Understanding and Fixing the Growing Divide Between Physicians and Healthcare Administrators

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Bridging the gap between physicians and healthcare administrators is crucial to reducing physician burnout, improving patient outcomes, and advancing value-based care. Changes in the practice of medicine and the increasing complexity of the healthcare system are key drivers of the gap. To begin solving the seemingly intractable problems facing U.S. healthcare, organizations must mend the fractured physician–administrator relationship. We propose that cultivating mutual understanding can achieve this goal. Strategies to increase physician–administrator alignment must center on teaching both groups to walk in each other's shoes. Specifically, we argue that healthcare organizations should: (1) create a patient-centered vision; (2) improve physician and administrator understanding of each other's roles; (3) increase transparency and create opportunities to collaborate; and (4) work to preserve and enhance physician autonomy and respect. These strategies require physicians, administrators, and institutions to come together and collaborate toward a common vision.

KEY WORDS: Physicians; healthcare administrators; physician–administrator relations; patient-centered; value-based care; transparency; interprofessional collaboration.

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Growth in the number of healthcare administrators has far outpaced growth in the number of physicians. Between 1975 and 2010, the number of U.S. physicians grew 150%, roughly proportional to population growth, whereas the number of healthcare administrators increased 3200%.[1] Supporters of this exponential growth argue that increased administration is necessary to navigate changes in healthcare delivery, including advances in information technology, new regulatory requirements, and unprecedented levels of scrutiny. On the other hand, critics say administrator growth increases physician burnout.[2] As administrators impose rules, management procedures, and regulations to streamline clinical processes and achieve the "triple aim" of healthcare, the burden often falls on physicians.

For physicians, increased administration translates to clerical fatigue, increased workload, and tedious documentation requirements—all of which fuel the burnout epidemic in American medicine. In fact, a recent study found that 51% of U.S. physicians experience feelings of decreased personal achievement, persistent cynicism, and emotional exhaustion.[3,4] Furthermore, mounting evidence links physician burnout to decreased patient satisfaction and higher rates of medical errors.[5] Physicians experiencing burnout symptoms are more likely to leave their organizations, or medicine entirely.[6]

Although 83% of healthcare executives acknowledge that physician burnout is a problem, few organizations have devised effective solutions to address the changing physician–administrator relationship.[7] As the number of administrators skyrockets, there is a growing imperative for physicians and administrators to work together and build a compact that is mutually reinforcing. Unfortunately, this imperative is thwarted by tensions between physicians and administrators.[8] Physicians blame managers for creating administrative hurdles that diminish autonomy and increase workload. Administrators blame physicians for failing to comply with resource constraints.[9] This blame game affects patient care: without alignment between physicians and leadership, care is disjointed, and well-intentioned

quality improvement efforts fall short. Moreover, the lack of engagement, understanding, and cooperation between those who deliver care, and those who administer it, damages workplace culture.

The strained physician–administrative relationship highlights the disconnect between those who practice medicine and those who manage the delivery of care. In this article, we argue that addressing this disconnect is possible, and we present concrete strategies to mend the fractured physician–administrator relationship. Specifically, we discuss how both groups can develop a basic understanding of each other's responsibilities, perspectives, and values. Fundamentally, we expect that cultivating mutual understanding, and expanding opportunities to collaborate, can bridge the divide between physicians and administrators.

DRIVERS OF THE PHYSICIAN–ADMINISTRATOR DIVIDE

Changes in the practice of medicine, and the increasing complexity of the healthcare system, are largely to blame for the gap between physicians and leaders of administration, policy, and finance. In the 1970s, hospitals functioned as "open workshops," where physicians treated patients with little administrative oversight. Now, the majority of physicians are employed by hospitals.[1] For physicians, this presents a host of unfamiliar challenges; they must follow official procedures, report to managers, and navigate ubiquitous red tape. Despite changes in the business model of healthcare, both physicians and administrators have struggled to adapt their relationship to the evolving paradigm of clinical medicine.[8]

This failure to adapt stems from differences in perspective and priorities. Although physicians and administrators share core values—service, altruism, and acting on challenges—they differ in approach and knowledge base. Physicians are focused on delivering patient-centered care, whereas administrators are focused on managing resources. Physicians are trained to think patient by patient, whereas administrators are trained to create system-level change.[10,11] These differences are significant—and gaps in mutual understanding can spawn distrust on both sides. To successfully rebuild physician–administrator partnerships, organizations must teach both groups to walk in each other's shoes.

THE WAY FORWARD: STRATEGIES FOR IMPROVING PHYSICIAN–ADMINISTRATOR RELATIONSHIPS

Improving the U.S. healthcare system requires collaboration between physicians and administrators. Rather than siloing the individual expertise of physicians and administrators, organizations must leverage this collective knowledge to improve patient care. We propose four strategies for strengthening physician–administrator relationships.

Unite Around a Common, Patient-Centered Vision

A frequent source of physician–administrator disconnect is a poorly defined vision. Because physicians are tied to their profession, and managers are tied to the organization, finding common ground requires a shared vision of care. For example, at the Mayo Clinic, this vision is explicitly stated: "the needs of the patient come first."[12] Centering patient needs is crucial for aligning the needs of physicians and administrations. A patient-centered culture can help hospital executives demonstrate their commitment to providing high-quality care and restore physician trust in managerial decision-making.

Crafting an organizational vision requires understanding and articulating the responsibilities of both physicians and administrators.

Additionally, organizations must emphasize that change comes from improvements in frontline care. Many healthcare organizations present a blurry vision that is focused on systemic, rather than clinical, improvements. To adequately recognize the contributions of physicians, organizations must refocus their vision statements. Instead of macro-level statements (e.g., "providing better outcomes at lower costs"), organizations can highlight the dedication, autonomy, and impact of physicians. A well-defined vision should acknowledge what physicians currently do, and also push them to improve with the organization. This strategy can re-engage physicians—and when physicians feel valued, they are more likely to collaborate with administrators.

Crafting an organizational vision requires understanding and articulating the responsibilities of both physicians and administrators. For example, the Wheaton Franciscan Medical Group (WFMG), a group of primary and specialty physicians, created a physician–administrator compact to codify expectations, facilitate intergroup discussion, and resolve conflicts when they arise. This compact is the basis for WFMG's strategic vision.[13] Organizations should thus: (1) articulate the roles and responsibilities of physicians and administrators; and (2) identify an operational vision consistent with these responsibilities.

Improve Mutual Understanding of Roles

Physicians and administrators come from vastly different professional backgrounds. The ensuing lack of

understanding about each other's roles creates a cultural gulf between the two groups. Although physicians trust other physicians due to shared experiences, studies show that physicians and non-physician hospital executives rarely share the same perspective.[9] Because neither physicians nor administrators are trained in understanding each other's language or arena of knowledge, both groups struggle to communicate with the other. To improve mutual understanding of roles, we need better education on both sides. Organizations must teach clinicians about administration, and likewise, teach administrators about clinical medicine.

Teaching clinicians about the "business of medicine" is essential. When physicians understand how administrators make decisions around the financing, delivery, and operations of healthcare, we can expect fewer misunderstandings and increased collaboration. To educate physicians on these topics, we can: (1) expand opportunities to gain management, policy, and leadership training during medical education; and (2) prompt healthcare organizations to offer similar training opportunities to practicing clinicians. As academic institutions recognize the value of equipping physicians with business skills, there has been a recent expansion in MD/MBA programs and administrative fellowships.[14] However, these programs are optional and are tailored to students already interested in management. Students expecting to enter full-time clinical practice have few opportunities to deepen their understanding of healthcare administration without sacrificing clinical training.

One potential solution is embedding basic training in hospital operations, finance, and policy in clinical rotations. Alternatively, rather than supplementing medical training, institutions could create opportunities for practicing clinicians to learn the basics of how healthcare is paid for, and how payment structures impact care delivery. For example, in the CareMore Health System, the CareMore Academy is specifically designed to educate physicians on finance, health plan network operations, and clinical analytics. In fact, administrative staff themselves train clinicians in these areas when new staff are onboarded.

It is equally important to educate administrators on the nuances of clinical medicine. Many administrators struggle to understand "clinical speak" and grow frustrated when administrative changes fail to drive clinical improvements. After all, physicians are at the heart of every healthcare organization. To have an impact on performance, administrators must first understand what medicine entails. One way for administrators to appreciate the complexities of care delivery is through clinical shadowing. At Mission Health, administrators experience Immersion Day, a 9- to 12-hour day of observing clinical procedures, walking through hospital departments, and speaking candidly with physician colleagues about their experience caring for patients. Board members see Immersion Day as transformative—not only does the experience inform their administrative priorities, but it also engenders trust from physicians.[15] By bringing administrators closer to clinical care, organizations can bridge the distance between boardroom discussions and the real-world care setting.

Increase Transparency and Provide Opportunities to Collaborate

Many healthcare organizations rely on top-down executive mandates. Moreover, administrative decision-making is siloed, and physician input is poorly used. To reduce physician distrust of administrators, organizations must: (1) increase transparency around how and why administrators make decisions; and (2) create opportunities for physicians and administrators to collaborate. Ultimately, administrative decisions impact clinical care. Without transparency and physician engagement in decision-making processes, organizations are ripe for physician–administrator conflict.

To improve system-wide transparency, organizations must include frontline clinicians in management decisions.

To improve system-wide transparency, organizations must include frontline clinicians in management decisions. Giving physicians a greater say through seats on administrative boards or hiring of physician–administrators increases their commitment to change. One study showed that, in management-led organizations, physicians felt excluded from efforts to control costs, improve performance, and change payment models. These physicians were more reluctant to embrace change.[16] Because administrators are often frustrated by physicians who resist new systems, engaging physicians in decision-making can improve physician–administrator alignment. For example, at Rochester General Health System in New York, the hospital uses a physician council consisting of physicians and executive team members to improve the practice environment and increase physician buy-in.[17] Physician engagement must extend beyond tokenism ("we have a physician on the committee"), however, to a genuine desire to understand how management practices influence the practice of medicine. The commitment must be to representation—and cultural transformation.

Increasing transparency also requires improving channels of communication. Given the bureaucracy of healthcare organizations, physicians may struggle to communicate their concerns to administrators. Only by communicating with each other can physicians and administrators create a shared agenda. Open lines of communication must entail more than newsletters, accessible email addresses, and social media updates. Rather,

administrators should increase physician facetime; for example, several organizations have demonstrated the value of holding open-door executive meetings.[17] Lastly, leadership must support an open, inclusive communication policy. Without the right people at the helm, we cannot expect institutions to advance transparency.

Alongside increasing transparency, organizations must create opportunities for physicians and administrators to collaborate. Rather than relying on top-down directives, organizations must innovate from the ground up. All levels of physicians—from trainees to attending—should contribute to decisions around care delivery and resource allocation. Harnessing the ingenuity of physicians also can improve care quality. One analysis of hospital CEOs showed that physician-led hospitals receive 25% higher quality scores than manager-led hospitals.[18] This result does not imply that all healthcare organizations should be physician-run—rather, it cautions against separating managerial and clinical knowledge.

Respect is as important as autonomy

To achieve this vision of physician–administrator collaboration, organizations must reshape the culture of innovation. As the landscape of healthcare delivery evolves, administrators must support leaders at all levels. This concept, known as "distributed leadership," views leadership as a social function rather than a position. Ample evidence shows that distributed leadership models increase staff engagement.[19] By sharing responsibility between physicians and administrators, we can increase physician satisfaction and reduce physician–administrator tensions. For this strategy to work, administrators must encourage physician-led innovation. Administrators could solicit quality improvement ideas from physicians and together brainstorm solutions to outstanding issues. Or, as the American Medical Association does in its Healthier Nation Innovation Challenge event, organizations can provide incentives for physicians to draw on their frontline clinical experience and develop solutions for improving care, operations, and financing.[20]

Preserve Physician Autonomy and Respect

Many fear that increased administration infringes on physician autonomy. Although physicians entered medicine to care for patients, they are burdened by the barrage of rules, regulations, and reporting systems. Despite their expertise in their own domain, physicians are forced to follow directives from nonclinical leaders. Without clinical autonomy, physician burnout is expected.[21] To preserve physician autonomy, administrators can engage physicians in active problem-solving, rather than passive rule-following. Consider the financial incentives distributed by alternative payment models. These models are designed under the assumption that physician behavior can be modified by financial compensation, although the limited success of these models suggests otherwise. Instead, organizations could teach physicians to use hospital data, identify problems with quality and cost, and provide input to administrators. When physicians are empowered to make informed decisions, physician–administrator alignment will follow.

Respect is as important as autonomy. Physicians feel alienated when administrators dismiss their concerns about administrative burden, workplace culture, and job responsibilities. Alongside implementing the aforementioned strategies to improve physician–administrator relations, institutions must cultivate a culture that prioritizes physician well-being. If institutions want to restore trust between physicians and administrators, they must respect physician complaints. And organizations must do more than listen: if physicians are overwhelmed by clerical work, managers should shift some administrative work to scribes. Administrators should also refer to physicians as "physicians" and not "providers." Although this seems a purely semantic issue, this change is important; when administrators use the term "provider," they devalue physicians' contributions, training, and experience. Respect and responsiveness are foundational to building trust between two groups that have historically been at odds with each other.

With the advent of value-based care, alignment between physicians and administrators is more crucial than ever. Although cultural change is never easy, healthcare organizations must recognize the value and necessity of bridging the physician–administrator gap. We cannot advance delivery reform without the robust engagement of both physicians and administrators.

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