

REFORMING THE HEALTH CARE STRUCTURE

Physicians and Hospital Leaders Must Come Together in a Genuine Partnership

We are now seeing the beginning of the end of what might be called the “industrial age of medicine.”¹ Health care in the 20th century was delivered almost exclusively in hospitals and long-term care (LTC) facilities. But the new century has brought with it a focus on new technologies, innovative treatments, and a new sensitivity to patient preferences, and these have changed how and where health care is delivered. Today care is often provided in a much less intensive setting than the hospital or LTC center; sometimes the venue is the patient’s own home.²

Current surgical and procedural trends—including recent developments in minimally invasive surgery, nanotechnology, and robotics—portend changes as yet unimagined.³ These trends raise certain urgent questions for health care leaders: Are they, for example, planning now for the demise of the familiar hospital infrastructure? Are they working for a less institutional, more fluid, highly mobile, and nimble system than the one they now lead?

STRUCTURES OF THE PAST

Almost everyone agrees that today’s health care infrastructure is rapidly becoming obsolete. Here are three examples.

The Changing Role of Nurses About 80 percent of the work done by nurses is based on the 20th-century belief that health care is best delivered in hospitals during admissions that require the patient to stay at least several days.⁴ Yet the average length of patient stays has fallen dramatically in recent years; for some treatments and procedures, hospital stays have been eliminated altogether. As a result, much of the work that nurses once performed in hospitals is now done elsewhere by other people. Although nurses often say they

don’t have time to do their work, they fail to realize that much of it could be done in other settings, often by the patients themselves.

The resulting dissatisfaction has led, on one hand, to nurses’ complaints that they no longer have an opportunity to use all the skills they were taught, and, on the other, to patients’ complaints that they no longer get all the nursing services they are used to receiving. The so-called nursing shortage is, in an important sense, additional evidence that the 20th-century hospital system has become an anachronism.

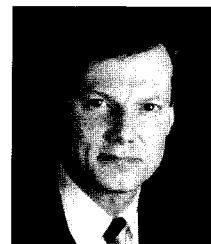
Both nurses and patients must be reeducated. Patients need to be taught how to help themselves; nurses need to learn new skills. Neither nurses nor patients will be satisfied until they change their relationships with each other.

An End to Compartmentalization The new age in health care requires a much closer alignment of hospitals and physicians, of tangible resources, on one hand, and cognitive/procedural skills, on the other.⁵

Unfortunately, the traditional hospital structure impedes this realignment. The compartmentalization represented by medical staff bylaws, unilateral hospital governance, and divided clinical and strategic decision making makes it difficult to establish new relationships. Further complicating factors are laws and regulations that block a more efficient use of resources. Some critics argue that these limitations could not merely challenge but cripple the development of U.S. health care.⁶

Inadequate and sometimes inappropriate financial laws and regulations especially constrain the development of necessary relationships between hospital boards and physicians. But they do not bar them. Boards must put the reform of such laws and regulations at the top of their advocacy agendas.

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For their part, physicians tend to be organized according to medical specialties and departments. This reinforces compartmentalization, thus hindering the formation of useful relationships among doctors, boards, and hospital executives. Because these relationships are absent, there is little discussion of integration or wholeness in care delivery. As a result, holistic health and wellness programs

are shunted off to practitioners of alternative medicine, nutritional supplements, exercise, fitness, and related services. It is a testament to the public's hunger for these products and services that they are among the fastest growing components of care delivery in the United States. Even so, physicians have not yet begun to seriously reform medical services in a way that would allow them to address populations, cultures, and whole persons, not body parts.

Making Medical Staffs Effective Medical staffs were originally created to help the physicians affiliated with a hospital communicate with each other and organize their work as effectively as possible. Today, however, the typical staff is barely organized and, arguably, only minimally effective. Hospitals still need a medical staff structure to carry out perfunctory processes such as credentialing and peer review and to satisfy the requirements of accrediting agencies such as the Joint Commission on Accreditation of Healthcare Organizations. But the fact is that most patient care provided by physicians now occurs *outside* the hospital.

Thus it is naive to think that the medical staff structure is the channel through which physician relationships are currently conducted. On the contrary, today's physician-to-physician interaction is usually an informal affair, based on patient referrals and business transactions. Hospitals and health care systems that seek to rebuild their relationships with physicians will have to create new organizational structures. These new physician organizations will be shaped by patient wishes, market requirements, professional concordance, clinical outcomes, and regulatory compliance.⁷ The independent practice association is a prototype for such organizations, which are self-creat-

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ed and self-governing bodies likely to be much more patient- and market-focused than the medical staff. Once the legal constraints on it have been eased, this structure will be the one that health care systems prefer as a partner.

Such partnerships will require a tight interface between the new physician organization, on one hand, and the hospital's board structure and processes, on the

other. Peter Drucker has argued that, in what he calls the "Age of Systems," relationship building is the primary leadership activity.⁸ Action guided by interdependence will determine a sustainable health care framework. Much of the work of leadership, whether medical or organizational, will lie in constructing the interfaces needed to bring together key stakeholders so that they can discern and design the foundations of health care for the foreseeable future.

PARTNERSHIP WITH THE NEW CONSUMER

Today's consumers seek ever-faster, personalized responses to their demands. Amazon.com's "Anything, anytime, anyplace" slogan has come to apply to the delivery of services as well as to products. Although health care is no ordinary set of products or services, it too must learn to adapt to consumers' heightened expectations.

Physicians and health care services must now deal with patients who can acquire health care information and obtain pharmaceuticals, health-related supplements, supplies, and equipment online, without first consulting a physician. It is pointless for professionals to lament this shift in power to consumers. Both physicians and service managers must learn to reconfigure health care services *in partnership* with the consumer, thereby guaranteeing that the consumer needn't seek health care outside that partnership. This new relationship will make consumers better informed about—and also more accountable for—their own situations and concerns. Physicians and health care services will have to work closely in this new arrangement because neither will be able to address consumer wishes without the other.

A more fluid, flexible, and mobile model of service will be required to sustain so intensive a rela-

relationship with the new consumer. MDExpress.com may serve as an example. This Internet site has become successful by creating new relationships with health consumers, in this case their subscribers. Online technology makes it possible for subscribers to track their interactions with the site and keep abreast of information relevant to their needs. The site constructs an Internet-based consumer profile that helps subscribers understand their health status and make informed choices about it. The site even creates referrals to medical providers, who, savvy about the process, can interface with the consumer both online and, when necessary, in person.

Other health care providers may want to use this site as a prototype. Physicians and hospitals now have no choice but to develop continuous, dynamic relationships with their "customers," employing the same model of mass customization that operates in other businesses. In doing so, they must accept certain facts:

- Hospital and physician information infrastructure must interface so that both can connect with the patient in his or her home.
- Neither the hospital nor the physician "owns" the patient. They must work together as partners, sharing information, support systems, and communication media.
- Patients, according to customer relations management theory, are increasingly unhappy with inconvenience or duplicated efforts that result from a poor interface between the hospital and physician. They should not, for example, be asked to fill out personal and health information by both the hospital *and* the physician.
- The Internet is not just a communications medium. It is now also an integral tool for keeping records, gathering information, and even making diagnoses.

Even so, no hospital or physician has as yet used today's technology to bring provider and patient into a truly new relationship.

NEW SERVICE AND STRUCTURAL IMPERATIVES

Scripps-Mercy Health System, San Diego, is constructing a comprehensive information infrastructure for its eight facilities and 1,500 physicians. When completed, this network will allow both physicians and patients to examine patient care records, thus ensuring that patients need give information only once in the service delivery process, wherever the service might occur. It will also relieve physicians and other health professionals from having to spend time searching for the information they need.

At the Duke University Children's Hospital in

Durham, NC, physicians and hospital managers have worked together to build a clinical/cost model that establishes "best practices" for various clinical services.⁹ An even more important product of this initiative has been the solid relationships established among the people and departments involved.

If they are to thrive over the next decade, physicians and hospitals must build stronger relationships in several key areas.

Board-Physician Leadership New therapies, including genomics, are forcing top health care leaders to reexamine programs, clinical approaches, service models, architecture—and their own relationships. Boards and physician leaders must work together in the strategic planning process, focusing on the development of service models likely to satisfy market demand.

Besides determining strategy and allocating capital for it, such leaders must also direct the construction of integrated clinical and financial information systems that link together hospital and physicians, providing them with performance data in a "balanced scorecard" format.¹⁰

Internet Use As noted, a more intense and sophisticated use of the Internet will link physician, hospital, and consumer, expediting communication among them and providing all three with a growing information database.

New Technology Health care leaders will develop a system for more efficiently researching, assessing, and acquiring new technology. Equally important, this system will retire technology that has become obsolete.

Clinical Processes and Protocols Health care leaders must develop, for managers and physicians at the point of care, processes and protocols for clinical problem solving to ensure a better fit between clinical service and the clinical characteristics of those served.

Architecture Top health care leaders must reexamine the congruence between a hospital's current operating infrastructure and the changing format and content of health care services. They must, for example, deal with the fact that although most hospitals were built to accommodate patient admissions lasting several days, today's therapies are increasingly brief and portable.

These last are *structural* imperatives. Carrying them out will form a foundation for establishing the performance-based activities needed in a changing model for clinical services. Unless boards and physician leaders commit themselves to building a solid structure, the necessary behavioral and relational changes necessary will not have sufficient support.

A CRITICAL INTERFACE

By now, it should be obvious to most health care leaders that they can no longer maintain the artificial boundaries between physicians and other components of the health service system, because such boundaries put the patient at risk. The compartmentalization of economics, regulation, and service has, in particular, reached the point where it blocks progress in health care. Three critical areas need special attention.

Regulation and Finances The primary obstacle facing today's health care is perhaps its constricting, 20th-century regulatory and financial structure. Hospital board and physician leaders have no choice but to try to amend that structure, keeping those parts that ensure good business practices, protect the best interests of patients, and preclude potentially immoral or unethical practices. Perhaps the reason that many inadequate and sometimes inane regulations continue to exist is that stakeholders from both hospital and physician constituencies still think they can advance their own agenda alone or at the expense of the other.

Even the most parochial thinker should see that this approach always leads to failure. Board leaders can accomplish much, especially at local and state levels, if they will take the helm in creating the relationships and coalitions needed to get such regulations amended. This action is the only way to accomplish change. Boards and physician leadership must, for the time being, spend more of their time working in the public and social arena. The 21st century requires a new regulatory and financial framework, and hospital and physician leaders must help create it.

Medical Staffs Hospital boards must also deal with the regulatory and legal obstacles that block reform of the medical staff system. Only thus can physicians become part of the decision-making process. On one hand, the board clearly must address constraint-of-trade and conflict-of-interest issues; protecting the integrity of both provider and system is vital. On the other hand, laws and regulations that bar physicians from decision making should be changed. They are barriers to the creation of new decision-making models that bring stakeholders together in the development of effective strategy, "best practices," advantageous market position, more efficient priority setting, firm normative practice standards, and more clearly delineated quality outcomes.

The longer such reforms are put off, the more the future of health care will be put at risk. Boards have no option but to make strengthening the

structural relationship between the medical staff and the health care organization a priority.

Technological Implications Design and practice are both inevitably affected by the advent of the very technologies that threaten the health care status quo. Physicians continue to use therapeutic models and processes that are resource intensive and often neither state-of-the-art nor cost effective. The fact that U.S. physicians vary widely in their methods is, some writers say, one reason why our health care is so expensive.¹¹ Such variety makes it difficult to determine which methods produce the best outcomes. As genomic targets, new pharmaceutical agents, miniature medical devices, and futuristic diagnostic tools become common, they will make methodological variety less tolerable. If health care is to use new tools efficiently, it must reform its current services and structures. Anticipating these new modes of delivery—and choosing among them wisely and efficiently—will be a high priority in the planning and design of clinical systems. Neither physicians nor hospital leaders can undertake this complex and critical shift alone. □

NOTES

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