M.D.s deny, finally accept change
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Modern Healthcare (January 1984): 108-110.

Faced with a threat to their professional lives, hospitals' medical staffs seem to be reacting in a way similar to terminally ill patients facing death.

These physicians' reactions progress from initial denial to eventual acceptance of changes being wrought in their careers by the evolving reimbursement system and tightening markets. It's important for hospital administrators to understand these reactions. Not only is the hospital one of the forces building these changes, but medical staff support may be the most crucial factor determining whether a hospital can succeed in its own struggle to cope. Physicians are a hospital's principal constituents. Yet, failure of administrators and trustees to understand the economic and professional pressures physicians face is causing much unnecessary tension and conflict in the strategic planning and change process.

Nationwide, there's a rising agitation among physicians. Medical journals and publications have documented a steady decline in physician office visit volume during the past 10 years. Physician net income adjusted for inflation has slipped during the same period. Many doctors experienced actual reductions in their incomes during 1982. In view of in expected 40% increase in physician supply during the 19809, these trends may be just the beginning of a significant reduction in physicians' economic and professional freedom.

This isn't just an issue of economics and freedom however. For the physician, it also involves an erosion of the, established doctor-patient relationship.

These conditions have been magnified by a growing hysteria in publications for physicians. Some popular journals have warned of the imminent demise of the private practice, while established periodicals have warned of the impending absorption of physicians into profit-making healthcare corporations.

Against this background, medical staffs have become increasingly concerned about the hospital's incursions into areas traditionally reserved for physician practice. These areas include ambulatory care, diagnostic services, industrial health and occupational medicine.

Pattern of adaptation. A predictable pattern of adaptation can be noted in observing medical staff and physician reaction to the new economic realities. The descriptive framework that most closely approximates this process is that devised by Elisabeth Kubler-Ross, M.D., the psychiatrist who studied how patients adapt to the onset of death. With apologies to Dr. Kubler-Ross, the stages of physician adaptation are: denial, anger, depression, bargaining and acceptance.

Of course, physicians aren't coping with the actual threat of death, but the realities seem only a little less threatening Doctors trained and have practiced in an atmosphere of steadily rising economic and professional expectations. The confounding of these expectations is always dangerous and can strain to the breaking point major institutions in any society. Physician response to an era of increased competition and economic pressure limits the hospital's ability to adapt itself to its own changing economic fortunes. It also confronts administrations and trustees with a not entirely rational set of human problems.

Physicians are emerging from what was a seller's market for their services. They had considerable power to determine their income, working hours, and the nature of arrangements with colleagues and hospitals. Physicians were free to locate geographically where they chose and to manage (within broad constraints of professional ethics) their relationships to their patients pretty much as they saw fit. Some physician communities are still in this idyllic "seller's market" stage.

The invisible "denial" stage. The movement from the idyllic 'seller's market" phase into the "denial" phase is largely invisible to administrators. Physicians may ask colleagues whether their office visit volume has been unusually depressed lately or whether they're having trouble collecting accounts receivables. The discussions tend to remain within the physician community.

Some physicians may begin to adapt to these pressures by integrating into their practices more of the services they have traditionally sent to the hospital, such as routine laboratory work and less intense special surgical and medical procedures. But physicians' dominant response in the 'denial" stage of adapting to a tightening market is to blame the overall economy for the downturn in their activity and, perhaps, incomes and to wait for the rebound. During this stage, doctors often are unwilling to support any dramatic alteration in the mission of the hospital at which they practice.

"Anger" stage broods conflict. Physicians reach the "anger" stage when they become convinced that the economic pressure they face isn't subsiding. In this stage, there's rising opportunity for conflict within the profession as well as between physicians and hospital. The source of the conflict isn't always rational. Indeed, the conflict often is brought about by physicians' unconscious search for someone to blame for their economic problems.

Sometimes, the conflict has taken the form of escalating public confrontation between osteopathic and allopathic physicians. Sometimes, it has taken the form of conflict between foreign-trained and U.S.-trained physicians, each blaming the other's recent arrival for their increased economic difficulties. Yet another variation is conflict among rival specialty groups over parts of the body.

Even more important conflict can arise between physicians and hospitals concerning the perceived encroachment of hospital-sponsored ambulatory services onto turf of the private-practicing medical staff. Woe to the administrator who failed to sense the mounting anxieties of his or her physicians and chose to launch (without consulting the medical staff) a new urgent care center or a contract with a new health maintenance organization during the anger phase. That hapless administrator has given physicians the "answer" to why their practices have leveled or declined.

During the denial stage, physicians tend to feel that the hospital should take no action that could aggravate the temporary leveling or actual decline in practice volume. In the anger stage, doctors can respond by fixing blame on the hospital for their diminished activity, even though physician supply conditions or other factors may, in fact have been responsible. The administrator's dilemma during these two phases is that he or she may sense the need to change the hospital's mission but finds that the political climate within the medical staff or physician community severely limits the hospital's freedom to make these changes.

Administrators who have an open door policy with their medical staffs and who are willing to listen and sympathize with the struggles physicians are facing may help position themselves to deal with the next two stages.

Pressures and "depression." The "depression" stage sets in when physicians real, that public conflict won't ease the economic pressures on them. During this stage, attendance at medical society and medical staff meetings may fall off and membership may drop. Physicians become increasingly willing to discuss their competitive problems with others-family members, administrators and board members.

But they still aren't willing to consider alternative arrangements, including joint ventures with the hospital. Such arrangements include joint financing and development of new services, and formation of independent practice associations or preferred provider organizations. Even in depression, physicians cling to the belief that the conditions in reversible.

The dilemma in "bargaining." Physicians reach the "bargaining" stage when they recognize that alternative arrangements may be necessary to preserve their contact with their remaining patients. The beginning of the bargaining stage presents an uncomfortable dilemma for administrators. The first manifestation is usually a young physician seeking help for his or her nagging practice or asking the administrator's financial support for setting up a new practice.

The danger arises in that the senior members of the physician community, including perhaps medical staff leaders or board members, may still be in one of the prior stages and would perceive

any public actions by the administrator to aid junior colleagues as favoritism or as worsening the existing competition.

The hospital's dilemma is that the young physician may be a serious future competitive threat to the hospital if the administrator can't develop some type of supportive relationship with the doctor. Administrator discretion and the cooperation of related organizations or even friendly bankers and real estate developers may help administrators cope with this problem. But there's no "silver bullet" solution to this political dilemma. There's much danger in dealing with the early stages of bargaining with Physicians.

One is well along in the-bargaining stage when the hospital's chief of staff enters the administrator's office with an article from a journal and says, “Do you think this IPA would work in our community?” or “Do you think we have enough physicians to form a PPO?" This is a truly golden moment for the administrator and one for which it's good to be prepared. Few Physicians have ready access to the technical and staff support needed to launch an alternative delivery system. It's in the hospital's interest to provide this support. Administrators may want to begin developing needed staff capabilities 80 that these ventures can be launched quickly.

The bargaining stage represents a search by physicians for a defensible framework for private practice as well as professionally satisfactory new accommodation between the physician and the hospital. If the atmosphere of trust has been dissipated by response of either side to previous stages, administration may be severely handicapped in responding openly and creatively to the new opportunities that present themselves in the competitive world.

A new world of “acceptance." The satisfactory resolution of these opportunities will bring on the stage of "acceptance" and, for physicians and hospitals, a new world in which effective physician-hospital cooperation will be critical in the success of both. But getting there won't be easy.

For administrators and trustees, it's critical to recognize that the readiness of their medical staffs to respond to changes in the hospital's mission or traditional relationships to physicians may be conditioned by physician response not only to changing economic realities but to changed expectations. Confounded expectations limit a hospital's freedom to alter its mission in the early stages of adaptation. Undoubtedly, these stages will differ in their manifestations in each community. Some communities seemed to have been mired in the "anger" stage for at least the past decade without any major movement toward the bargaining stage.

Administrators may be able to speed the movement of their medical staffs through these stages of adaptation by assembling and sharing information regarding the local health economy, patient migration patterns, physician supply levels and other key variables that may affect private practice. It's unreasonable to expect that administrators will be able to achieve unanimity of medical staff support for changed hospital objectives, grudging acceptance of the need for change may be enough. But making dramatic changes with no ban of physician support or, worse, moving into competition with the medical staff may end up being a career-limiting move for the administrator.