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Managing Physicians Part 2

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Contracting: Overview

- Another option instead of directly hiring physicians
- Common with specialists and surgeons
- Option to pay for outpatient clinic time or surgery/procedure

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Contracting: Costs

- Overall costs typically larger than direct hire
- Can be difficult for patients to afford if no insurance coverage

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Case 1: Neurosurgeon and Orthopedic Surgeon

- Neurosurgeon and Orthopedic Surgeon contracted by mission hospital
- Charge 50% of surgical fee
- Inflated surgical fees to $2,000 (surgeon making $1,000)
- Patients with no insurance unable to afford

- What would you do?

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Case 1: Neurosurgeon and Orthopedic Surgeon

- Neurosurgeon and Orthopedic Surgeon contracted by mission hospital
- Charge 50% of surgical fee
- Inflated surgical fees to $2,000 (surgeon making $1,000)
- Patients with no insurance unable to afford

- What would you do?
- Could define costs of each procedure ahead of time

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Contracting: Flexibility

- More flexibility than direct hires
- Able to come a few hours a day or week
- Can cover half-day or full-day clinic as needed
- Often non-Adventist
- Typically have government job or private clinic
  - Can also be a challenge

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Case 2: General Practice physician

- GP physician has private practice
- Sees patient at ED and hospital and refers them back to his private clinic

- What would you do?

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Case 2: General Practice physician

- GP physician has private practice
- Sees patient at ED and hospital and refers them back to his private clinic

- What would you do?

- Could specify in contract not to refer to private clinic

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Contracting: Mission Fit

- Can be more challenging to find the right mission fit
- Often non-Adventist
- Focus can be on money vs. mission
- Can be more difficult to change physician behavior

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Case 3: Radiologist

- Radiologist doing ultrasounds, reading x-rays
- From government hospital so spends limited time
- Making several mistakes in imaging (misses twins on OB ultrasound)
- Begins coming to compound late at night to meet with nursing students
- No other radiologist available in community

- What would you do?

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Case 3: Radiologist

- Radiologist doing ultrasounds, reading x-rays
- From government hospital so spends limited time
- Making several mistakes in imaging (misses twins on OB ultrasound)
- Begins coming to compound late at night to meet with nursing students in his vehicle
- No other radiologist available in community

- What would you do?
- Should be let go (if following code of conduct, more information later)

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Work Ethic: Overview

- Requires an organizational commitment to engage physicians
- Key is management/physician partnership
- Once the basics are in place, dealing with disruptive physicians becomes a logical progression

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Work Ethic: Stages of Organizational Commitment

- Stage 1: Create and Communicate Organizational Vision and Goals
- Stage 2: Leadership Development and Accountability for Performance
- Stage 3: Establishing Physician Confidence and Trust
- Stage 4: Building Physician Leadership
- Stage 5: Training Physicians
- Stage 6: Physician Measurement
- **Stage 7: Implementing Physician Behavioral Standards**
- **Stage 8: Dealing with Disruptive Physician**
- Stage 9: Recognizing Physicians

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Work Ethic: Management/Physician Partnership

- Providing Leadership training for physicians
  - Select those with good mission fit, good interpersonal skills, good team skills
- Set clear goals and objectives
  - Physicians can be part of decision making processes, provide feedback
- Rounding on physicians
  - **Fosters trust with management more than any other tactic**

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Case 4: Physician Rounding

- Orthopedic surgeon
- Asked if there was anything they needed from administration
- So impressed, had never been approached by administration in 15 years of work
- Although did not need anything specific, appreciated the engagement very much

- What do you think this could do for your physicians?

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Work Ethic: Physician Behavioral Standards

- US requires every healthcare organization to have a code of conduct
  - Defines acceptable and unacceptable behavior
  - Defines formal process for managing unacceptable behavior
- May be the most volatile element of physician engagement
- If Stages 1-6 are implemented, behavioral standards will be seen as logical progression
- Sequenced late in the process by design, after other steps are implemented
- Code of conduct should also be in place for management
- Physician leaders/champions will promote the code of conduct

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Code of Conduct

- Assemble physician leaders to draft code of conduct
  - Ownership is enhanced when physicians create the standards
- Determine desired and unacceptable behaviors
- Physician leaders communicate with other physicians

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Code of Conduct: Unacceptable Behaviors

- Shouting or yelling
- Use of profanity directed at another person
- Slamming or throwing objects in anger or disgust
- Hostile, condemning, or demeaning communications
- Criticism of performance delivered in an inappropriate location and not aimed at performance improvement
- Behavior demonstrating disrespect, intimidation, or disruption to patient care
- Retaliation against any person who addresses or reports unacceptable behavior

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Code of Conduct: Expected Behaviors

- Interaction with Staff
- Interaction with Physician Colleagues
- Interaction with Patients

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Expected Behaviors: Interaction with Staff

- Recognize that every member of the team is important
- Be available and cooperative when on call
- Communications (spoken, written, email) should be professional, constructive, respectful
- Provide constructive feedback in the spirit of improvement and in private if inappropriate staff behaviors are observed

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Expected Behaviors: Interaction with Physician Colleagues

- Make time for direct doctor-to-doctor communication for emergent/urgent consultations
- Work in a collegial manner with physician colleagues
- Treat referring providers with an appropriate spirit of accommodation and service
- Present physician colleagues positively to patients as a referring or consultant physician

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Expected Behaviors: Interaction with Patients

- Introduce yourself to patients and family members and explain your role in the care team
- Smile, make eye contact, address patients by name
- Thank patients for waiting if you are running late
- Wash hands before and after every patient contact
- Respect patient privacy by using curtains and doors when appropriate
- Treat patients with respect and kindness
- Explain diagnosis and treatment plans with patients in a way they can understand

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Applying Code of Conduct

- A true code of conduct exists only if it changes what physicians do
- It's a necessity for patient safety, clinical quality, and physician/hospital success
- Part of physician orientation
- Be very clear: violations of code of conduct must have consequences
- If a code of conduct has no consequences, it's not a code of conduct
- Physicians should sign the code of conduct to improve awareness and knowledge and raise accountability for compliance

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Case 5: Surgeon

- Threw items in surgery at staff
- Staff very afraid
- After one case, sponge count incorrect, but staff unsure and afraid to confirm
- Patient later died from post-op sepsis due to sponge left inside

- What would you do?

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Case 5: Surgeon

- Threw items in surgery at staff
- Staff very afraid
- After one case, sponge count incorrect, but staff unsure and afraid to confirm
- Patient later died from post-op sepsis due to sponge left inside

- What would you do?

- Tragic case, patient safety issue, surgeon needs to be talked to and if behavior doesn’t change, they shouldn’t continue working

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Sources

- Engaging Physicians: A Manual to Physician Partnership
  By Stephen Beeson, MD

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