Enhancing Alignment between Physicians and Hospital Administrators

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Introduction

Rapid changes in healthcare present numerous challenges to successfully fulfilling the multiple missions of healthcare organizations (HCOs), medical practices, clinics, and hospitals. Healthcare costs have risen exponentially over the past several decades and continue to rise with diminishing reimbursements by third-party payers (Medicare, Medicaid, and commercial payers)\(^1,2\); now more than ever, providing safe, high-quality patient care and enhancing patient satisfaction at a lower cost are critical metrics for fiscally responsible and well-managed HCOs. Physician engagement is an important factor in achieving this goal.\(^3,5\) The constructs for governance in HCOs and healthcare systems are increasingly more complex for key stakeholders in providing optimal patient care.\(^1,2,6\)

Based on my own professional experience of over three decades as a physician and physician-leader, as well as and executive, administrator, and educator in hospitals affiliated with large academic institutions, the working relationship between physicians and “hospital administrators” (a term applicable to all administrators of organizations involved in healthcare) is unfortunately often not congruent and can even become contentious resulting in an “us” versus “them” antagonism across healthcare systems. The magnitude of this incongruence may vary with the organizational complexity and culture of the HCO, being typically more pervasive in large academic medical centers while better physician-administrator congruence tends to occur in smaller medical group practices. An oppositional physician-administrator relationship is detrimental to all stakeholders, resulting in a compromised healthcare delivery to patients along with other suboptimal outcomes. Although the factors for such an antagonistic working milieu are complex and multifactorial, understanding and addressing these intricate issues would greatly help to reduce conflicts among these key stakeholders in achieving the common goal of providing optimal patient care.\(^1,6\) From my personal observation—and as a number of monographs and articles on the subject attest, while physicians and hospital administrators generally agree on the overall goal of optimizing patient care (i.e., enhancing patient outcomes and efficiency), there is a perception of conflicting agendas among these two groups.\(^3,6\)
present treatise provides a broad, literature-based, descriptive overview in an evolving historical context coupled with my own observations based on extensive professional experience and highlights the root causes of this nonalignment between these two important groups. Further, and more importantly, this manuscript proposes a framework for short- and long-term solutions toward a more cohesive and collaborative team approach based on understanding the respective roles, strengths, and contributions of the two groups. Akin to hospital administrators, this monograph will also provide Medical Managers with a broad perspective on the conundrum toward understanding the physicians’ stance and highlights the importance of a much-needed symbiotic working relationship in their medical practice(s).

**Factors Affecting Perspectives and Behaviors of Physicians and Hospital Administrators**

1) *Historical Context and Perspective*: The evolution of the healthcare system in the United States over the past two centuries has significantly and sequentially impacted the role of practicing physicians. The ramifications have been multifaceted affecting the physician-patient relationship, control of decision-making, allocation of resources, and remuneration. Until the late 18th Century, medicine in the United States was deemed a “family affair” and labeled “domestic medicine.” In 1781, the University of Pennsylvania ushered in a new era of scientific and formal medical school teaching and training leading to physicians being more circumstantiated and practicing medicine as small impresarios charging fees for their services. With further urbanization and the construction of hospitals in the mid-1800s, physicians began treating patients at a single location with pay-for-service medicine in private rooms and after the end of the Civil War in 1865, hospitals metamorphosed to being either public or private. Starting in 1864 and continuing for the next century, great influence over the politics and practice of American medicine was exercised through the *American Medical Association* (AMA), and by the
early 20th Century, physicians were garnering more authority and being better paid than ever before.7–9 Private health insurance had emerged prior to World War I; however, insurance plans such as Blue Cross and Blue Shield came into effect in the 1930s to bear the costs of hospitalization and physician services and began replacing the “fee-for-service” reimbursement system. The post-World War II era brought about even more escalation in healthcare costs with technological advances in ancillary laboratory tests and diagnostic techniques and expansion of professionalized roles for non-physicians such as physical therapists, radiology technicians, etc.7–9 Medicare was signed into law in 1965 providing comprehensive health coverage for individuals aged 65 and older with coverage for the poor and disabled provided by Medicaid. While the influential and powerful AMA and other organizations had successfully warded off the creation of a universal coverage medical system, privatization of healthcare continued in the 1980s with the merging of HCOs into larger healthcare systems. In the same decade, the growth of Health Maintenance Organizations (HMOs) began to dominate the organization of healthcare and reimbursements to physicians resulting in less control by physicians of their practices. As physicians found themselves working more for corporations that made profit from pre-paid healthcare, managed care and the “capitation” payment method eventually replaced fee-for-service.7–9 Along with the increased complexity of HCO governance, administrators have had to cope with concomitant increases in regulatory policies and procedures. The signing of the Affordable Care Act (ACA) in 2010, further advances in web-based information technology and communication, telemedicine, healthcare information accessibility, increasing regulatory controls, bundled payments, and greater emphasis on preventive medicine and population health will likely continue to shape the traditional and historical role of physicians.7–9 Proliferation of large, Accountable Care Organizations (ACOs), private practice medical homes, community health centers, concierge practices, and small aligned groups will further modulate the physician-administrator working relationship.
2) **Core Values:** The practice of medicine by the majority of physicians is dictated by core values that are deeply embedded in the professional tradition of providing care to the needy and impoverished. With this premise, for centuries there has been a strong undertone of altruism that has resulted in an uneasy “marriage” between the monetary aspects of medical practice and the unadulterated delivery of healthcare to the ailing. This dichotomy is prevalent in many physicians although with the evolution of materialism in Western societies and despite the changes in reimbursement schemes away from fee-for-service, many physicians still find the monetary gains associated with the practice of medicine very alluring. It is common knowledge in academic medical education and residency training programs that there has been a generational shift in reasons for pursuing the medical profession (i.e., monetary gain, “work-life balance,” etc.) with many new physicians choosing medical and surgical specialties that yield high monetary returns. Medical education and training have not moved in tandem with the rapidly changing terrain of healthcare. Furthermore, the majority of practicing physicians have done little to understand and incorporate the rapidly changing laws and regulations of the “business” of healthcare while still maintaining the core values of the medical profession.

3) **Business Knowledge and Management:** With the changing and increasingly stringent regulatory statutes of the past few decades, not infrequently, there has been financial disarray in physician-led HCOs due to suboptimal financial management, perhaps more so in larger HCOs than in smaller private medical practices. This phenomenon has been largely attributable to the inability of these physician-leaders to grasp and cope with rapidly changing healthcare laws and regulations, time constraints in the acquisition of these facets, and difficulty bridging the knowledge gap in the business aspects of healthcare while providing optimal patient care. Further compounding the problem is the predominant and pervasive attitude of high-mindedness among many physicians along with the rationalization attributable to the argument in support of the “ethics of medicine” in providing healthcare to the population irrespective of financial costs.
or the burden of questioning the relative value or worth of individual human life and health in monetary terms. With the relative demise of such physician-led HCOs, changes were in order and there was a timely opportunity for non-medical personnel to seek leadership positions as hospital administrators (e.g., Chief Executive Officers, Chief Operating Officers, Chief Financial Officers, Vice Presidents for Marketing, etc.) under a governance structure akin to the corporate world.⁹ With the explosion over the past few decades of healthcare Masters of Business Administration (M.B.A.) and Masters of Health Administration (M.H.A.) training programs has come an exponential increase in the number of non-physician professional managers in HCOs. There has also been a substantial concomitant increase in the number of non-physician managers in professional organizations such as the American College of Healthcare Executives.¹⁰ All of these developments have aroused resentment in physicians who feel that they have ended up working for the “suits” whose core values are mostly profit-oriented. Furthermore, physicians contend that they have been disenfranchised and stripped of their collective bargaining power by legislative rulings resulting in their voices and perspectives not being considered in the instituting of patient-centric policies. To circumvent these complexities of healthcare, an increasing number of physicians have recently been enrolling in Executive MBA programs.¹⁰

4) Phenotypes and Prototypes: Physicians as a group have been labeled as being fiercely independent and autonomous with egotism as a corollary characteristic. The substrate for this is possibly deeply rooted in the code of ethics stated in the Hippocratic Oath (c. 400 B.C.) that has an individualistic focus on the conduct and practice of medicine illustrated by statements centered around “I swear…….” or “I will…….”¹² Some examples from the traditional Hippocratic Oath include the following:¹²

“I swear by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation…..”
Echoes of this individualistic focus are found in the following excerpts from the alternate modern and commonly-used versions of the *Physician’s Oath*:

“That I will be loyal to the Profession of Medicine and just and generous to its members

That I will lead my life and practice my art in uprightness and honor.”

It is self-evident from both the traditional and updated versions\(^{12,13}\) that this code of professional conduct is a construct focused on physician and patient. This code of conduct coupled with medical school training geared toward being “reactive” and becoming effective “deciders,” pressure of peer expectations, ardent loyalty toward their patient(s), and identifying with their profession underscores the individualistic approach to patient care.\(^1\) Length of training for specialty board-certificated physicians (i.e., 4-year post-baccalaureate medical school, 4-6 years of residency training, 1-3 years of post-doctoral subspecialty fellowship training for physicians as opposed to 1-2 years post-baccalaureate for Masters in Business Administration or Masters in Health Administration for administrators) is frequently a contentious issue among physicians who feel resentful of the wide differential in their average base salaries of $50-75K during residency and post-doctoral fellowship training as compared to the far larger salaries of administrators. Furthermore, throughout the course of their training, physicians are taught that dissent is approved of, will not be taken as a personal criticism, and will even be rewarded as reinforcing the “independent-equal” construct.\(^{14}\) In an administrative setting, however, dissent by a physician is frequently taken personally. In contrast, an administrator’s position within an organizational matrix reinforces the “superior-inferior” construct, and dissent from physicians is interpreted by administrators as the physicians’ lack of understanding of the issue at hand, which is interpreted by physicians, in turn, as ignoring their input.\(^{14}\) Conversely, non-physician hospital administrators are deemed to have proactive personalities, to be planners and delegators, to be participative and to value collaborations, to have consensus-based thinking focused on decision-making, and to be loyal advocates for the HCO.\(^{1,10}\) These fundamental differences in the
phenotypic and prototypic substrate and professional repertoire are the foundation for the incongruence between these two key stakeholders.

**Perceptions**

1) *Role Perception:* Among physicians, a pervasive label for hospital administrators is that of “bean counters” fixated on cost-containment, perhaps more disproportionately so than on helping find newer streams of revenue in certain HCOs. These physicians perceive hospital administrators as being far removed from the “front lines” of patient management and their major job as “policing” physicians and acting as enforcers of policies and procedures without understanding the role of physicians in a broader context. Physicians frequently lament that they are given neither the resources including equipment, services, or workforce (e.g., scribes to help offset increasing documentation requirements, front-end staff to help with reminder calls for appointments, etc.) nor the time (e.g., mandated times for evaluating new and follow-up patients) with unrealistic goals (i.e., clinical productivity, quality metrics such as optimizing Length-of-Stay, attenuating no-show and readmission rates, and improving patient satisfaction) to provide optimal care to their patients while hospital administrators push the “bottom line” as the only metric for success. There is further resentment from physicians that administrators perceive non-revenue generating activities that are important for the academic mission of a teaching HCO (such as teaching medical students, residents, and post-doctoral fellows in-training) as being superfluous. Physicians also believe that administrators lack empathy toward patients and their families, and have little understanding of other important elements such as “end-of-life” discussions, prognostication, and outcomes-based decision making, factors that are critical to their clinical practice. Conversely, physicians are perceived by hospital administrators as being irresponsible in financial matters, wasteful, inefficient, deeply rooted in archaic medical practices, and obstinate in finding ways to circumvent constricting resources. Based on evolving behaviors of physicians, administrators frequently insinuate that physicians view traditional expectations of
Physicians desire more autonomy, independence, and control and are frequently frustrated and stifled by the “barriers” of systems, facilities, policies, and processes created and implemented by administrators that are perceived as unnecessarily adding complexity and impeding efficiency and productivity.\(^1\)

2) **Composition of Governing Authority:** Membership of the governing authority and board of HCOs is heavily skewed toward representation by non-physicians who are frequently appointed based on political motivations and who have strong ties to local community. There is a concurrent paucity of physician representation as members on the governing boards which have variable interaction and engagement with Medical Staff Executive Committee or Physician Practice Plan leadership. This culminates into the perception that the perspectives of physicians are not being voiced, heard, or appropriately considered. The complexity of governance structure in larger HCOs stymies physician-administrator congruence as opposed to smaller solo or group medical practices where there is more alignment because it is easier to delineate the valued roles of the two groups. However, protocol-driven and algorithmic care of patients requiring specialized care for targeted programs (e.g., dialysis centers for patients with end stage renal disease, coronary artery disease, stroke centers) has been successful with physician-administrator partnerships.

3) **Alignment:** Many HCOs frequently lack congruence of mission, vision, and values between the governing authority and many stakeholder groups. More importantly, it is not uncommon to have a lack of consensus in resource allocation and in the prioritization of select programs and their growth, development, implementation, and execution with a milestone-driven short-term and long-term strategic plan much to the discontent of the physician stakeholders. Recently, “dyad” constructs have been developed that have a physician and an administrator as co-leaders of a team for focused projects such as addressing length-of-stay, 30-day mortality, and re-admission rates
for specific service lines or subset of patients. Such frameworks have been reported as being highly successful.

Environmental Influences and Challenges

1) Complexity of HCOs: Mergers of hospitals and their acquisition by large health and integrated systems is adding complexity to the governance structure, whether centralized or distributive. Different physical locations of outpatient clinics and hospitals necessitating cross-coverage by physicians, other healthcare providers, and administrators adds another layer of operational complexity in providing optimal patient care. Nevertheless, as alluded to by Lloyd,\textsuperscript{15} the “six transformational competencies and values critical for a 21\textsuperscript{st} Century HCO” include: mastering change, systems thinking, shared vision, continuous quality improvement, redefined healthcare, and serving the public community.\textsuperscript{10} These desired and shared goals can only be met by augmenting and delineating the roles of executive, middle management administrators, and front-line physicians in HCOs.

2) Disparate Growth and Incomes: Existing data from the Bureau of Labor Statistics suggests that there is a rapid and disproportionate increase in the number of hospital administrators as compared to physicians with a relative increase of almost 3000\% in the number of hospital administrators since the 1970s (Figure 1).\textsuperscript{16} While these data do not clearly indicate if hospital administrators includes physician-leaders who have assumed a role and function in administrative positions, there is a definite substantial increase in the number of non-physician administrators in certain departments across most HCOs (e.g., Human Resources, Compliance, Information Technology, and Financial Services including Revenue Cycle) to meet the demands of expanding regulatory measures and controls. Furthermore, a recent survey suggests that the base pay of insurance executives, hospital executives, and hospital administrators often far outstrips salaries of physicians.\textsuperscript{17} And studies suggest that administrative costs account for 20 to 30\% of healthcare bills in the U.S., far higher than in any other country.\textsuperscript{17} Concurrently, there is a
paradigm shift from recruiting physicians to developing programs that are focused and managed predominantly by “mid-level providers” or “physician-extenders” (e.g., nurse practitioners, physician assistants, nurse midwives) in providing direct patient care. These paradigm shifts are a major cause of discontent among physicians, who perceive their role as being undervalued and have a pessimistic professional outlook for the future. In the marked trend toward early physician retirement, some have suggested that the Patient Protection and ACA may play a prominent role. According to a survey conducted by The Physicians Foundation, Boston, 59.3% of physicians said they were less positive about the direction and future of healthcare in the United States after the passage of the ACA in 2010.

**Figure 1.** Adapted from Physicians for a National Health Program. Source: Bureau of Labor Statistics; NCHS; Himmelstein/Woolhandler analysis of CPS

**Proposed Solutions for the Future**

The key elements in short- and long-term operational framework toward enhancing physician-administrator alignment are highlighted in Table below.
The substrate for this proposed framework lies in a multi-faceted approach that includes creating a commonality of purpose, optimizing the governance structure, teamwork, building trust, effective communication and investing in teaching, training, and mentoring.

1) **Commonality of Purpose and Congruence**: Physicians and hospital administrators frequently do not share the same mission, vision, and values. Matheson and Kisson submit that “*the conflict arises because each group perceives that they are responsible for meeting mutually exclusive objectives.*”¹⁴ Physicians have a mission that is more narrowly focused on practice development and the individual patient.¹ The leadership of the HCO must invest in developing an enduring commonality of purpose and nurturing a positive organizational culture that is shared by all stakeholders, specifically between physicians and administrators toward providing safe and high-quality patient care (i.e., safe, effective, patient-centered, timely, efficient, equitable).¹²⁶ It is critical for the HCO leadership to frequently return to this commonality of purpose to serve as a reminder to all stakeholders, constantly aligning and realigning day-to-day activities to achieve pre-set goals. The mission and vision are clearly the most important and defining starting points that cannot have too many reminders and revisits.

<table>
<thead>
<tr>
<th>SHORT TERM</th>
<th>LONG TERM</th>
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<tbody>
<tr>
<td>✔ Reinforcing HCO’s Mission, Vision, and Values repeatedly, regularly, and frequently to all stakeholders</td>
<td>✔ Organizing a governing structure reflective of physician and administrator balance in leadership</td>
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<tr>
<td>✔ Creating and implementing “dyads” with physicians and administrators as co-leaders for specific projects</td>
<td>✔ Incorporation of business aspects of medicine in medical student education and post-graduate residency training</td>
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<tr>
<td>✔ Effective communication; data sharing on day-to-day activities and metrics on targeted projects</td>
<td>✔ Education for administrators in the humanistic aspects of medicine e.g. ethics</td>
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<tr>
<td>✔ Transparency in financial state and sharing information in a timely and regular fashion</td>
<td>✔ Regular and frequent meetings with organization’s leadership</td>
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<td>✔ Goal-setting with clearly defined milestones</td>
<td>✔ Common goals in long-term strategic planning and blueprint</td>
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<td>✔ Administrator participation in physician-related activities e.g. family meetings, “end-of-life” decision making</td>
<td>✔ Physicians being educated in financial and operational domains</td>
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2) **Optimizing Governance Structure:** HCOs must endeavor to develop a governance structure that empowers both groups and builds on the strengths of each with clear delineation of roles and responsibilities by giving physicians adequate representation on the governing authority or board of directors and hospital committees and subcommittees. There must be public recognition of contributions and accolades for achievements by individuals in each of the two groups with avoidance of rigid behaviors characterized as the “board mandates, management dictates, and physicians vacate”.

3) **Teamwork by Building Trust:** It is paramount that organizational leadership underscores the importance of team work and building a culture of trust as this brings about a strong bond among the stakeholders in the organization. Recognizing the need for the tandem roles of physician-leader and administrator is critical for the HCO to survive and thrive. Below are certain important facets that require operational focus.

a) Functioning as a team (as opposed to “solos”) with a common purpose and consensus-building based upon mutually agreed milestones and goals with effective communication (close, timely and meaningful), idea-exchange (joint meetings, direct interviews, surveys, etc.), and strategy assessment process to function with more synchrony and harmony. The goal should be to institute physician-led integration of teams (decision-making and strategic skills) with a focus on “implementing innovative quality systems, leading information technology implementations, influencing for improved patient care, and understanding integrated health systems”. As alluded to previously, the formulation and implementation of “dyads” for specific quality improvement projects with clear milestones have been shown to be highly successful based on my personal observations.

b) Accepting each other’s roles, nurturing a culture of collaboration, and maintaining mutual respect and a trusting relationship between the two groups, as well as recognizing their strengths and achievements are critical toward building a “symbiotic relationship” irrespective
of the size of the HCO. Empowerment of stakeholders will facilitate interdependent interaction at multiple levels and consensus-building for decision-making among physicians and hospital administrators.

c) Contributing to the activities of the other group such as hospital administrators participating in physician-lead “patient-care rounds” and, conversely, physicians and physician-leaders learning the basics of healthcare finances, marketing, etc., would greatly enhance the focus on the mission.

d) Defining and identifying gaps among physicians’ present needs, emerging needs, and the supply of manpower, ancillary services, equipment, or space will enhance delivery of safe and efficient patient care. Bureaucracy and infrastructure should be streamlined by the administrative leadership so that physicians can carry out their jobs effectively and efficiently.

e) Encouraging physicians to being more receptive to cost containment by being more judicious in ordering ancillary diagnostic tests and paying attention to quality metrics such as patient satisfaction and outcomes will help the HCO move toward providing efficient care at low cost.¹

4) Effective Communication among physicians and administrators:

   a) Providing transparency in financial statements and data sharing on important undertakings by hospital administrators to all stakeholders in a regular and timely fashion is important for sustained improvement in an HCO. This information and other parameters of accounting (e.g., days in accounts receivable, charity care, bad debt), in-patient services (e.g., daily patient census, bed occupancy, length of stay), and outpatient clinics (e.g., patient volumes, no-show rates, and slot utilization) should be shared at regular departmental staff meetings. Plans and updates on mergers and acquisitions of services and capital equipment as well as changes in policies and procedures of hospitals or medical practice(s) should be shared among physicians and administrators.
b) Understanding the needs of both physicians and administrators by holding town hall meetings and via annual surveys through actively listening, sharing information, and nurturing an environment where physicians can freely voice their ideas, views, and expectations is essential for building trust and underscores the common mission and vision. In HCOs where tensions run high between physicians and administrators, periodic joint retreats and other social gatherings may help ease tensions and cultivate professional and personal relationships and discourage dissent.

c) Delivering on promises and commitments backed by concrete actions and accountability and not merely “talking the talk,” but “walking the walk” in a realistic timeframe reinforces the shared mission, vision, and values of the HCO. Frequently, the time expectations of physicians for deliverables are generally much shorter for desired support for goals than for administrators. This requires reassurance on the part of administrators to physicians that ongoing projects are receiving due attention commensurate with strategic goals sequentially prioritized.

e) Ensuring that the CEO and leadership of the HCO are regularly available for listening and communicating with the two groups in joint sessions will greatly enhance communication among key stakeholders. While styles may differ, the leadership must aspire to lead by the principles of “servant leadership” whereby each stakeholder is kept informed and given a voice in strategic goal-setting and its blueprint for the HCO. The leadership should also share with physicians and administrators rates of attrition and plans for transitional and succession planning for key positions.

5) Teaching, Training, and Mentoring: The overarching goal is that both groups endeavor to learn about the function and value of the other groups’ contributions to the organization.

a) Physicians and educators in collaboration with administrators must invest in developing physician-leaders of the future by incorporating business-related subjects and curricula during
medical school education and training (ability to build strong trusting relationships, developing “systems-thinking,” ability to assess risk and persuade others to take risk). Working from this premise, an increasing number of medical schools are incorporating business aspects of medicine as part of their educational curriculum, and more than 50% of U.S. medical schools now offer combined M.D./M.B.A. degree programs. Furthermore, physicians must serve as good role models and invest in mentoring medical students, residents, and fellows in training as to the importance of having a healthy, collegial, and respectful working relationship with administrators.

b) Using a holistic approach to mentor and teach hospital administrators the compassionate aspects of medicine including empathy and the ethical aspects of healthcare delivery including “end-of-life” decision-making and quality-of-life discussions will elevate the quality of care to patients and their families. Because of the increasing complexity of healthcare, many contend that physicians are taking a keener interest in the organizational aspects of healthcare systems management at the expense of their natural purview of providing direct patient care. While many propose that physicians should remain focused on what they do best—i.e., patient care, many policymakers believe that the physician-leader or physician-executive’s understanding of the clinical processes can be a unique advantage to a HCO. Indeed, the substantial increase in membership (~ 2500) of Certified Physician Executives in the American Association for Physician Leadership® (Certifying Commission in Medical Management) will further augment comprehensive patient care in the rapidly changing terrain of healthcare in the United States.

**Conclusions**

A contentious working relationship between physicians and administrators pervades U.S. HCOs, particularly in large hospital settings. The root causes of this nonalignment are embedded in history, perceptions and misperceptions of others’ roles, and actual or perceived conflicting agendas. Despite
competing views as to who is best equipped to lead HCOs, as the complexity of healthcare policies and delivery continues to mount, it is critical that the physician as front-line provider and the administrator as organizational facilitator cooperate through understanding each other’s important roles and complementing each other’s actions with a view to optimizing patient care (service, quality, patient safety, and patient loyalty). According mutual respect for traditional as well as changing roles, recognizing strengths and weaknesses, and sustaining a commonality of purpose will ensure a more cohesive approach to reaching our overarching goals. Developing a symbiotic relationship between physicians and administrators will become even more crucial as the focus of healthcare in the United States shifts from “volume-based” to “value-based” metrics, with commensurate evolution of mandates, policies, and procedures aimed at enhancing patient outcomes and population health.
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