POLICY PAPER:

PARTNERING WITH PHYSICIANS

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vision
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Collaboration
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doctors of bc

Better. Together.

DOCTORS OF BC POLICY: PARTNERING WITH PHYSICIANS

Policy Statement: The Doctors of BC supports the development of collaborative and constructive partnerships between physicians, the Ministry of Health, health authorities and the University of British Columbia for maintaining and enhancing high-quality care.

Commitments

In order to improve and promote physician engagement in BC, the Doctors of BC is committed to:

1. Promoting physician engagement on matters related to quality, patient safety and health system planning and evaluation.
2. Supporting transparent decision-making that is based on meaningful physician engagement, the best available evidence, and the Institute of Health Improvement's Triple Aim principles (e.g., enhancing patient care, improving population health, reducing per capita cost of care).
3. Promoting effective medical leadership for creating, improving and maintaining effective and efficient health care services.

Recommendations:

With an aim to improve and promote physician engagement in BC, the Doctors of BC recommends that:

1. The Ministry of Health and health authorities provide physicians with meaningful opportunities to partner in the design, implementation, and evaluation of health care services. Adequate resources and support are needed to ensure physicians have the time and tools to support change.
2. Physicians maintain the right and ability to raise concerns and issues about quality of care without reprisal.
3. Medical leadership be valued, adequately resourced, and supported with training opportunities in management, health care improvement, and leadership skills.

I. What is physician engagement?

Engagement has recently become a popular and much-used term in health reform, but it is rarely defined [1]. As a result, different interpretations of engagement may hinder real change or collaboration. The Doctors of BC supports the development of effective working relationships between physicians and operational leaders in facilities and communities, and in doing so has defined physician engagement as:

"The active and positive contribution of physicians within their normal working roles to maintain and enhance the performance of the organization, which itself recognizes this commitment by supporting and encouraging high-quality care." [1]

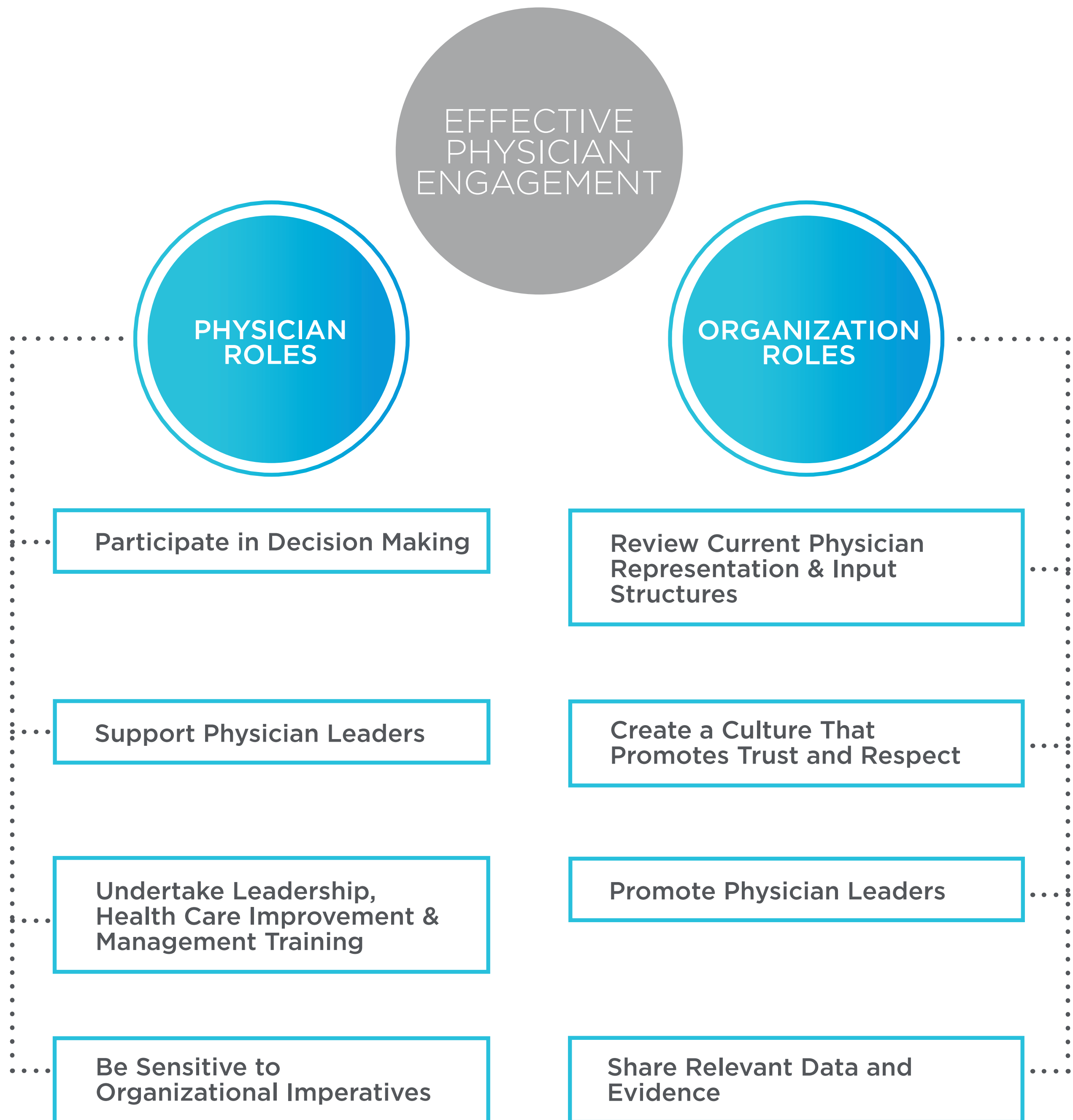
Key related concepts include the following [2-4]:

- Effective physician engagement is best pursued as a partnership with a focus on building constructive and collaborative relationships.
- The key to creating a culture of physician engagement is encouraging and empowering physicians to take the lead on a wide range of quality improvement initiatives locally and provincially, and to be influential in setting the overall direction of health care services.
- Physician engagement does not happen on its own. Organizational culture, structures, communication and processes can either encourage or inhibit an individual physician's propensity to engage. Physicians need to recognize their individual and collective responsibilities to the health care system for ensuring high quality care, and demonstrate their willingness to partner in health system reform.
- Measuring physician engagement over time is needed to ensure that there is a return on investment in terms of quality and safety improvements and that the successes and failures of physician engagement efforts are identified.

As a corollary, Figure 1 identifies key steps and roles that physicians and organizations need to undertake in order to build effective partnerships. Descriptions of these roles can be found in sections 4 and 5 in the document.

Figure 1.

ROLES OF PHYSICIANS AND ORGANIZATIONS IN BUILDING EFFECTIVE PHYSICIAN ENGAGEMENT



II. Why is physician engagement important?

In response to demands for improved performance, greater accountability and cost containment, there is growing international interest to create greater alignment and engagement between physicians and organizations on goals and values [5]. While some BC health authorities and organizations have developed physician compacts with mixed results [6-8], opportunities remain for improving physician engagement, for example:

- In the 2012 Doctors of BC Member Survey, 85% of physicians indicated "ensuring physician consultation about regional program and facility changes" as an important area for greater Doctors of BC support [9].
- Recent Gallup surveys conducted by several BC health authorities have indicated that physician engagement is a challenge, and opportunities for improvement exist [10-12].

Securing greater physician engagement at all levels is critical for health system reform and organizational performance [2, 13]. Research shows there is a strong positive link between an organization's clinical and financial performance and the degree to which physicians are engaged in maintaining and enhancing its performance [1, 14]. But engagement is more than doing what the organization wants the physician to do or vice versa. It is about physicians sharing their knowledge and understanding of patient care and physician services by taking a leadership role in system planning, and getting physicians to engage with each other to drive quality and safety, as well as patient and professional satisfaction.

III. What are the barriers to effective physician engagement?

A critical step in improving physician engagement is identifying the individual and organizational factors that can influence physicians' willingness to engage. These include:

- **Lack of physician time.** Engaging physicians in system reform and quality can be difficult because their schedules are often fully booked for patient care. Furthermore, physicians are skeptical about the value of spending time on leadership and engagement, as opposed to treating patients [15]. The time physicians spend on leadership and engagement should be supported and valued (e.g., flexible meeting times, clerical support, timely responses to physician input and requests).

- **Limited training.** Physicians are taught to do their very best in providing individual patient care and to work autonomously, whereas operational leaders are concerned with preserving the organization as a whole and are trained to think "systematically" and "collaboratively." To help bridge the physician-management

divide, opportunities for physicians to improve their understanding of how the health care system functions, and their knowledge of health care improvement models should be provided. Training opportunities should include areas such as leadership, strategic planning, "systems thinking", change management, project management, persuasive communication, and team building [3]. Mentorship for physician leaders and peer physician leadership networks would also foster medical leadership.

- **Professional autonomy.** Professional autonomy plays a vital role in clinical decision-making: physicians must make decisions that are in the best interest of the patient without being unduly limited by external or system constraints. Professional autonomy is also essential to ensure that the provision of physician services focuses on clinical priorities that improve patient health, rather than short-term fiscal goals. Because professional autonomy is a core value amongst physicians, physician leaders may experience challenges in their interactions and relationships with their physician colleagues [16]. Developing strategies to improve collegial support for physician leaders will require as much attention as those encouraging medical leadership. For example, creating opportunities for physician leaders to maintain their clinical competence and experience will help build trust and credibility amongst other physicians.

- **Organizational culture.** A key component for successful physician engagement is creating trust between physicians and organizations. Organizations that are hierarchical, where lines of communication are poor, where physicians are not asked for their opinion, or are asked for their input after a decision has already been made, discourage engagement [15]. Strained relationships with managers, and centrally-mandated targets related to operational efficiency measures have made physicians feel disrespected and disempowered [17]. Informing physicians of a decision should never be construed as engagement.

- **Top-down approach to medical leadership.** A centralized approach to medical leadership can increase physician distrust [18]. Instead, medical leadership that is diffused throughout the organization rather than being centered at the top is becoming increasingly important for building credible leaders, nurturing physician engagement, and engendering change [17]. Encouraging medical leadership at all levels includes appointing physicians in strategic leadership roles, identifying physician champions for clinical governance, and developing shared leadership.

- **Inadequate resources.** Government must take practical steps (e.g., compensation, time, resources, information, skills) to ensure physicians have the time to adequately participate in quality initiatives, and the levers to achieve change [5, 19]. Resources are always scarce, but not engaging physicians is often more costly in the long-term for the organization.

IV. What is the physician's role?

Because of the inherent tensions between costs and patient welfare, physicians must recognize their individual and collective responsibilities in ensuring health system reforms focus on improving patient health [20]. Below are some specific actions physicians can take:

- **Participate in decision-making at all levels.** Physicians' active participation and leadership in quality, patient safety, and health system planning and evaluation are important because their decisions have significant influence over patient care and outcomes. It is therefore important for physicians to be involved when given meaningful opportunities to engage and lead.

- **Undertake leadership, health care improvement and management training.** Medical education, which historically focuses on the physician-patient relationship, does not train physicians for leadership roles. Acquiring management and leadership skills and an understanding of how to improve the health care system will help physicians bridge the clinical and administrative divide and enable them to engage and advocate effectively. Such skills can be used in various settings including leadership and management of medical staff, involvement with strategy and organizational development, champions of clinical governance and operational roles that require a mix of clinical and managerial expertise [3].

- **Value and support physician leaders.** Engaging with physician leaders both in clinical and operational positions is needed to ensure that organizational goals and strategies resonate with front-line physicians. Practising physicians need to support and encourage those physicians who take on leadership and management roles provided they engage with medical staff in an inclusive manner.

- **Be sensitive to management culture and organizational imperatives.** Balancing the allocation of scarce resources to individual patient care and the care of communities and populations in our system is a challenging task. The Institute of Health Improvement's Triple Aim principles (e.g., enhancing patient care, improving population health, reducing per capita cost of care) are steps toward achieving equilibrium between clinical priorities and organizational imperatives [15]. Decisions based on the best available evidence and reached with appropriate consultation and engagement need to be respected.

V. What is the organization's role?

Organizations need to develop and implement strategies that invite and support physicians to lead and engage. These strategies include:

- **Creating a culture that promotes trust and respect.** The relationship between physicians and operational leaders in many parts of the province needs to improve. Part of repairing these relationships requires understanding and addressing the underlying characteristics and values of engaged physicians, ensuring open communication, and sharing evidence of successful collaboration. The development of a physician compact that clarifies roles, expectations and accountabilities can help guide relationships between physicians and operational leaders only if it is developed through an inclusive, collaborative and transparent process, and provides avenues for addressing common issues going forward to demonstrate its elements in action.

- **Reviewing current structures for input and representation.** Medical staff bylaws, medical advisory committee and medical staff structures should be reviewed to ensure these structures are representative and working effectively. These structures should provide physicians with meaningful opportunities to collaborate and influence health system reform and quality at a local or regional level. Engagement activities should value and optimize physicians' time with supports where appropriate, and use meeting times effectively.

- **Sharing relevant data and evidence.** In order to collaborate effectively and build trust, physicians should have access to relevant data to help identify quality and safety gaps, develop performance metrics, and evaluate clinical services. Generating data for system improvement can encourage physicians to take a systems view, and create opportunities for operational leaders to work with physicians on evaluating progress.

- **Promoting physician leaders – both clinical and operational.** Experience in BC and elsewhere has shown that using physician champions or leaders, especially for quality improvement, is effective. With or without a formal title, the background of physician leaders and their standing among peers have a major bearing on their ability to exercise effective leadership, and to bring about change. However, incentives for physicians to become leaders are not always in place or obvious especially when competing with other priorities. Organizations need to create and promote leadership, health care improvement and management training opportunities to all physicians. Physician leaders also need to be supported, rewarded, and recognized for their contributions (e.g., innovation, leadership, management, quality).

References

1. Spurgeon, P., P.M. Mazelan, and F. Barwell, *Medical engagement: a crucial underpinning to organizational performance.* Health Services Management Research, 2011. **24**(3): p. 114-120.
2. Clark, J., *Medical engagement: Too important to be left to chance.* 2012, The King's Fund.
3. Denis JL, B.G., Black C, Langley A, Lawless, B, Leblanc, D, Lusiani M, Hepburn CM, Pomey MP, Tre G. , *Exploring the Dynamics of Physician Engagement and Leadership For Health System Improvement.* 2013.
4. Kaissi, A., *A Roadmap for Trust: Enhancing Physician Engagement*. 2012.
5. Taitz, J.M., T.H. Lee, and T.D. Sequist, *A framework for engaging physicians in quality and safety.* BMJ Quality & Safety, 2012. **21**(9): p. 722-728.
6. BC Women's Hospital, *Medical Staff Compact*. 2012.
7. Fraser Health Authority, *Statement of Expectations between Physicians and the HA*. 2012.
8. Vancouver Coastal Health Authority, *Vision for Physicians and Operational Leadership Collaboration.* 2012.
9. Doctors of BC, *2012 Membership Survey: Board Presentation by Ipsos Reid.* 2012.
10. Providence Health Care. *Medical Staff Engagement*. 2012 [cited 2013 September 26]; Available from: http://medstaff.providencehealthcare.org/?section_id=5116.
11. Interior Health Authority, *2012/13 - 2014/15 Service Plan*. 2012.
12. Northern Health Authority, *2012/13 - 2014/15 Service Plan.* 2012.
13. Reinertsen JL, G.A., Rupp W, Whittington JW., *Engaging Physicians in a Shared Quality Agenda, in IHI Innovation Series White Paper*. 2007, Institute for Healthcare Improvement: Cambridge
14. Ham C, D.H., *Engaging Doctors in Leadership: What we can learn from international experience and research evidence?* 2008, NHS Institute for Innovation and Improvement.
15. Metrics@Work Inc., G., K, Swettenham, J., *Compass for Transformation: Barriers and Facilitators to Physician Engagement.* 2012.
16. Ham, C., *Improving the performance of health services: the role of clinical leadership*. The Lancet, 2003. **361**(9373): p. 1978-1980.
17. Bohmer, R., *The instrumental value of medical leadership: Engaging doctors in improving services*. 2012, The King's Fund.
18. Currie, G. and A. Lockett, *Distributing Leadership in Health and Social Care: Concertive, Conjoint or Collective?* International Journal of Management Reviews, 2011. **13**(3): p. 286-300.
19. Parand, A., et al., *Medical engagement in organisation-wide safety and quality-improvement programmes: experience in the UK Safer Patients Initiative*. Quality and Safety in Health Care, 2010. **19**(5): p. e44.
20. Canadian Medical Association, *The Evolving Professional Relationship Between Canadian Physicians and Our Health Care System: Where Do We Stand?* 2012.

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