Hospital–Physician Relations in a Regional Clinical Department of Psychiatry

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Objective: To review the literature on hospital–physician relations and to describe the experience of one regional clinical department of psychiatry in recruitment and retention of psychiatrists.

Method: Several MeSH headings under organization and administration were examined. The most pertinent literature was found under the heading “hospital–physician relations.”

Results: A recent and growing evidence-supported literature from the United States describes numerous strategies for enhancing hospital–physician relations. Several of these strategies have been used to successfully recruit and retain psychiatrists in a regional clinical department of psychiatry. In four years, 42 psychiatrists were recruited to a region that had lost 30 psychiatrists over the previous three years of regionalization. The net gain was three. The strategies can be summarized under physician leadership, department–system relations, care-management practices, strategic planning, primary care or specialist relationships, management and governance and physician recruitment.

Conclusions: Consistent application of evidence-supported strategies can be used to enhance recruitment and to retain psychiatrists in a regionalized health system.

Key Words: hospital–physician relations, knowledge, health services research, organization and administration, hospital departments, multiinstitutional systems

This brief report was written to address two questions. First, is there evidence-based literature that describes strategies for recruitment and retention of physicians? Second, is that evidence relevant generally to the Canadian context and, in particular, to the context of a single region? Regionalization has become an established facet of health service delivery in Canada (1). According to the HEALNet Regionalization Research Centre in Saskatoon, http://www.regionalization.org/Index.html, nine provinces and one territory now provide health services through regional health authorities (RHAs). In Alberta, RHAs were established in 1994. In Calgary, four separate hospitals, three mental health board clinics and individual physician offices comprised the local mental health system. At the time of regionalization, 90 psychiatrists had privileges with the region and a proportion of this group worked across both the region and the mental health board. Whatever the goals of regionalization, there was a rapid impact on psychiatrists. Within three years, 30 (33%) of the psychiatrists had left the RHA.

The first stage of regionalization explicitly excluded physician involvement, and it took three years before the medical bylaws changed to reflect regionalization. During the interim, the medical staff remained within a site-based structure, while decisions about site closures and moving services were being made at a senior regional level. A
single regional clinical department of psychiatry was established in 1997. In the three years between regionalization and the establishment of a regional department, the number of psychiatrists had dropped below the minimum required to maintain the beds available to the region. As a result, enhancing hospital–physician relations was a priority. This paper reviews the literature that supports these strategies and describes the outcome through the concrete measure of physician recruitment.

Method

Medical subject headings (MeSH) were reviewed for appropriate headings, and nine of these were explored. These included health-care category, organization and administration, hospital departments, hospital–physician relations, hospital restructuring, models, organizational, multinstitutional systems, organizational culture and physician incentive plans. Most did not yield useful references. The most productive was hospital–physician relations, with the following MeSH definition, includes relationships between hospitals, their governing boards and administrators in regards to physicians, whether or not physicians are members of the medical staff or have medical staff privileges.

This yielded 15 references that, upon review, were relevant to the issue (2–17). Several of these included data-based studies using surveys and statistical analysis of the results. The search term “hospital–physician relations” is included in the title, even though the local terminology is “regions” rather than “hospitals.” This connects the article to the literature and reflects the continuing importance of an individual’s identification along three psychological dimensions: the desire to remain with the organization, willingness to exert effort on its behalf and belief in and acceptance of its goals.

Alignment or commitment has been linked to performance. It is easier to demonstrate a link between alignment and performance in business, whereby profit is a concrete outcome measure. Reichheld has used the term “loyalty” to capture the concept of a positive alignment between the organization and the individual (13). Reichheld has shown that loyalty which is measured by alignment between business and customer and business and employee or contractor is an important correlate of profitability. In the medical business literature from the United States, Shortell has noted that many health systems are experiencing difficulty remaining profitable (17). He argues that the traditional approaches to obtaining alignment, such as governance and contract arrangements at the macro level of the organization, have been inadequate. He argues that obtaining successful alignment also requires a sophisticated understanding and use of compensation mechanisms, culture, and physician involvement. Developing the necessary leadership skills is one of the challenges in implementing such alignments.

In Canada, the regional model most resembles the Health Maintenance Organization but differs in that it is not profit-driven. An equivalent economic imperative, however, is a requirement that organizations manage within budgetary restrictions. No Canadian studies of physician–hospital integration were found from the above search. Extrapolating from the study by Dynan (9), it could be argued that a centralized regional organization would not in itself enable physician integration. This is borne out by the early years of regionalization in Calgary.

Implementing Changes at the Local Level

Several steps were taken to improve physician alignment. These changes could be described as structural, aimed at the level of the physician’s organization, and individual, aimed at the level of physician incentives. It was important that the two approaches complement each other and that both sets facilitate communication between the physician and the organization. The process of change management is as important as the changes proposed. Because the focus of this article is on the latter, the change process is not discussed further; however, extensive literature exists on change management (18).

Departmental Structure

The new regional structure was designed to reflect the population-based mandate of the RHA. It also needed to connect with the psychiatrists and the academic department of psychiatry. To achieve the regional population-based responsibilities, the structure of the department was based upon two main principles: the clinical population served and the relationships with other health-care providers. This resulted in seven divisions: child and adolescent, geriatric, forensic, adult inpatient, adult specialized programs, adult primary care and consultation-liaison.

To address the site-based structure of service delivery, four division chiefs also took on the role of site coordinator. The psychiatrists generally connected to the organization through their affiliation with their hospital site or clinic. In addition to the divisions, a regional clinical department of psychiatry executive was established. This
structure allowed for regional planning and site-based implementation. Communication within the department occurred through the executive and in monthly site-based meetings.

The integration between academic and clinical departments occurs through joint appointments of a regional and an academic department head, division chiefs and clinical medical directors.

Realignment of Psychiatrists’ Incentives
A six-point plan was implemented. The components of this plan included the following:

- a regional sessional payment system with agreed-upon principles and transparent accountability (Sessions are used to pay for nonbillable services that support psychiatrists’ activities that meet regional objectives.)
- a regional office rental system with the rent adjusted in relation to the amount of service provided to the region
- a uniform on-call role and process for psychiatrists at each site, with an agreed-upon protocol for transfer of emergency admissions between sites
- sessional support for unfunded services provided when on call
- an agreed-upon role for clinical medical directors, designed to complement the role of patient care manager and supported with sessional dollars

Within four years, these strategies resulted in the recruitment of 42 new psychiatrists and an increase in total numbers from 60 to 93. These strategies can be fitted into the above categories, although specifics vary considerably (Table 1).

Conclusions
This brief report does answer the two questions that were posed at the onset. First, the evidence-based review of the literature suggests that there is a growing body of data-based evidence that provides some guidance on physician–hospital relations. Second, the case example suggests that it is relevant to and can be applied in the Canadian context. It is impossible to tell which strategy is more important than any other. Deming has described the elements of knowledge that underpin change that leads to improvements in systems (19). These include an appreciation of a system, an understanding of variations and a theory of knowledge and psychology. Deming argues that it is the focus on the interaction of these four components that drives the science of improvement. The evidence from business suggests that constructive relations are critical success factors for organizational performance. Physician retention is not a primary outcome variable for achieving improved health-care service delivery, but it is an important intervening variable.

References


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