re**marks**

Culture Clash

Employed physicians and hospitals are often finding themselves at odds. To make the marriages work, hospitals and physicians must both do their parts, says one director of recruitment.

BY SUE OLSON

In the early 1990s, hospitals adopted the gatekeeper model hoping to gain access to managed-care contracts and to better control health care in their local and regional markets. Developing a primary-care network (PCN) by employing physicians made sense. It was the right strategy at the time. Hospitals expected to emerge stronger and better positioned than they had been previously.

However, hospitals quickly learned that they did not understand the business they were getting into, and they greatly underestimated the financial and administrative integration that would be necessary to successfully run a primary-care network. Today, hospitals frequently ask themselves why they hired physicians in the first place, and very often they wonder if the stress and the financial loss they have endured are really worth it.

Conflicting priorities

Business values, management styles, culture, and strategy are very important big picture issues. In the recruitment process, hospitals talk with physicians about what it will mean to be employed by the hospital, but either they don't concentrate on the issues enough or physicians don't listen carefully enough.

Regardless of whether they are employed or independent, physicians want control of their practices, control of their patients, and to retain their autonomy. At the same time, they want the financial security of employment and to avoid the down side risk that is inherent in health care.

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The culture clash between a for-profit practice and a not-for-profit hospital takes both physicians and hospitals by surprise. Hospital administrators tend to manage a physician practice like another department of the hospital without getting the buy-in from hospital directors that will mean the success or failure of internal integration. The slow pace at which most hospitals make decisions, from procurement to staffing, is simply not understandable to physicians. And most certainly, physicians do not fully understand the need for JCAHO surveys or how and why hospitals are influenced by the Stark bills or the Fraud and Abuse Act.

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These are frustrating issues for vice presidents and CEOs who are ultimately responsible for the profit or loss generated by their employed physicians. When hospitals have trouble gaining physicians' full cooperation in these issues, they truly question whether or not physicians considered what it would mean for them personally to become employed and thus give up a portion of their entrepreneurial spirit.

The learning curve

Ouch! If physicians did not fully understand what they would have to give up for the security of employment, hospitals were not as prepared as they thought they were to manage the business of physicians. Their business savvy showed they could successfully run a for-profit venture. What they didn't understand was the scope and complexity of a physician's practice and what it would take to integrate a PCN into the hospital system. The following reasons, among others, contribute to the failure of physician employment arrangements:

- cultural differences
- loss of autonomy by physicians
- lack of trust between physicians and hospitals
- lack of strategic or business plan for the PCN beyond the recruitment phase
- management inefficiencies
- insufficient resources dedicated to integration
- slow paced integration efforts
- poor communication

Although it may have been slow in coming for some hospitals, they are more than willing to admit their shortcomings and step up to the plate to correct the problems. Hospitals are willing to commit their executives' time and their finances to address these issues. They have to. In a recent national survey by Coopers & Lybrand, hospitals were found to be losing an average of $97,000 per physician annually. The seriousness of this type of loss affects a hospital's bond rating and its ability to do business. Hospitals simply cannot afford to sustain the operational losses associated with their employed physicians.

Physicians also have a lot of work to do if employment arrangements are to be successful. They must be willing to provide leadership within the hospital's departmental organization. Some think it will take physician leadership at every level of the hospital organization, from information systems to administration, before integration will be successful. The physicians who are willing to provide this leadership must also realize that their involvement will take some getting used to by hospital directors who are bound to feel threatened by their presence. Despite this opposition, physicians must be willing to communicate their feelings and opinions through active participation on governance committees, in strategic planning processes, and by taking a role in conflict management.

The Financial Nightmare

MGMA's recently released publication, *Cost Survey: 1999 Report Based on 1998 Data*, reveals that hospital-owned groups typically are not as fiscally sound as their physician-owned counterparts.

Physicians often say that their practices made money before the hospital purchased them, so they can't understand why the practice fails to break even after the purchase. Physicians however sometimes fail to admit that their income has actually increased now that they are employed, regardless of how profitable the practice is as a whole. It's really not their problem if collections are low or if reimbursements have decreased. They look to the hospital to fix these problems without the physician's help.

Financially speaking, the deck of cards is often stacked against the hospital-owned practice. Changing a hospital's accounting systems to accommodate a PCN has proved to be much more complicated than anyone imagined. It may be one of the main reasons hospitals are unable to get a grip on practice expenses early in the relationship.

For one thing, practices are accustomed to operating on a cash basis and hospitals tend to operate on an accrual basis. Also, when hospitals strip away ancillary revenues from their owned practices without at least giving the practice credit for this revenue, it causes the practice to look even more unprofitable than it may actually be. The health of the practice begins to pale even further when hospitals add in the depreciation, amortization, and other types of expenses that are typically charged back to the practice by the hospital.

Another factor is that physicians in a start-up mode are very often paid at full compensation rather than on a sliding scale, with their pay increasing over time as their productivity increases. Hospitals use the employment model and a full compensation package to attract employed physicians. It does allow them to recruit better physicians, but it would not be economically feasible in a private practice environment. This is changing, however, as hospitals across the country are taking a tougher stance on this issue. Physicians are being hired at a percentage of their desired salaries with the opportunity to earn the remaining portion through incentives. Physicians who want to work hard will do well, but physicians who do not want to excel will find themselves earning less money or perhaps

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relocating to another opportunity.

The Challenge

How can these relationships be improved? Hospitals need to clearly communicate the mission and strategy of the primary-care network to their physicians and hospital support staff. Management needs to fully understand why the PCN is important to the hospital system. Hospital departments need to be retrained in the support of physicians' practices. Physicians and management need to know what their responsibilities are and who has final authority.

Physicians need to be recognized for their clinical expertise and hospitals need to step back and let physicians have more input in the health-systems' management. Physicians must create their own medical group culture within the primary-care network, while hospitals must put the infrastructure in place to help physicians be successful. Hospitals must standardize the billing and collection processes and put the information systems in place so physicians, their practices, and the hospital are linked to each other.

The key to success is a true partnership between physicians and hospitals and a sharing of responsibilities. Both physicians and hospitals have to look beyond any friction that exists and collaborate. Employment arrangements are relational and, like any strong relationships that endure, they require strength from both parties, trust, and a commitment to succeed. ■

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