

Strategies to help you survive hospital politics

A hospitalist veteran gives tips for succeeding at political tug-of-war

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If a hospitalist program is going to survive and succeed, it needs to negotiate the politically charged waters that permeate every hospital, plague every medical staff and drive every group's dynamics. Put a large group of people together in a complex work setting, after all, and politics will inevitably follow.

Perhaps no one understands the political dynamics that hospitalists face better than Stacy Goldsholl, MD, a veteran hospitalist who is currently president of TeamHealth Hospital Medicine. Over the last 13 years, she has directed a number of different types of hospitalist programs. That long track record gives her valuable insights into what works—and what can go wrong.

Speaking at a meeting sponsored this summer by HCPPro on how to develop a hospitalist program, Dr. Goldsholl discussed the intersection of medical practice and politics, outlining strategies that hospitalists can use to navigate tricky political waters.

Parce out the "asks"

To successfully maneuver through workplace politics, Dr. Goldsholl said, hospitalists should start by getting to know the various stakeholders in their hospital. This includes the hospital's administration, who may be funding the program; hospitalists working for other groups; emergency department physicians; primary care physicians; nurses; consultants on the medical staff; and payers and patients.

A critical factor is how well all these factions get along. "Natural dissonance is there," Dr. Goldsholl told the audience. While that can be managed, you need to understand the expectations of each group.

For instance, how will the scope of practice of the local primary care physicians change when a hospitalist program comes in? Or does a highly productive surgeon want capital funding for a new cardiothoracic unit, forcing the hospital to decide where to put its money?

A useful way to think about workplace politics is to consider "asks", which Dr. Goldsholl defined as who is asking for what. Politics come into play, she said, when you consider "how to manage these asks," and how to make the outcome positive not only for the hospitalists, but for other stakeholders.

"There's often a struggle for power, and everyone has his or her own agenda," she said. "Sometimes the hospitalist is just trying to keep clean and stay out of trouble."

Defining hospitalist roles

One factor that will affect hospital politics is the role that hospitalists play in patient care. For instance, a common expectation is that hospitalists will do much of the work formerly covered by "house officers."

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TeamHealth Hospital Medicine



Dr. Goldsholl said that when that's the case, programs would be well-advised to include from the start a 24/7 midlevel service overseen by the hospitalists. Fail to address the expectations of around-the-clock coverage, she warned, and the environment will sour quickly.

Another expectation that hospitalist programs should anticipate is how physicians' roles will change over time as the program grows and expands. In many facilities, hospitalists started out as glorified house officers. Now, however, hospitalists are often essential inpatient managers, more central to hospital operations than the higher paid surgeons and procedurally oriented specialists. As roles change, Dr. Goldsholl said, so do politics.

"It's all about what the hospital needs," she said, as well as about who can provide those needs and how.

What PCPs want

Finding out what primary care physicians want is critical to managing expectations.

"The No. 1 thing they want, I find, is the return of their patient," Dr. Goldsholl said. As a result, hospitalists need to set up their program in such a way that there can be no opportunity for patient stealing.

Another common political hurdle to clear occurs when primary care physicians ask hospitalists to provide "split call arrangements." This typically occurs when some of the doctors in a call-sharing group want to refer their inpatients to hospitalists, while others don't. Managing that ask, she said, "can get a little convoluted."

One solution, particularly for a start-up hospitalist group, can be a night admitting service, Dr. Goldsholl said. A night admitting service can serve as a way for the medical staff to "get a taste" of hospital medicine—and to encourage them to refer all their inpatients.

She cautioned, however, that this type of service has to be structured extremely carefully, so the quality of patient care doesn't suffer because of confusion over which doctor is responsible for which patient during the day.

And what about primary care physicians who ask for only vacation and weekend coverage? "It's best to prune that tree before it takes root," Dr. Goldsholl said, by telling PCPs upfront that that is not how the program operates. To cover weekends and vacations, she explains, primary care physicians must give the program their regular business.

That doesn't mean, however, that the conversation is closed. "We might say, 'Let us get to that next year. Let's develop relationships with you where we will be happy to provide that coverage for you. Let's see where our volume is.'"

What subspecialists want

Common requests from subspecialists on the medical staff generally have to do with the scope of service that hospitalists can provide. Concerns can include using consultants equitably, allowing consultants to work with other consultants on your patients, co-managing surgical patients and handling transfers of care.

As an example of how a hospitalist group can change a hospital's political landscape, she recalled that in one hospital where she started a practice, there were two cardiology groups, one with 14 physicians and one with just two or three.

While the larger group dominated the hospital, it was often too busy to give timely consults to the hospitalists. Members of the smaller group, on the other hand, were quick to respond, getting patients to the cath lab in a matter of hours, not days. As a result, the hospitalist group gave much of its business to the smaller group.

“After about 18 months, we grew that group to six physicians,” Dr. Goldsholl recalled. The hospitalists had to deal with the political ripples, going back to the primary care physicians who referred to the larger group and explaining why the hospitalists needed to make other referrals.

Politics related to scope of practice and throughput also come into play between the hospitalists and the emergency department. Dr. Goldsholl said that specific questions usually are variations of the general question: Where does your job end and my job start?

Like many other asks that hospitalists have to field, she said, these are often best handled by defined rules of engagement and communication. She recommended regular monthly meetings between the medical directors of the hospital medicine and the ED programs.

Medical director

Another potential political minefield for hospitalist programs: hiring a medical director. Dr. Goldsholl said that exactly who is tapped to lead a program will have far-reaching consequences in determining how well the program copes with workplace politics.

From her own experience, Dr. Goldsholl said that she has learned to “never underestimate” the fact that the hospitalist program director must be part of the local community and of the hospital’s culture.

“A very large hospital approached me about running their program years ago, and I thought it was a great offer,” she said. But she quickly learned that as an outsider, she wasn’t the right candidate for the job

For one, she had no interest in moving to the rural community where the hospital was located. While the hospital’s administration approved the idea of her working off-site part of the time, “the medical staff did not think it was OK.”

Looking back, Dr. Goldsholl said, she was clearly not the right match. The physician who replaced her came from a local internal medicine practice. While he was a relative newcomer to hospital medicine when he started, she said, “the physicians trusted him, and he’s still there. The group is now hiring its 21st hospitalist.”

And when it comes to starting up a new program from scratch, Dr. Goldsholl suggested bringing a medical director on board a month or two before the service opens for business.

That gives the new director time “to schmooze, to meet, to greet, to educate, to have lunch with your surgeons, your orthopedists and your primary care doctors,” she said. “That person needs time to describe the vision of the program and develop relationships before you unleash the torrent of patient volume.”

Hospitalist satisfaction—and turnover

Finally, when it comes to managing requests of various groups, it’s important to draw the line when saying “yes” will hurt hospitalist job satisfaction. Because it’s so difficult to recruit hospitalists, Dr. Goldsholl said, satisfaction and turnover play a critical role in the political dynamics of hospital medicine.

A good example is addressing primary care physicians’ requests that you care for their patients only on weekends or during vacations. If you say yes, she explains, expect pushback from your physicians. “That’s going to be a tough sell,” she said, “particularly when you’re trying to recruit physicians to the group.”

If that pushback translates into turnover, your program could be in trouble. Turnover is costly both in terms of money and quality, she pointed out. And then there’s the amount of time it takes for a new hospitalist to become adept at maneuvering through the politics in a new hospital.

“The rule of thumb,” she said, “is at least a year.”