accountability of the physicians for the substantial responsibility suggested here to bring their values to the forefront of the organization's culture. Since all the physicians involved in any one of these organizations cannot possibly be included at once in all of the activities along the continuum of involvement, an organized process/structure can assure that representative functions are fulfilled appropriately. Just as collegiality motivates group dynamics, representation implies a mechanism to select representatives; so, how selection of representatives occurs ought be addressed explicitly. A corollary of representation is a mechanism to accommodate diversity among physicians and a respect for

minority viewpoints. Because of the crucial issues upon which physicians and accountable organizations will contend, tensions will surely arise. If there is a formal structure through which dialogue and process can proceed to mediate tensions, the entire endeavor will be more effective.

Still further, the physician value on due process and equitable procedures requires a formal mechanism where the respective rights, responsibilities and obligations of the parties is set forth. The principles of due process do not mandate a specified schema. Rather, due process, even in constitutional terms, requires only that process which is due, given the nature of the determination to be made. Within accountable health care organizations, different decisions may require different procedures. The point is that some rules of engagement will be necessary for all the parties to understand the principles of interaction.

For the physicians acting through an organized mechanism, the organizational structure becomes a vehicle to transmit physician-representatives' knowledge of the process and its mechanisms to physician successors. This assures a perpetual renewal and reinforcement not only of the fundamental values that the partnership and collaboration of the physicians with the accountable health care organization have created, but also of the efficiency of their inclusion. Without a clear understanding of how new physicians enter the dialogue, while those with longitudinal perspective remain for some time, the risk increases for constant reeducation of the participants without a seamless continuation of hard won effective integration.

Accountable health care organizations represent diverse constituencies including other practitioners and internal stakeholders who can bring different values to bear on the issues to which physicians should be speaking. Therefore, at various points on the physician involvement continuum it also becomes important to define the respective roles of the multiple stakeholders where multidisciplinary values are to be incorporated and to identify where physician primacy may be more important. As the continuum suggests, there are some matters on which physician involvement and values should be more directive of the outcome than others. For that reason, an organizational structure provides a defined framework to accomplish that purpose.

To maximize their contributions, an accountable organization should seek to have the most constructive physicians performing representative functions. Therefore the qualifications and characteristics of those individuals – both to reflect diversity of the physicians and to assure that the most effective physicians are involved in these critical tasks – can best be accomplished through a formal organized structure. Making sure that the right people are involved is also a major determinant of the success of physician involvement – to the physicians as well as to the organization to which they relate.

Who Are the Right Physicians

It is beyond the scope of this immediate consideration to describe the attributes of effective physician leaders.[22] But, if the values of physicians are to be incorporated into an accountable health care organization in a way that will maximize the capacity to benefit from their unique potential contribution, it is essential that the right physician players are at the table. Selection of the relevant leaders must speak to the needs of the organization as well as the needs of the physician constituency. Five basic traits are critical:

1. Because of the physicians' concern with respect to their representatives' understandings of the tensions and anxieties they feel in the current setting, it is vital that the leaders be physicians who have in fact practiced in the trenches, experiencing the reality of the working lives of those for whom they would speak. While that does not mandate that every physician at the table must be someone in active clinical practice, it does mean that turning to theorists, physicians who are

long removed from clinical practice, will in some settings undermine the effectiveness of those individuals as credible representatives.

2. Whoever is chosen to represent the physicians must have standing among them – peer respect within the physician culture.

3. Physician leaders must have demonstrated integrity and the ability eschew personal or specialty specific parochial goals in favor of the broader good even while they perform their representative function.

4. Effective physician leaders for these purposes will be good communicators who can simultaneously translate and communicate from and to the physician constituency as well as from and to the others at the table. The representative function is one which entails essential information conduit activities.

5. Those who are engaged in the activities along the physician continuum must be those with a willingness both to learn the skills necessary to perform effectively and to teach others within the physician culture how to relate within the broader clinical culture of that accountable health care organization.

Challenges for Physicians

To make an activist physician involvement real, incorporating the principles of engagement (III), through an organized mechanism (IV), that draws on the talents of the right people (IV.I), many physicians around the country relating to the varieties of organizations at issue (e.g. hospitals, integrated delivery systems, MCOs and PPMCs) will have to change certain behaviors associated with the traditional hospital medical staff. In addition, there are challenges in this exercise which should be explicitly understood by physicians before they enter into a reinvigorated role in the new context.

Physicians who seek to sit at the table as directive and influential participants along the continuum of involvement must be willing to be accountable for their role. This means taking the heat when difficult decisions are made and members of their constituency are unhappy or threatened by the organization's chosen strategic goals. Physicians as a group within accountable health care organizations that involve physician leaders extensively along the continuum must learn to trust their representatives. Enlightened leadership based on intra-professional trust cedes to the leaders the ability to make independent judgments as necessary to the task at hand. Insistence on a "town meeting" culture where all physicians speak to all issues will undermine the capacity of accountable health care organizations to recognize a reinvigorated role for physicians in the development of a quality clinical culture. In some cases, accountability may mean replacement of selected representatives when their involvement is not effective in light of the broader needs of the organization.

Physicians do not deal well with major system change. Moreover, the vast changes of recent years have been so disquieting to physicians that any context in which additional change is imposed on them is seen by some as threatening and potentially a further encroachment on the autonomy that characterized their former lives. Management and strategic consultants abound on dealing with issues of change and chaos within organizations. Those issues are beyond the scope of this consideration but must be acknowledged as a potential impediment to successful integration.

Physicians involved in these activities will have to be able to practice a respect both for diversity of opinions and multidisciplinary values to be accommodated throughout the enterprise. Minority viewpoints, however, need also be taken into account without reliance on the traditional physician model of consensus decision making. Often in physician organizations major issues are revisited continually

until those who are unhappy with the proposed judgment become more comfortable with it. This is so inefficient as to undermine the credibility of physicians when they work with others in a more business-like environment.

On the side of the organization itself, volunteerism, which has traditionally characterized physician involvement in the hospital medical staff context, can only go so far. Others who are at work on the issues to which physicians would speak are economically valued for their contributions. Physicians cannot participate effectively and fully if they stand at economic loss for doing so. Some recognition of the economic value of this participation, then, will be important in some clinical cultures. On the other hand, it should also be acknowledged that when such stipend or economic recognition is made available, it can also color the views of the physician constituency with respect to the loyalties of a leader. There is no defined answer to this issue but it may well have to be addressed in multiple settings. For many physicians, learning what is necessary to perform effectively in these settings will represent yet another demand on their time in an environment in which they feel beleaguered under any circumstances. Effective participation, though, will require commitment on the part of the leaders to move through this transitional process with some sacrifice.

Traditional organized medical staff activities have worked very well in some settings. In others, however, common criticisms have been levied about some ways in which physician organizations have been less effective:[23] a multitude of redundant, large committees to perform functions delegated to the staff; inconsistent physician attendance in these processes which undermines continuity; selection of representatives based on popularity rather than their capacity to function as true leaders and representatives; separation of the physician functions from the real action out of a paranoid desire for autonomy; anachronistic focus on departmental concerns; dilatory, consensus based decision-making which impedes timely maneuvers; unproductive insistence on broad based individual member involvement in relatively minor issues (town meeting culture); annual or biannual turnover of physician leadership; and lack of physician leadership training have all been cited.

To overcome past failings and meet the challenges of the new settings, physicians in accountable health care organizations should expect to be held accountable themselves for their contributions to the clinical culture they would seek to create. Performance evaluation is a developing core attribute of the entire health care system and should be expected to apply here too.

There is no monolithic mechanism that could legitimately be proposed for the many varieties of entities and the diversity of markets in which physicians will find themselves confronting these issues. Nonetheless, wherever a physician-involved clinical culture emerges, it will reflect recognition of the singular values physicians bring to the organization. At the same time though, involved physicians ought to recognize the need to accommodate and collaborate on these issues. Rigid insistence on a semi-autonomous mechanism will undermine the physician contribution. On the other hand, compromise of clear clinical values in the blind furtherance of business goals alone will destroy the balance which is the very purpose of a strong, defined physician role.

VI. Benefit to Accountable Health Care Organizations

Overarching all of the activities of health care organizations today is a dramatically increased emphasis on performance measurement and data describing how care is provided. The debate over quality is more and more grounded in real information about what physicians, hospitals, systems and managed care organizations are doing for the communities and constituencies they serve. This shift to evaluation of performance based on data will only broaden and intensify in the near term. Accountability of health care organizations will find its proof in both regulatory and market behaviors. Within this unfolding drama, each of the major organizational actors to which physicians relate will want to subscribe to the principles articulated here for their own purposes.

Hospitals

In many institutions around the country the hospital medical staff flourishes and performs effectively its delegated responsibility from the governing board, advising them with respect to clinical issues. In many other locations, though, the traditional medical staff is no longer at the center of the fundamental activities of the organization. In many settings where there are dysfunctionalities between the organized medical staff and the hospital governing board, these exist because of a failure to recognize the vital contribution of the medical staff in new business initiatives as well as the failure of the medical staff to re-conceive their role in light of the new reality.

A successful hospital in the latter part of the twentieth century will recognize the centrality of its clinical culture to its ultimate purpose –to provide health care services to patients and communities. Such an institution will want to legitimately claim that this essential role is being performed with explicit recognition of the singular premium placed on the doctor-patient relationship and physician values. As the business culture has come to dominate much in the hospital setting, reassurance of this commitment will be increasingly important not only ethically but also strategically. Hospitals that seek to position themselves as patient-responsive organizations will want to walk the walk and not just talk the talk of a physician-involved clinical culture. In a more data driven environment, to the extent that physician involvement enhances quality and clinical care, in a well integrated, accountable organization, better statistical results should be the consequence. More immediately, a well operating clinical culture will also enhance risk management. It will not be possible to do the right thing for patients and to improve the way that is done over time without a strong, visible role for the physicians from whom so much of the other activities of the hospital emanate.

Physician Practice Management Companies/Management Services Organizations

Even where physician practice management companies or management services organizations have bought physician assets or are managing physician businesses, the fundamental principles articulated here will be relevant. Physicians are their customers. To proceed without their intimate involvement in creating the clinical culture for which the business will stand is foolhardy. The activities of these organizations are not joint ventures but an exercise that is purely derivative of the practice of medicine. Logically, then, enhancing the clinical viability of their customers should be a major motivating force for these companies as well. For these companies to both manage and to represent effectively in contract negotiations their physician customers, the managers will have to be able to speak to the clinical credibility of their customers and networks in a quality driven world. Business expertise will be insufficient to prevent concerns, already expressed in the lay press, around the business culture of these entities and the way they are reorienting the physician practices that they manage.

Integrated Delivery Systems

In the integrated delivery system, the difficulties in managing the borders between and among multiple hospitals, facilities providing other levels of care, multiple physician networks, employed physicians and subsidiary and ancillary business activities is daunting. If the lawyers and financial managers who designed these systems create settings without a strong physician presence along the continuum of involvement articulated here, the clinical culture will be lost in favor of boxes and arrows on an organizational chart. One of the fundamental challenges for integrated delivery systems is true integration. Many of them today reflect corporate and organizational re-orientations without much infrastructure. The purpose of creating these entities has purportedly been to achieve through concerted effort and collaboration around a central organizing principle more efficient, better functioning operations which otherwise would be redundant and cost enhancing. If the integration in these delivery systems is to have any meaning, as multiple commentators have observed, the role of the physicians is undeniable.[24]

As these integrated delivery systems take more financial risk, they become more like managed care organizations and subject to the same anxieties the public has generated around those entities.

Managed Care Organizations

At the top of this pyramid and the focus of the principal anxieties of the American public today are managed care organizations where people fear that green eye shades have taken over the way their care will be provided. Being able to speak of and through a physician driven clinical culture cannot help but rebuild consumer confidence that their individual clinical needs will be met when care is provided to them. As the caselaw increasingly imposes on these enterprises liability for outcomes to their patients and subscribers, truly interweaving a clinical culture into the fabric of the organization will be more critical from a business perspective. Still further, the varieties of data produced, demanded and generated about these organizations will only increase. A quality sensitive clinical culture will enhance strategic positioning of these organizations when they choose to step up to the plate and be accountable for the fundamental business in which they are engaged.

VII. Conclusion

There is no question that the industrial revolution of the last four years has been oriented around the need to change clinical behavior away from what happens in a world of unfettered payment which, at its extremes, motivates increased utilization of services without reference to their clinical necessity. As the need for more business-like approaches has been fulfilled though, widespread questions about compromise of quality have been expressed.

This paper has made the case in the most basic terms for system-wide, reinvigorated incorporation of core physician values into health care. The need for a reemphasis on the clinical legitimacy of health care businesses is manifest. The primacy of physician involvement in efforts to make health care enterprises accountable for quality will be key to any believable efforts. To make any such undertakings work, critical principles of engagement set forth here will have to be brought to bear; and, to give meaning to such a strategic initiative an organized mechanism, well- articulated, endorsed and supported by the highest levels of the organization will be essential. The core competency for large parts of that initiative rests with physicians. Their meaningful involvement so as to truly affect how the business of health care is conducted will characterize accountable health care organizations because it will safeguard the quality of care. Accountable health care organizations of the twenty-first century will find a way to successfully develop and project their clinical cultures to speak to the compelling, fundamental purpose around which these organizations exist -- to provide decent health care of an ever-improving quality to people who need it.

Appendix

1. See, Gosfield, "Who is Holding Whom Accountable for Quality?",16 Health Affairs, 26-40 (May-June, 1997).

2. See Moskowitz, Ranking Hospitals and Physicians: The Use and Misuse of Performance Data, Faulkner and Gray, New York 1994.

3. See Gosfield, Chapter 5, "The Wheat from the Chaff: Accreditation and Regulation", in Gosfield, Guide to Key Legal Issues in Managed Care Quality, Faulkner and Gray, New York, 1996, pp. 111-132.

4. NCQA, Health Plan Employer Data and Information Set 3.0, 1997.

5. See Roth, Chapter 6, "What Big Brother is Watching: Federal Controls on Health Care Quality" in Gosfield 3.

6. See discussion of U.S. v. Geri-Med in Gosfield, Chapter 4, "Carrots and Sticks: The Federal Fraud and Abuse Laws and Quality" in Gosfield 3.

7. See Gosfield, Chapter 2, "Who's Responsible?: Liability in Managed Care Caselaw", in Gosfield 3.

8. Harper v. Healthsource New Hampshire, Inc., (No. 95-535, Supreme Court of N.H., April 6, 1996).

9. See, Landau et al, "A Conceptual Model of the Effects of Health Care Organizations on the Quality of Medical Care", 279 JAMA, 1377 (May 6, 1998); and Rothenberg, et al, "Changing Pediatric Practice in a Changing Medical Environment: Factors That Influence What Physicians Do" Pediatric Annals 27:4/April 1998, pp. 241-250.

10. Reinertsen, "Health Care: Past, Present, and Future,", Group Practice Journal, March/April 1997, pp. 37-43, at 38.

11. Cohen, "Remembering the Real Questions", Annals of Internal Medicine, 1 April 1998 128:563-566.

12. See, Millenson, Demanding Medical Excellence: Doctors and Accountability in the Information Age, University of Chicago Press, 1997.

13. For a broader discussion of the cultural differences between attorneys and physicians and their implications for conducting business transactions, see, Gosfield, "Physician Practice Concerns", in National Health Lawyers Association, Health Law Practice Guide, Vol. 3, Chapter 35, Clark Boardman Callaghan, Ltd., New York City, 1997.

14. See, Gosfield, "Is Less Really More?: Utilization Management in the 1990's", in Gosfield ed, Health Law Handbook, 1996 ed., Clark Boardman Callaghan, New York, pp. 89-122.

15. See, Field and Lohr, Guidelines for Clinical Practice: From Development to Use, National Academy Press, Washington, DC, 1992.

16. AHCPR, Using Clinical Practice Guidelines to Evaluate Quality of Care, HHS, PHS, AHCPR Pub. No. 95-0045, March, 1995.

17. See, creation of AMA's National Patient Safety Foundation, among other similar initiatives.

18. Shortel, Gillies & Anderson, "The New World of Managed Care: Creating Organized Delivery Systems", Health Affairs, Winter, 1994 at 53.

19. The Hospital Research and Educational Trust, Governing Health Systems: Ten Stories Milbank Memorial Fund, 1997, New York City; National Committee for Quality Health Care and Health Care Horizons, Six Competitive Health Care Markets: Putting the Pieces Together, October, 1996.

20. Zuckerman, et al, "Physicians and Organizations: Strange Bedfellows or a Marriage Made in Heaven?" Frontiers of Health Services Management, 1998, pp. 3-34.

21. For an articulation of the ways in which medical staff bylaws define and reflect institutional culture see, Gosfield, "Defining Institutional Culture: The Role of Medical Staff Bylaws in Hospitals and HMOs", in Gosfield ed., Health Law Handbook, 1992 ed., Clark Boardman Callaghan, New York, pp. 299-326.

22. See Reinertsen, "Physicians as Leaders in the Improvement of Health Care Systems", Annals of Internal Medicine, May 15, 1998, 128: 833-838.

23. For some criticisms of past experiences see Lord, "The Changing Role of the Organized Medical Staff: The Challenge for Medical Staff Leadership", The Physician Leader's Guide, Bader & Associates, Inc., 1992, Rockville, MD; Horty, "The Successor to the Medical Staff: How to Get There From Here", Action Kit for Hospital Law, May, 1994; Fifer, "The Hospital Medical Staff of 1997", Quality Review Bulletin, June, 1998, pp. 194-197.

24. "You need to solidify the various components of your system, and physicians have to be part of the team because they drive costs and qualities; if they are not with the administration you are not going to be successful.""Physicians who have a role in managing the hospital have an increased motive for cooperation.""Physicians as partners should have a direct say-so in putting the system together.""Physician leaders at the highest levels of governance and sure that physicians' vision is adequately represented on the Board and that management is responsive to physician needs." All quotes cited in n.18