A Roadmap for Trust: Enhancing Physician Engagement

Amer Kaissi

Where Evidence Meets Action
Preface

Physician engagement is a top-of-mind issue in health organizations and systems.

Physician engagement arises out of the broader concept of employee engagement. Employee engagement has many definitions, and one that is commonly used is “...a positive, fulfilling, work-related state of mind characterised by vigour, dedication, and absorption.”¹

When organizations have engaged employees, their bottom line tends to be higher; their turnover is lower; they are more likely to develop, attract and retain high-calibre employees.² Health organizations and systems have taken note that there are potential returns from having more engaged employees and their physician colleagues. Research from countries around the world is underscoring that when physicians are engaged their organizations tend to perform better, have higher satisfaction levels, lower turnover rates, and improved patient satisfaction scores and patient outcomes.

In late 2011, the Regina Qu'Appelle Health Region (RQHR) completed a baseline physician engagement survey. The survey results demonstrated room for improvement in a number of areas including insufficient involvement of physicians in decision making, and a lack of trust and respect between physicians and administration. Significant work is now being focused on how to improve the situation regionally and provincially.

To this end, RQHR has now embarked on its Enhancing Physician Engagement (EPER) project. An established research framework for the project forms the fundamentals of ‘true engagement’—acting together and deciding together. It builds on the regional RQHR values of compassion, respect, collaboration, knowledge and stewardship.

Three research papers have been authored over the summer of 2012. They are:

- Anchoring Physician Engagement in Vision and Values: Principles and Framework by Graham Dickson
- Compass for Transformation: Barriers and Facilitators to Physician Engagement by Metrics@Work Inc., Kelly Grimes, and Julie Swettenham
- A Roadmap for Trust: Enhancing Physician Engagement by Amer Kaissi

The RQHR believes that engagement is a leadership competency required for transformation and is not simply a top of mind, corner of the desk strategy. The RQHR hopes to further physician engagement, both within its own region and beyond by sharing its leading research and up-to-date insights from international leaders in physician engagement.

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Team for the preparation of *A Roadmap for Trust: Enhancing Physician Engagement*

### Author
Amer Kaissi

### Internal Challengers
Glen Roberts  
Tracy Bertram

### External Challenger
Brian Geller

### Project Leader
Glen Roberts

### Editor/Layout
Jane Coutts  
Lynda Becker

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Executive Summary

The purpose of this report is to provide specific recommendations to enhance physician engagement in healthcare organizations. It summarizes the evidence on physician engagement, drawing on peer-reviewed articles and reports from the grey literature, and suggests an integrative framework to help healthcare managers better understand and improve physician engagement. While we examine some other international examples and experiences, we mainly focus on physician engagement in Canada, the United States and the United Kingdom.

Research addressing physician engagement has proliferated in the last few years. However, it is important to note that most of the papers and reports published in this area have been based on opinions and experiences, rather than strong theoretical models and empirical evidence; therefore, the evidence provided in this report should be considered cautiously.

Healthcare organizations have traditionally been described as professional bureaucracies where physicians have significant control and autonomy. Legislative, political and administrative changes in the last few decades have resulted in pressures that have affected physician independence. In addition, significant cultural differences have also contributed to the tensions between physicians and managers/hospitals. Physicians and managers have different socialization, training, worldviews, value orientation and expectations resulting in important gaps in beliefs and attitudes. These factors have led to serious problems of physician distrust, skepticism and disengagement.

Physician engagement is defined as “the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organization which itself recognizes this commitment in supporting and encouraging high quality care” (Spurgeon, Barwell, and Mazelan, 2008; Spurgeon, Mazelan, and Barwell, 2011). Therefore, it is conceptualized as an on-going two-way social process in which both the individual and organizational/cultural components are considered. It is closely related to other important concepts in the physician-management literature. Effective communication and perceptions of power lead to physician trust in management/hospitals, which is the willingness to rely on, and engage with management/hospitals even under high-risk conditions. Trust allows the two parties to overcome the differences and barriers that exist between them, and to align or integrate. In turn, this can lead to physician engagement, which encompasses satisfaction and commitment. When physicians are engaged, they act as leaders in the healthcare organization, which can improve performance.

Determinants of physician engagement include individual factors and experiences of physicians, consisting of functional and personal connections established in the organization. Functional connections reflect a perceived partnership between the physician and the organization built and strengthened through reliable and efficient delivery of high quality healthcare, whereas personal connections reflect emotional bonds that form and mature between a physician and an organization.

It is also important to note that one report found that younger physicians tend to be less engaged than older ones, while the evidence is mixed on whether salaried physicians are more or less engaged. However, physician engagement cannot be appropriately understood at the individual physician level alone. To a great extent, the organizational and cultural conditions under which the physician operates that determine whether engagement is encouraged or inhibited. At the individual level, engagement is affected by his or her perceptions of personal empowerment, confidence in taking on new challenges and increased self-efficacy.

While measuring physician engagement had proven to be elusive in the past, the Medical Engagement Scale (MES) recently developed in the U.K. provides a valid and reliable tool centring on three meta-scales: feeling valued and empowered; having purpose and direction; and working in an open culture.
In addition, a new tool developed in the U.S. by Morehead Associates gives nine important drivers of physician engagement:

- having confidence in the organization’s success;
- believing that the organization cares about its customers;
- being satisfied with the teamwork demonstrated among departmental staff;
- being satisfied with the overall performance of hospital administration;
- feeling patients are satisfied with the quality of care they receive;
- perceived usefulness of the continuing medical education offered;
- being satisfied with the performance of the nursing staff;
- feeling the organization cares about quality improvement; and,
- believing that the organization treats physicians with respect.

Most applications of physician engagement have focused on involving physicians in quality improvement and safety initiatives. Empirical studies have provided a strong link between physician engagement and organizational outcomes such as improved quality, service and financial measures. A few have even shown a specific return on investment (ROI) for physician engagement efforts.

Several conceptual models and frameworks for physician engagement have been presented in the peer-reviewed and grey literature. Of these, three are most noteworthy. The “Medical Engagement Model” developed by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal College emphasizes the interaction between the availability of organizational opportunities to engage, and physicians’ individual capacity to engage. Morehead Associates’ empirical “Physician Engagement Model” says four domains influence physician engagement: administration, organization, department and staff; and argues that the most engaged physicians have favourable attitudes toward these domains. More recently, drawing on various national and international studies and perspectives, the NHS proposed a new framework for physician engagement with an emphasis on physicians wanting to take centre stage and accept increased responsibility, as “engaged shareholders.”

Recent results from physician satisfaction or engagement surveys in Canada, the U.S. and the U.K. have shown that physicians are generally distrustful of hospital management, feel uninvolved in major hospital decisions and strategies, and are disillusioned with the communication and support they get from hospital management.

Strategies and practices used by high-performing organizations with a successful record of engaging physicians have appeared in the literature in the last five years. They vary from enhancing physician engagement in general, to engaging them in specific organizational domains or projects such as leadership or quality improvement. For example, the Institute for Healthcare Improvement (IHI) proposed a framework for engaging physicians in quality and safety that stresses discovering common purpose; reframing values and beliefs; segmenting the engagement plan; using “engaging” improvement methods; showing courage; and adopting an engaging style. Based on its work with 300 hospital clients in the United States, Morehead Associates suggested three best-practice themes for increasing physician engagement are focusing on communicating; building trust; and partnering and aligning with physicians. Recent approaches have included creating physician-manager dyads, and developing a physician-hospital compact establishing a consistent set of rules and behavioural expectations for both sides.

We propose a new integrative framework for enhancing physician engagement in healthcare organizations that builds on several frameworks and examples (Figure 9). We suggest that in order to enhance physician engagement, organizations should focus on the following strategies:

- Developing clear and efficient communication channels with physicians;
- Building trust, understanding and respect with physicians; and
- Identifying and developing physician leaders.
Moreover, we propose specific tactics and practices under each strategy. These are meant as recommendations, rather than a prescriptive how-to manual. There is no one-size fits-all in physician engagement and organizations can choose to focus on some practices more than others. However, it is our opinion that organizations that want to affect physician engagement in the medium- to long-term should start by:

1. Holding formal and informal face-to-face meetings with all physicians to listen to their issues and address them (through appropriate follow-up), preferably in settings convenient for physicians.

2. Involving most physicians in the majority of managerial decisions and strategic plans and integrating their input.

3. Creating formal training and development opportunities for physicians to cultivate and refine their leadership skills.

Obviously, adopting these practices will require significant commitment of time, energy and money on the part of healthcare managers. However, we strongly believe that enhancing physician engagement is a worthwhile endeavour that will have far-reaching positive effects on the clinical, service, and financial outcomes of any healthcare organization, and should be given precedence by healthcare managers. Now is the time for healthcare managers to set aside traditional differences and historical conflicts and engage their physicians for the betterment of their organizations.
I. Introduction

Healthcare organizations are complex institutions that are strongly dependent on physicians to deliver high-quality, cost-effective care. Improving the bond between physicians and the organization, which most organizations have done a poor job of, is a key challenge facing healthcare managers in most health systems today. It is striking how many organizations spend great resources on attracting and recruiting the best and brightest physicians, and then somehow disengage and alienate many of them.

There is strong evidence that engaging physicians and involving them in managerial projects and issues is a crucial strategy for managers: physician engagement is not a luxury or an optional extra, but a necessary ingredient for the long-term success of the organization.

The term “physician engagement” has become more common in the scientific and popular literature in the last decade. However, only recently have there been serious attempts to define it as a separate construct. Numerous efforts, especially in Canada, the United States and the United Kingdom, have materialized to better understand and measure physician engagement, and to find ways to enhance it in healthcare organizations. However, it is important to note that most of the papers and reports published in this area have been based on opinions and experiences, rather than strong theoretical models and empirical evidence. Therefore the evidence provided in this report should be considered cautiously.

This report will summarize the evidence on physician engagement, drawing on peer-reviewed articles and reports from the grey literature, and will provide an integrative framework that can aid managers to enhance physician engagement in their organizations. While we will examine some other international examples and experiences, we will mainly focus on physician engagement in Canada, the United States and the United Kingdom.

II. Physician Engagement

“Transforming health care organizations requires effective strategies for engaging doctors and developing medical leaders who can overcome the inertia of traditional professional bureaucracies.” —Ross Baker and Jean-Louis Denis, 2011

Historical and Current Contexts of Physicians in Hospitals

Healthcare organizations have traditionally been described as professional bureaucracies (Mintzberg, 1979). In these types of organizations, front line staff such as physicians have significant control over their work by virtue of their training and specialization. They typically have greater control over day-to-day decisions than staff in formal positions of authority such as managers and leaders. As a result, managers and leaders have to negotiate, not impose, new rules and regulations, and control is achieved through horizontal, not hierarchical, processes (Ham and Dickenson, 2008). In this setting, physicians have traditionally maintained a model of individual professionalism and clinical autonomy, “where each practitioner works with his or her own patients in discrete areas of practice and where the defining influence on medical decision-making is based on assessing the needs of the patient” (Baker and Denis, 2011, p. 355).

Starting in the 1960s, external pressures challenged physicians’ professional dominance in healthcare organizations. These pressures have varied by healthcare system (as discussed below), and their effects have been studied by numerous scholars. Friedson argued that despite the pressures, physicians managed to maintain their clinical autonomy in the 1970s and 1980s through “internal differentiation” (Friedson, 1985). This resulted in the emergence of a new professional regulatory élite that designed and implemented internal control over medical practice without jeopardizing its autonomy. However, others have argued the external pressures have led to the
corporatization of medicine (Starr, 1992; Bazzolli, 2004) and to significant reduction in physicians’ autonomy (McKinlay and Arches, 1985).

In Canada, the move to a universal healthcare system (starting in 1966 and continuing in 1984) was not well received by many physicians, who were frustrated by the government’s dictating of where they practice, how they practice, and the fees they receive for their clinical services (Choudhry, 1996). Since then, attempts by government and healthcare organizations to improve efficiency and reduce costs have often been seen by physicians as further infringements on their practice and autonomy. As such, the “restructuring of the health system continues to be viewed by some physicians with suspicion and the concern that it is not about improving patient care, but about reducing physician power and autonomy over their clinical practice” (Simms, 2008, p.9). Recent studies have shown that only 51% of Canadian physicians are satisfied with their relationship with hospitals (Comeau, 2007). However, other sources show physicians have been able to maintain some power and autonomy within the system even in a period of economic constraints (CIHI, 2010).

In the United Kingdom, the formation of the National Health Service (NHS) in 1948 emphasized clinical autonomy, as physicians continued to control and regulate their own activities without interference from politicians or managers (Ham and Dickenson, 2008), which may be different from the experience physicians have in the NHS nowadays. In 1983, the publication of the Griffiths report argued for a greater role for general management in healthcare organizations to create more accountability for clinical decision-making (Griffiths Report, 1983). However, the changes generated by the report and other subsequent developments have had a limited impact on physicians, who have largely been able to maintain their autonomy and influence (Ham and Dickenson, 2008). Nonetheless, feelings of distrust, especially on the physicians’ side, have continued, as more and more physicians believe that managers are driven more by financial than clinical priorities (Rundall, Davies, and Hodges, 2004).

In the United States, managers gained more control over the allocation of resources and started to play a more central role in the hospital starting in 1974 with the passage of the Health Planning and Development Act. However, the implementation of the Medicare Prospective Payment System in 1983 created competing incentives for managers and physicians, as managers’ most important incentive became cost-containment, while physicians only concern remained patient care. Consequently, managers realized the importance of obtaining physicians’ cooperation, and a new period of physician-manager relationships developed, characterized by shared authority and increased physician involvement in governing and strategic decision-making. In the 1990s, the relationship became even more complex as factors such as declining reimbursement rates, cost-containment pressures, relationship with Health Maintenance Organizations (HMOs), increasing malpractice costs, and regulatory pressures intensified (Kaisi, 2005; Burns, 1993). That period also witnessed a trend of hospitals’ acquisition of physician group practices and employment of physicians. But the trend was reversed by the late 1990s and early 2000s as hospital financial losses accumulated (Kaisi and Begun, 2008). The last decade has witnessed two opposing trends in physician-hospital relationships in the U.S.: on the one hand, physicians have separated from hospitals and competed with them by developing their own specialty hospitals, ambulatory surgery centres and ancillary services; on the other, they are working with hospitals in joint ventures and employment agreements (Berenson, Ginsburg, and May, 2006). The passage of healthcare reform in 2010 and its implications for reimbursement has created real incentives for a repeat of the 1990s wave of physician acquisition, and physician employment by health systems has been on the rise in the last few years.
Differences between Physicians and Managers

In addition to external pressures, several cultural differences also contributed to the tensions between physicians and hospitals (and consequently physicians and managers, Table 1). Waldman and Cohn referred to these differences as “the gap,” a substantive and perceived gulf between physicians and managers characterized by differences in thinking and approach, priorities and incentives, and responsibilities and roles (Waldman and Cohn, 2008). Kaissi suggested that physicians and managers represent different “tribes,” with different socialization, training, worldviews, value orientation and expectations (Kaissi, 2005). More specifically, Edwards described how physicians and managers differ in their views on five key dimensions: accountability vs. personal autonomy, clinical purists vs. financial realists, systemization of clinical work, individuals vs. collectives, and power (Edwards, 2003). Similarly, Mohapel and Dickson highlighted differences in attitudes and perceptions, culture and norms, and structural systems (Mohapel and Dickson, 2007). More recent studies have provided empirical evidence to differences in perceptions of reality (Klopper-Kes, Siesling, Meerdink, Wilderom, and Van Harten, 2010) and to managers’ perceptions of physicians (Von Knorring, De Rijk, Alexanderson, 2010).

Table 1: Manager and Physician Cultures (Adopted from Kaissi, 2005)

<table>
<thead>
<tr>
<th>Area</th>
<th>Managers</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Assumptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central logic</td>
<td>Rationalization, efficiency</td>
<td>Collegial control, expertise</td>
</tr>
<tr>
<td>View of work</td>
<td>Make a living</td>
<td>Work is living</td>
</tr>
<tr>
<td>Values</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary loyalty</td>
<td>To the organization</td>
<td>To the patient</td>
</tr>
<tr>
<td>Responsibility</td>
<td>Shared</td>
<td>Personal</td>
</tr>
<tr>
<td>Tolerance for ambiguity</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Patient focus</td>
<td>Broad</td>
<td>Narrow</td>
</tr>
<tr>
<td>Time frame of action</td>
<td>Middle-long</td>
<td>Short</td>
</tr>
<tr>
<td>View of resources</td>
<td>Limited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Artifacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basis of knowledge</td>
<td>Social/Management sciences</td>
<td>Biomedical sciences</td>
</tr>
<tr>
<td>Exposure to others while in training</td>
<td>Little</td>
<td>Great</td>
</tr>
<tr>
<td>Relationships</td>
<td>Hierarchical</td>
<td>Collegial</td>
</tr>
<tr>
<td>Career development</td>
<td>Hierarchical advancement</td>
<td>Achievement</td>
</tr>
<tr>
<td>Vocabulary</td>
<td>Cost, benefit, revenue</td>
<td>Quality, patient outcomes</td>
</tr>
</tbody>
</table>
Along the same lines, Bujak uncovered differences in beliefs and attitudes between physicians and managers (Bujak, 2003). He postulated that physicians have an “expert culture” where decisions are made quickly, whereas managers have a “collective culture” where teamwork is emphasized and the process of decision-making is sometimes more important than its outcomes. Physicians also have differing perceptions of time: for physicians “now” means immediately, whereas for managers “now” may mean the next quarter or next budget cycle. In addition, physicians have a linear, reductionist perspective characterized by thinking that “I am responsible for this patient and I need what I need now, no matter the consequences,” in opposition to managers who have a more systemic perspective characterized by always trying to do the greatest good for the greatest number. In relation to patient care, Bujak describes the “problem of the apostrophe”: physicians act as the patient’s advocate (singular), whereas managers act as the patients’ advocate (plural).

More pragmatically, Holm describes differences in decision-making and personal investment (in an American context): while physicians make decisions in entrepreneurial environments in their own practices, managers make decisions in bureaucratic environments in hospitals; and while physicians sometimes invest from their own funds, managers have lower stakes because they always invest from organizational funds (Holm, 2004).

These substantive differences between physicians and managers create serious problems and barriers to working with each other. Chervenak and McCullough describe two important problems in physician-manager relationships: “strategic procrastination” and “strategic ambiguity” (Chervenak and McCullough, 2003). Strategic procrastination is a tactic used by physicians when they do not cooperate with data collection, do not attend managerial meetings, and delay implementation of managerial projects. The goal is to protect physician autonomy and power by keeping old practices undisturbed. Strategic ambiguity in communication is a practice used by physicians when they exaggerate patient symptoms to justify inapplicability of practice guidelines, when they decline to provide clinical evidence, and when they make vague, unsubstantiated criticisms of hospital management. The goal is to preserve the power that might be lost with transparency and avoid the hard work of improvement (Chervenak and McCullough, 2003). Other problems such as “victimhood” (O’Connor and Annison, 2012); “scapegoating” (Garelic and Fagin, 2005), skepticism and resistance (Gollop, Whitby, Buchanan, and Ketley, 2004) have also been described.

It is important to note that attempting to eliminate or ignore the differences is not the right pathway to solving the problems. Edwards Marshall, McLellan, and Abbasi (2003) discussed this issue in depth: “The fundamental problem is a paradox between calls for a common set of values and the need to recognize that doctors and managers do and should think differently. If managers suddenly became preoccupied with the needs of an individual patient, irrespective of the consequences for others or for their budget, then the health system would collapse. If doctors decided that their principal concern was to ensure the smooth running of the system and the delivery of policy irrespective of the consequences for the patient in front of them, then both the quality of care and public support would collapse. Doctors worry about patient outcomes. Managers worry about patient experience (which includes outcomes, but only as part of a mix to be met out of finite resources). Patients are, again, best served by a tension between the two” (Edwards, et al., 2003, p. 609). Therefore, the solution starts with an understanding and appreciation of the differences, on both sides. Only then, can physicians and managers work to overcome these differences and solve these problems, and can managers engage physicians in their organizations.

**Concept and Definitions**

The term engagement has recently gained vast popularity in management and healthcare literature. However, “as is often the case with words that acquire popular currency, they are frequently misused and lose specific meaning” (Spurgeon et al., 2011, p. 114). Any serious attempt to enhance physician engagement has therefore to start with a deep understanding of the construct and its unraveling from other related constructs.
Definitions of staff and employee engagement are abundant in the literature. The NHS defines engagement as “the degree to which an employee is satisfied in their work, motivated to perform well, able to suggest and implement ideas for improvement and their willingness to act as an advocate for their organization by recommending it as a place to work or be treated” (NHS Employers, 2012). Engagement has typically been used to refer to a psychological state (involvement, commitment, attachment, mood); a performance construct (effort or observable behaviour); a disposition (positive affect), or some combination of these (Dawson and Clark, 2012).

A good understanding of engagement requires an understanding of burnout, its opposite. Burnout is a negative psychological syndrome strongly linked to stress, and characterized by three dimensions: cynicism (indifference or distant attitude to work), exhaustion (depletion or draining of emotional resources) and inefficacy (lack of satisfaction with expectations) (Maslach and Leiter, 2008). It is also important to note that engagement as a concept is more than just consultation, “which is at times perceived by those being consulted as tokenistic and without influence or impact” (Sheedy, 2008, p. 9).

In this rest of this section, we centre on physician engagement as a specific construct. Maslach and Leiter’s definition of engagement as “an energetic state of involvement with personally fulfilling activities that enhances one’s sense of professional efficacy” focuses on engagement from the individual’s view (Maslach and Leiter, 2008, p. 498). In their interviews with physician leaders, Snell and her colleagues drew on that definition and described engagement as “the experience that some physicians have as being actively interested in the quality of their workplace, and are motivated to take an active leadership role in helping to improve that workplace” (Snell, Briscoe and Dickson, 2011). Similarly, Morehead Associates defined it as “the association and partnership physicians feel toward a healthcare organization” (Morehead Associates, 2012).

Spurgeon and his colleagues offer a broader definition of physician engagement as a process that should be reciprocated between the physician and the organization: “The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organization which itself recognizes this commitment in supporting and encouraging high quality care” (Spurgeon et al., 2008; Spurgeon et al., 2011). In this sense, physician engagement cannot be in consideration of the individual physician alone. The organization must reciprocate the engagement by putting in place processes and conditions where physicians want to participate and can find opportunities to participate. Therefore, both the individual and cultural components are considered (Spurgeon et al., 2011).

Others have taken a similar approach in viewing physician engagement as an on-going two-way social process. Mohapel and Dickson say physician engagement is more than just an intellectual property, but is about establishing relationships that nurture a sense of meaning and purpose (Mohapel and Dickson, 2007). Dickinson and Ham argued that physician engagement is a social process, not an “on-off” switch and therefore may be hard to sustain over a prolonged period (Ham and Dickinson, 2008). The NHS alliance also emphasized the process and the involvement aspects of engagement by defining it as an “involvement which is two-way…with that involvement at a level that influences decision making. It is involvement at the beginning and as an integral part of the decision making process, rather than as an add-on or after thought once the decisions are more or less in place” (NHS Alliance, 2003). Hamilton echoed this and posited that “it is clear that engagement is not a one-way process. It is not about asking doctors to be more engaged and shrugging shoulders when they choose not to. Each organization must develop reciprocal competences to enable it to create and respond to opportunities, regardless of where it is in the cycle of organizational growth and change” (Hamilton, Spurgeon, Clark, Dent, and Armit, 2008). Similarly, Atkinson et al. suggested that physician engagement takes time but physician disengagement can be sudden and precipitous (Atkinson, Spurgeon, Clark, and Armit, 2011).

Erlandson offered an intriguing and somehow cynical approach to physician engagement as a term typically used to describe what the other party should do. He argued that when managers talk about physician engagement, they are typically referring to what they
would like physicians to do but cannot get them to do, whereas when physicians talk about physician engagement, they are typically referring to what they already do that is not appreciated, valued or supported by managers (Erlandson, 2003).

Another valuable approach to understanding physician engagement is to explore the characteristics of engaged physicians. Mohapel and Dickson quoted a thesis study by Baxter (2003) describing the characteristics and attitudes of physicians engaged in administration: they felt respect and credibility towards the personalities and qualities of those with whom they interact; they are attracted to strong visions that are clear and challenging; they value relationships with others which are based on integrity, honesty, fairness and consistency (among others); and they tend to be more open-minded, enjoy intellectual challenges and risks and are self-directed learners (Mohapel and Dickson, 2007; Baxter, 2003). Clark took a different approach and suggested that a physician is considered engaged if he or she consistently says positive things about the organization as a place to work; if he or she intends to stay and continue to practice at the organization; and if he or she strives to achieve above and beyond what is expected in his or her daily role (Clark, 2012). Along the same lines, Morehead Associates postulated that physician engagement is demonstrated by providers who are committed, loyal, take pride in, and recommend the organization (Morehead Associates, 2012).

Relationship with Other Concepts

As is clear from the above discussion, physician engagement is a multi-faceted and complex construct. It is also closely tied to several other constructs such as physician trust and collaboration, physician alignment and integration, physician satisfaction, physician commitment and physician leadership. It is important to note that many studies and reports tend to use some of these terms interchangeably, because of limited theoretical work conducted in this area. While numerous studies have been conducted on physician relationships, few are based on strong theoretical and conceptual grounds. In this section, we attempt to delineate these constructs and their relationships to physician engagement.

1. Physician Trust

Trust can be defined as “the willingness to rely on others under conditions of risk and the expectation that others' behaviour is predictable and beneficial” (Succi, Lee, and Alexander, 1998). It is thought to be the foundation of all meaningful and sustainable relationships, and it develops in proportion to the frequency of meaningful interactions (Bujak, 2003). More closely related to the context of physician engagement, Montgomery discussed trust as the “willingness to engage with others — to cooperate — even in the absence of opportunities to monitor and control the others’ behaviour” (Montgomery, 2001). For physicians to build trust with managers (and vice versa), they should be willing to understand managers’ points of view, have a shared understanding of reality (rather than telling managers over and over how they see things), and develop mutually acceptable solutions (O’Connor and Annison, 2002). In this sense, communication between the two parties is crucial, and the only way to establish mutual trust is to apply honest, factual and timely communication principles (Howard, 2003). Bujak (a physician himself) suggested that physicians are predisposed to mistrust as competitive individuals, and when faced with the possibility of a win-lose situation, they default to lose-lose, rather than win-win. The main reason behind this mistrust is miscommunication between managers and physicians. This leads to misperceptions and assumptive biases that result in misunderstandings that are then labeled as reasons why managers are not trustworthy (Bujak, 2003). However, it is important to note that these statements were not supported by data.

On another note, an important empirical study found that physicians perceived greater trust with managers when they held more power in four decision areas: (1) cost-quality management; (2) partnership management; (3) strategic management; and (4) physician-panel management (Succi et al., 1998).
In a recent paper, Trybou and colleagues developed an integrative framework of physician-hospital alignment, and posited that trust is an important antecedent to integration and alignment (Trybou, Gemmel, and Annemans, 2011). They used Shortell’s definition of alignment as “the degree to which physicians and hospitals share the same mission, vision, goals, objectives and strategies, and work toward their accomplishment” (Shortell et al., 2001). Alignment was discussed as part of integration, and three types of integration were proposed: economic integration (alignment realized by hard financial means); non-economic integration (alignment realized by cooperation); which when present together can lead to clinical integration (coordination of patient care) (Trybou et al., 2011). Similarly, Carlson and Greeley discussed cultural alignment between physicians and hospitals as preceding economic alignment and clinical alignment (Carlson and Greeley, 2010). Gosfield and Reinertsen focused on clinical integration as a key driver of physician engagement and defined it as “physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities” (Gosfield and Reinertsen, 2010).

2. Physician Satisfaction and Commitment

Before the popularization of physician engagement as a concept and as term, researchers and practitioners were mainly focused on physician satisfaction and physician commitment. Physician satisfaction is defined as “a physician’s appraisal of the perceived work environment, and emotional experiences at work” (Morehead Associates, 2010). It is affected by professional support and efficacy, sense of belonging and appreciation, time (work/life balance) and family and community support (Scheurer, McKean, Miller, and Wetterneck, 2009; Kelly, Kulusky, Brownley, and Snow, 2008). Physician commitment is defined as “the strength of an individual’s identification with and involvement in the organization along three psychological dimensions: the desire to remain in the organization (continuance commitment), willingness to exert considerable effort on its behalf, and belief in and acceptance of its goals and values” (Burns et al., 2001). It is therefore clear that those two concepts share some characteristics with physician engagement. However, many posited that physician engagement is a broader concept with distinct features, and is a better predictor of performance (as will be discussed later) (West and Dawson, 2012).

Morehead Associates commented that physician satisfaction alone is inadequate for truly determining the overall health of the physician-hospital relationship, and that a multi-faceted approach (using physician engagement) that includes loyalty, dedication, pride and satisfaction was needed (Morehead Associates, 2010). Spurgeon and his colleagues suggested that “higher levels of engagement generate a greater frequency of positive affect such as satisfaction and commitment, and this in turn flows through to enhanced work performance” (Spurgeon et al., 2011). A recent white paper by American company Press Ganey differentiated between engagement and satisfaction: it argued that hospital managers should focus on physician engagement and physician satisfaction in order to create a successful “partnership” with physicians. When physician engagement and physician satisfaction are both high, physicians act as “dedicated partners,” when only engagement is high they act as “discontented colleagues,” when only satisfaction is high they act as “satisfied spectators,” and when both engagement and satisfaction are low they act as “distanced patrons” (Press Ganey, 2010).

3. Physician Leadership

Physician leadership is defined as “the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organization which itself recognizes this commitment in supporting and encouraging high quality care” (Spurgeon et al., 2008, p. 214). Traditionally, physician leadership has been lacking in healthcare organizations, mainly due to gaps in physician leadership skills and of training and development programs to address these gaps. As Berwick and Nolan suggested: “Nothing about medical school prepares a physician to take a leadership role with regard to changes in the system of care. Physicians are taught to do their very best within the system and to perfect themselves as individual professionals by advancing their skills and
knowledge every day. But being a better physician and making a better system are not the same job. They require analogous, but somewhat different, skills.” (Berwick and Nolan, 1998, p. 290).

In the last few years, physician leadership and physician engagement have been discussed in tandem in many studies and reports. In fact, the main application of engagement in the literature has been “engagement as a physician leader” (Snell, Briscoe, and Dickson, 2011). Mohapel and Dickson emphasized this idea when they discussed physician engagement as an “inherently leadership issue” (Mohapel and Dickinson, 2007). They suggested both physicians and managers need to leverage their leadership capacity to increase physician engagement: leadership of self, leadership of others and leadership of organizations.

In a recent review, Baker and Denis suggested that traditional efforts to physician leadership have focused on structural changes that integrate physicians into administrative structures. However, these efforts have had limited impact. More recent efforts that have focused on a systemic approach of engaging physician through distributed and collective leadership have a greater potential for success (Baker and Denis, 2011). A somewhat related concept to physician leadership is that of physician talent management. Morehead Associates’ lifecycle framework described four stages of talent management: 1) attract and recruit (physicians); 2) onboard; 3) align, develop and retain (focusing on physician engagement) and 4) exit or transition (Morehead Associates, 2009). The LEADS in a Caring Environment Framework, which consolidates the competency frameworks and leadership strategies in the Canadian health sector, echoes many of the above ideas and connections between leadership and engagement. LEADS stands for Lead self, Engage others, Achieve results, Develop coalition, and Systems transformation (Canadian Health Leadership Network, 2012). Engaging leaders are those who foster the development of others, contribute to the creation of healthy organizations, communicate effectively and build teams.

The goal of this section was to assess the relationships between physician engagement and other important concepts in the physician-management literature. It appears that effective communication and perceptions of power lead to physician trust in management and hospitals, that is, the willingness to rely on, and engage with them even under high-risk conditions. Trust allows the two parties to overcome the differences and barriers that exist between them (discussed in previous sections), and to align and integrate. In turn, alignment and integration can lead to physician engagement, which encompasses satisfaction and commitment. When physicians are engaged, they act as leaders in the healthcare organization, which can result in improved performance (discussed in later sections). Figure 1 is a visual representation of these relationships.
Figure 1: Relationship between Physician Engagement and Other Physician-Specific Constructs

- Perception of Power
- Effective Communication
- Trust
- Economic Integration/Alignment
- Non-economic Integration/Alignment
- Clinical Integration
- Engagement (Commitment / Satisfaction)
- Leadership
- Performance
Determinants of Physician Engagement

Any serious effort to devise strategies for enhancing physician engagement should include an assessment of the determinants that affect whether physicians become engaged or not. In general, there are two important sources of engagement. First, job resources, including the level of autonomy in roles; task identity; the variety of skills needed to perform the role; the significance of tasks performed; and feedback received from supervisors and colleagues. Second, personal resources such as self-efficacy; self-esteem; and personal optimism also affect engagement but may be less controllable by management (West and Dawson, 2012).

In their in-depth interviews with Canadian physician leaders, Snell and colleagues suggested that physician engagement “begins with the underlying character and values of the engaged physician” (Snell et al., 2011). More specifically, personal factors such as physicians wanting to make a difference and to improve things; choosing to be engaged; being acknowledged for their efforts; and feeling a sense of purpose were identified as important determinants of being motivated to engage. The implication here is that some physicians are “naturally engaged” and that they choose to remain engaged regardless of the situation. However, several environmental factors were also found to influence engagement and disengagement. In relation to their roles within the organization, the engaged physicians noted that engagement represented taking an active role beyond their formal role in the organization, that it was important to balance their work and life responsibilities, and that engagement allowed them to build their leadership skills. In relation to their settings, a work environment that is supportive, that allows for autonomy to pursue areas of interest, and that gives respect and recognition to being engaged was perceived as one that fosters physician engagement. Many discouragements to engagement were also identified: bureaucratic processes (policy-driven and hierarchical workplaces); lack of compensation for engagement activities; managers’ not valuing physician leadership; poor organizational communication practices; and conflicts, among others (Snell et al., 2011).

Morehead Associates’ assessment of determinants of physician engagement starts with the experiences that physicians have within their health system (organization). These experiences are influenced by both “functional” and “personal” connections physicians maintain in the system. A functional connection “reflects a perceived partnership between the physician and an organization that is built and strengthened through reliable, efficient delivery of high quality products and services,” whereas personal connections reflect emotional bonds that form and mature between a physician and an organization.” They are based on professional, friendly, and comfortable exchanges between the physicians and members of the organization. When functional and personal connections are maximized, physicians are satisfied, which then leads to physician engagement (See Figure 2). It is important to note that this approach of viewing satisfaction as a determinant of engagement is different from the approach that we adopted in the previous section, where satisfaction was seen as part of engagement.

Figure 2: Relationship between Physician Experiences, Their Satisfaction, and Their Engagement with the Healthcare Organizations (Morehead Associates, 2010)
Variations in Physician Engagement

A related issue to the determinants of physician engagement is whether different types of physicians have different degrees of engagement regardless of other conditions. In this section we consider variations in physician engagement by mode of compensation and by age (generation).

There is some evidence in the physician literature linking physician compensation practices to the effectiveness of the relationship between physicians and their health systems (Gillies et al., 2001). Physician satisfaction surveys in Canada have shown that physicians who were paid by a blended form of remuneration (such as fee for service and salary) were more satisfied with their current professional life than those earning more than 90 percent through fee for service. Data from the National Physician Survey show that the percentage preferring fee for service as their sole source of income has declined over time from 50 percent in 1995 to 28 percent in 2004 and to 23 percent in 2007. This is even more pronounced among female physicians; only 18 percent of them preferred fee for service compared to 26 percent of male physicians (CHSRF, 2010).

A more recent assessment of physician satisfaction in the United States has shown that physicians who are employed by their hospitals are generally more satisfied that those who are not employed. More specifically, a survey of 27,000 physicians in 2008 concluded that overall satisfaction scores for employed physicians were 76.3 percent compared to 74.1 percent for non-employed physicians (traditional medical staff model). It appeared that employed physicians were willing to trade personal autonomy of being one’s own boss with the stability that comes with employment (Press Ganey, 2009).

As for engagement by physician age (by generation), a recent report by Morehead Associates has shown stark contrasts in degrees of physician engagement. The report assessed physician engagement using a recently-developed physician engagement survey (discussed in later sections) and compared three generations: Traditionalists (born between 1930 and 1945), Baby Boomers (born between 1946 and 1964) and Generation Xers (born between 1965 and 1980). The results showed that Generation Xers displayed the lowest level of physician engagement whereas Traditionalists represented the most engaged group of physicians. More specifically, Generation Xers scored the lowest on “likelihood to remain aligned with the healthcare facility for the next three years,” which suggests that there is a significantly elevated risk that Generation X physicians were intending to sever their relationships with healthcare organizations and seek new partnerships in the near future. In opposition, traditionalist physicians (most likely in the final stages of their career) had this as their most favourable engagement item. In addition, Generation Xers scored lower on all of the remaining engagement items: “this hospital provides high-quality care and service;” “this hospital makes every effort to deliver safe, error-free care to patients;” “I would recommend this hospital to family and friends who need care;” and “I am satisfied working with this hospital” (Morehead Associates, 2010). However, these results should be considered with caution as the report does not provide specific data on sample size and methodology.

Levels of Physician Engagement

As is clear from the above discussion, physician engagement is different from other terms because it is a broad construct that functions at multiple levels. In their discussion of a comprehensive approach to effectively engage physicians in a closure of a hospital in Vancouver, British Columbia (Canada), Puri and his colleagues developed a model that emphasized engagement at three levels: individual (open door policy, personalized letters, etc.), group (team building sessions, leadership meetings, etc.) and organizational (involvement of medical staff, communication, etc.) (Puri, Bhaloo, Kirshin, and Mithani, 2006).

Similarly, Morehead Associates’ “Model of Physician Engagement” revealed four domains (which can be understood as levels) that affect physician engagement. The administration domain centres on the experiences physicians have with hospital administration and how they feel about the physician-administration relationship they maintain.
The model argues that engaged physicians have confidence and trust in administration. The organization domain focuses on the experiences the physicians have regarding the state of the organization, especially the organization's strategic direction. The model contends that engaged physicians believe the organization is committed to working with their physician partners in facilitating and delivering high quality care. The department domain reflects the experiences physicians have with key departments such as radiology, operating room, laboratory services, and the emergency department. Accurate and timely information from these departments can significantly affect physicians' level of engagement. The staff domain focuses on experiences between physicians and the staff and how those experiences contribute to patient care. According to this model, engaged physicians have confidence in a competent and committed nursing staff (Morehead Associates, 2012; Moorhead Associates, 2010).

It is obvious that physician engagement cannot be appropriately understood at the individual physician level alone. Rather, the organizational and cultural conditions under which the physician operates greatly determine whether physician engagement is encouraged or inhibited (Spurgeon et al., 2008). Therefore, a differentiation between the individual and organizational levels of engagement is necessary. The most significant contribution to the understanding of the levels of physician engagement has been the Medical Engagement Scale (MES) (Spurgeon et al., 2008). The scale (described in the next section) is based on an understanding of engagement that differentiates between the individual’s personal desire to be engaged and the organization’s encouragement of involvement. At the individual level operate the perceptions of the physician’s enhanced personal empowerment, his or her confidence in taking on new challenges and increased self-efficacy. At the organizational level operate the cultural conditions that facilitate physicians to become more actively involved in leadership and management activities (Spurgeon et al., 2008).

Measures of Physician Engagement

Researchers have measured general engagement using three different approaches: as a description of a condition under which people work; as a behavioural outcome; or as a psychological orientation (West and Dawson, 2012). Despite widespread use of the physician engagement concept, it remains a construct that is poorly conceptualized and measured. Two important exceptions have emerged in the last few years: The Medical Engagement Survey (Spurgeon et al., 2008) and Morehead Associates’ Physician Survey (Morehead Associates, 2012).

The MES was developed by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal College in the United Kingdom as part of the Enhancing Engagement in Medical Leadership project (Spurgeon et al., 2008). The scale was developed over years of testing in numerous NHS trusts involving thousands of physicians. It consists of either an 18-item instrument or a 30-item instrument. The 18-item instrument measures engagement on three “meta-scales.” Meta-scale 1: feeling valued and empowered; Meta-scale 2: having purpose and direction; and Meta-scale 3: working in an open culture. The 30-item instrument includes the same three “meta-scales” but with two subscales each:

Meta-scale 1: feeling valued and empowered
- Subscale 1: climate for positive learning
- Subscale 2: good interpersonal relationships

Meta-scale 2: having purpose and direction
- Subscale 3: appraisal and rewards effectively aligned
- Subscale 4: participation in decision making and change

Meta-scale 3: working in an open culture
- Subscale 5: development orientation
- Subscale 6: commitment and work satisfaction

The MES is a reliable and valid measure of physician engagement that is quick and relatively easy to administer and complete. It has been used recently in research assessing the effects of physician engagement on organizational performance, which will be discussed in more detail later (Spurgeon et al, 2012).
The Morehead Associates’ Physician Survey has been in use only for the last few years, and specific details about its testing and development have not been fully disclosed (Morehead Associates is a consulting company and charges fees for the use of the tool) so its validity and reliability are not as documented as the MES. The survey items are classified as relating to one of four domains (discussed in the previous section): administration domain (admin); organization domain (org); department domain (dept); and staff domain (staff) (Morehead Associates, 2012). Some of the survey items include:

- This hospital makes every effort to deliver safe, error-free care to patients (org).
- Overall, this hospital provides high-quality care and service (org).
- I would recommend this hospital to other physicians as a good place to practice medicine.
- I would recommend this hospital to family and friends who need care (org).
- If I am practicing medicine three years from now, I am confident that I will be practicing at this hospital (org).
- Overall, I am satisfied working with this hospital (org).
- This organization cares about its customers (org).
- This organization conducts business in an ethical manner (org).
- This organization is respected in the community (org).
- I have confidence that this organization will be successful in the coming years (org).
- I am satisfied with the ease of the scheduling process for my patients (org).
- The amount of job stress I feel is reasonable (org).
- This organization's patients are satisfied with the quality of care they receive (org).
- The continuing medical education (CME) offered by this hospital for physicians is useful (org).
- This organization cares about quality improvement (org).
- This hospital treats physicians with respect (org).
- This organization cares about its customers (org).
- This organization makes use of new technologies and clinical practices that will improve patient care (org).
- I have the opportunity to review this hospital’s patient satisfaction data (org).
- The quality of patient care has improved during the past 12 months (org).
- The nursing staff at this hospital is committed to providing compassionate care (staff).
- Overall, I am satisfied with the performance of the nursing staff (staff).
- Patient care between shifts is adequate at this hospital (staff).
- I have adequate input into decisions that affect my medical practice (admin).
- Senior management is responsive to physician feedback (admin).
- I can easily communicate my ideas and concerns to senior management (admin).
- I am satisfied with the overall performance of hospital administration (admin).
- I am satisfied with the teamwork demonstrated between the operating room services nursing staff and technical staff (dept).
- I am satisfied with Ambulatory Services – efficiency of clinic (dept).
- Different work units work well together in this organization (dept).

Of all these items, nine items have been identified through regression analysis as the most significant key drivers of physician engagement. These items (in order of their relative influence on engagement) are:
1) I have confidence that this organization will be successful in the coming years; 2) This organization cares about its customers; 3) I am satisfied with the teamwork demonstrated between the operating room services nursing staff and technical staff; 4) I am satisfied with the overall performance of hospital administration; 5) This organization's patients are satisfied with the quality of care they receive; 6) The continuing medical education (CME) offered by this hospital for physicians is useful; 7) Overall, I am
satisfied with the performance of the nursing staff; 8) This organization cares about quality improvement and 9) This hospital treats physicians with respect (Morehead Associates, 2012). However, it is important to reiterate that the evidence presented by this report should be carefully considered as limited information is available on how the survey items were developed and tested, and the sample size used in the above-mentioned regression analyses.

Applications of Physician Engagement

Including physicians in managerial and organizational decisions and projects has been a recurring theme in the physician-hospital literature. Earlier on, “involvement” was the term most commonly used, and gaining physician support was described as crucial for total quality management programs (McCarthy, 1993); quality improvement efforts (Weiner, Shortell and Alexander, 1997); care management activities (Waters et al., 2001); and practices to achieve service improvement (Gollop et al., 2004), among others.

More recently, the term “engagement” has replaced “involvement” in research assessing the inclusion of physicians in hospital decisions, but the main focus has remained on quality improvement initiatives. In a well-known report, the Institute for Healthcare Improvement (IHI) highlighted specific practices to be used by organizations in order to engage physicians in a shared quality agenda (Reinertsen, 2007). Similarly, Caverzaggie, and colleagues assessed the role of physician engagement as a mediating factor between a practice-based improvement model and physician participation in quality improvement (Caverzzagie, Bernabeo, Reddy, and Holmboe, 2009), Liebhaber and colleagues collected data in five communities and suggested specific strategies for physician engagement in quality improvement (Liebhaber, 2009), while Taitz and colleagues developed a framework for physician engagement in quality and safety (Taitz et al., 2011). These studies will be discussed in more detail in subsequent sections.

Other studies have applied physician engagement to non-quality related initiatives. For example, engaging physicians by using communication, education and support and feedback, was determined to be crucial in the success of a hospital closure (Puri et al., 2006), while factors that drive physicians to be engaged in reducing health disparities (Vanderbilt, Wynia, Gadon, and Alexander, 2007) and in primary care reform (Simms, 2008) were also assessed.

Outcomes of Physician Engagement

It has been postulated that organizations with high physician engagement tend to have better performance outcomes than those with low physician engagement. As a report published by the King’s Fund in the United Kingdom put it, “engagement is not only a topic of academic interest; it has enormous practical significance. Put simply, organizations with more engaged clinicians and staff achieve better outcomes and experiences for the patients they serve” (King’s Fund, 2012).

Several studies have provided empirical evidence to support these claims. Goldstein and Ward showed that hospitals where physicians are engaged in strategic planning and decision-making perform better than those where they are alienated from these processes (Goldstein and Ward, 2004). In a landmark study comparing 15 high-performing and 7 low-performing NHS trusts in the United Kingdom, Hamilton and her colleagues found that in high-performing trusts, 44 percent of the physicians were engaged (as compared to 17 percent in low-performing trusts) and that the engagement score was around 4 on a 1-5 scale (as compared to 2.5 in low-performing trusts) (Hamilton, Spurgeon, Clark, Dent, and Armit, 2008).

In relation to specific quality and safety outcomes, Taitz and his colleagues studied ten high-performing hospitals in the U.S. and established that physician engagement can reduce unjustifiable variation in patient care (Taitz et al., 2011), while a study of 2,000 Dutch physicians concluded that those who are engaged are less likely to make mistakes than those who are not (Prins et al., 2010). Recently, Spurgeon and his colleagues demonstrated a persuasive link between levels of medical engagement (as measured by the MES) and independently gathered
performance measures: high levels of medical engagement were associated with lower patient mortality, fewer reported incidents and higher levels of service and compliance (Spurgeon et al., 2011). They submitted that “the importance of medical engagement makes commonsense…. since it is difficult to argue how radical changes in service delivery via disengaged, disaffected and uncooperative medical staff can be achieved” (p.116). Similarly, Stoll, Swanwick, Foster-Turner and Moss argued that “without medical engagement, care continues to be delivered in isolated clinical pockets, preventing coordinated action to produce system improvements, let alone better population health outcomes” (Stoll, et al., 2011).

**Return on Investment for Physician Engagement**

While the link between physician engagement and performance outcomes has been well documented, very few studies have assessed its return on investment. While the social and political returns on physician evidence are worth considering, the evidence is limited on financial returns.

Quoting a study by the Gallup Healthcare Group, Mohapel and Dickson suggested that “data show that organizations with high physician engagement receive higher revenue and earnings per admission and per patient day, increase referrals from engaged physicians, reduce physician recruiting costs, and sustain significant growth and profitability” (Gallup Healthcare Group, 2006; Mohapel and Dickson, 2007).

A recent report by Morehead Associates supported these claims. The analyses used structural equation modeling in two case studies to evaluate the return on investment of physician engagement on key business outcomes. First, based on a sample of 6,000 staff physicians in a multi-facility health system, the report found that physicians with low engagement levels admitted only 10 to 25 patients per year to the hospital. Physicians with average engagement levels admitted 51 to 75 patients annually, whereas highly engaged physicians admitted more than 100 patients annually. Translating these numbers into estimated inpatient revenue contribution per physician, they projected that a physician with a low-engagement level contributes only $420,000 per year for the hospital, a physician with average engagement contributes about $1.5 million per year, and a physician with high engagement contributes $2.4 million per year. In another sample of 12,000 physicians practicing in children’s hospitals across the United States, the numbers were even more striking: the highly-engaged physicians admitted on average 76-100 patients per year with a contribution margin of $3.4 million per year (Morehead Associates, 2010).

**Conceptual Models or Frameworks**

Several conceptual models or frameworks of physician engagement have been presented in the peer-reviewed and grey literature. In this section, we present and discuss them.

To our knowledge, the first model presented in the literature was the “Physician Engagement Model” by Puri and his colleagues in their hospital closure study (discussed in previous sections) (Puri et al, 2006). The model (Figure 3) incorporates ten strategies to engage physicians. It stresses the importance of fully engaging, communicating with, educating and supporting physicians throughout the process (before, during and after closure) at the individual, group and department level. Moreover, physician feedback is encouraged on all aspects to facilitate the transition.

In 2007, IHI published its landmark “Framework for Engaging Physicians in Quality and Safety” (Figure 4) (Reinertsen, et al., 2007). It comprised six elements that organizations should adopt to successfully engage physicians such as discovering common purpose; reframing values and beliefs; segmenting the engagement plan; using “engaging” improvement methods; showing courage; and adopting an engaging style. Hospital leaders can use the framework to build a written plan for physician engagement (discussed later).
Figure 3: Physician Engagement Model (Puri et al., 2006)

**Individual Level**
1. Open-door policy
2. Personalized letters
3. Access to counseling

**Group Level**
4. Medical affairs and CEO open forum
5. Team-building sessions
6. Leadership meetings
7. Medical staff newsletters

**Organizational Level**
8. Involvement of senior medical staff
9. External communication
10. Communication strategy

Figure 4: IHI's “Framework for Engaging Physicians in Quality and Safety” (Reinertsen et al., 2007)

6. Adopt an Engaging Style:
   6.1 Involve physicians from the beginning
   6.2 Work with the real leaders, early adopters
   6.3 Choose messages and messengers carefully
   6.4 Make physician involvement visible
   6.5 Build trust within each quality initiative
   6.6 Communicate candidly, often
   6.7 Value physicians' time with your time

5. Show Courage:
   5.1 Provide backup all the way to the board

4. Use “Engaging” Improvement Methods:
   4.1 Standardize what is standardizable, no more
   4.2 Generate light, not heat, with data (use data sensibly)
   4.3 Make the right thing easy to try
   4.4 Make the right thing easy to do

1. Discover Common Purpose:
   1.1 Improve patient outcomes
   1.2 Reduce hassles and wasted time
   1.3 Understand the organization’s culture
   1.4 Understand the legal opportunities and barriers

2. Reframe Values and Beliefs:
   2.1 Make physicians partners, not customers
   2.2 Promote both system and individual responsibility for quality

3. Segment the Engagement Plan:
   3.1 Use the 20/80 rule
   3.2 Identify and activate champions
   3.3 Educate and inform structural leaders
   3.4 Develop project management skills
   3.5 Identify and work with “laggards”
The “Medical Engagement Model” (Figure 5) developed in 2008 by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal College emphasizes interaction between the individual physician and the organization. Two factors are considered: the availability of organizational opportunities to engage, and physicians’ individual capacities to engage. Organizations should strive to create a combination of factors that increase organizational opportunities and expanded individual capacities for physicians, which makes physicians feel engaged (the top right quadrant). In addition, another model suggested by the same source views physician engagement as a continuum, starting where physicians feel frustrated in the organization and ending in the other, where they feel embedded in it (Figure 6).

Figure 5: The “Medical Engagement Model” (Spurgeon et al., 2008)
In 2010, Morehead Associates developed an empirical physician engagement model based on physician research (Figure 8) (Morehead Associates, 2010). As previously discussed, the model stresses four domains that influence physician engagement: administration, organization, department, and staff, and argues most engaged physicians have favourable attitudes toward these domains. While all of the domains exhibit a strong and significant influence on physician engagement, the company’s research shows that the organization and administration domains have a stronger impact on physician engagement than the department and staff domains. Physician engagement is therefore determined to a large extent by the relationship between the physician and his or her larger organization and administration.

Moreover, the model includes the effect of physician engagement on organizational outcomes, such as clinical, service, and financial improvements.

More recently, drawing on various national and international studies and perspectives, the NHS proposed a new framework (Figure 7) for physicians to be engaged in leading improvements in health and the delivery of health care (Clark, 2012). The emphasis is on physicians wanting (and being encouraged) to take centre stage and accept increased responsibility. A new role for physicians as “engaged shareholders” is presented and eight specific strategies (discussed later) are highlighted.
Figure 7: Framework for Achieving Greater Physician Engagement (Clark, 2012)

1. Establish focus groups of all P/G and senior doctors to establish vision
2. Ensure focus is on what doctors want to contribute rather than executives consulting on their preferred approach
3. Measure extent of current engagement and assess against benchmarks
4. Create opportunities for doctors to lead quality and safety initiatives
5. Create opportunities for shared leadership at all levels
6. Identify medical leadership champions to support medical engagement and P/G leadership competence
7. Support engagement with development and rewards
8. Sustain engagement strategy

Figure 8: Morehead’s Model of Physician Engagement (Morehead Associates, 2010)

ADMINISTRATION DOMAIN
Perceptions of the performance of hospital administration

ORGANIZATION DOMAIN
Perceptions of the state of the organization

DEPARTMENT DOMAIN
Perceptions of the performance of key departments

STAFF DOMAIN
Perceptions of the performance of hospital staff

PHYSICIAN ENGAGEMENT
Benefits of a satisfied and engaged medical staff
Improvements in -
• Quality and safety performance
• Clinical outcomes
• Hospital-physician collaboration
• Hospital-physician relations
• Physician retention
• Patient admissions
• Patient satisfaction
• Overall financial results
III. Physician Engagement
Recent Results

Regina Qu’Appelle Health Region Results

The Regina Qu’Appelle Health Region (RQHR), which has commissioned this report, partnered with Metrics@Work, Inc. to design and conduct a physician engagement survey in November-December 2011 (RQHR, 2012). The survey consisted of 22 engagement drivers; five items that relate to organizational engagement; five items that relate to job engagement; 3 items that relate to patient safety, and five items that relate to inter-professional collaboration, in addition to three open-ended questions. There were 198 responses out of 571 approached, a rate of 34.7 percent.

The RQHR engagement driver average was 55.1 percent. In terms of specific engagement drivers, the five lowest-ranking items related to respondents’ satisfaction with physician recruitment and retention activities; satisfaction with involvement in physician decision-making; trust in RQHR senior administration; consideration of physician needs in strategic planning; and satisfaction with IT office inter-connectivity. With the exception of the last item, the main problems are in the areas of physician involvement in decisions that affect them, physician inclusion in strategic planning, and physician-administration trust (RQHR, 2012).

The analyses also allowed comparison of RQHR’s scores with benchmark data collected from other organizations. The engagement driver items on which RQRH’s scores were 5 percent or more below the database average related to trust in senior administration; satisfaction with involvement in physician decision-making; satisfaction with quality improvement practices; effectiveness of equipment and technology; feeling like being treated with respect; sufficient information from department/section heads; and appropriate feedback from department/section heads. Therefore, RQHR seems to be lagging other organizations in the general areas of involvement in decisions, trust, communication, and respect (RQHR, 2012).

As for organizational engagement, measured in terms of intention to remain with the region, feeling it is a good place to practice, recommending it as a good place to practice, overall satisfaction with RQHR and feeling a strong sense of belonging to it, the overall score for RQHR physicians was 64.6 percent, which is significantly lower than the database average of 68.5 percent (RQHR, 2012).

The open-ended questions echoed some of the problem areas described above (RQHR, 2012). When asked about specific actions that can be taken by senior management to make the organization a better place to practice, the top five responses related to being more open to input and feedback; being more supportive of physicians; improving staffing levels; reducing waiting times; and improving communication. Setting aside the operational issues of staffing levels and waiting times, the main areas for improvement thus related to physician-administration relationships that include communication, involvement, support, and transparency. Some of the most significant physician statements included the following:

- Involve the staff in decision-making processes.
- There is too much "top down" activity by this administration. Nobody in admin listens. Everything comes top / down in the form of a Mandate.
- LISTEN to the STAFF!! I personally am tired of Senior Management appearing to care what we have to say, and then proceeding with their original plan anyway. Tell us that that is what you are going to do if that is the plan, and at least acknowledge our requested input.
- Physicians are increasingly isolated from the process of the delivery of care. Programs are created without our input or consultation […]. No input. No dialogue. No partnership.
- Physician ideas have to be taken seriously. There is no point giving lip service to physicians and when ideas get tabled to be dismissed.
- Improve communication.
- Make transparent decisions for change.
Additional general recommendations or comments by the respondents centred on similar themes such as providing more support to physician issues, improving satisfaction with senior administration, quality of care and enhancing morale and teamwork. Some of the specific physician comments included:

- Too often, physicians are consulted to create the impression of engagement, without any real intention to listen, seriously consider and implement physician recommendations. I'm not looking for all physician recommendations to be implemented, but I do believe all physician recommendations require serious consideration.

- Distrust in senior management has not been at such a low since I have been practicing here.

- To engage physicians, those who follow must not feel that they are being led in a directive fashion. After all, we are independent practitioners who provide a service to the Region in exchange for privileges. To take the metaphor further, we are less like a standing army and more like mercenaries. To lead us, you must provide a system of incentives (and/or disincentives) to align our personal interests with the strategic interests of the Region. We must feel like we are leading ourselves in line with your goals, rather than being directed where we would rather not go.

In summary, RQHR’s physician engagement survey reflected a physician workforce that is distrustful of management and feels alienated from managerial and clinical plans and excluded from major decisions.

**Results from the United States**

National physician surveys in the United States have traditionally focused on measuring physician satisfaction. The most recent results come from Press Ganey Associates. In 2007, the company collected data on experiences of 27,671 physicians practicing at 302 hospitals/facilities nationwide (Press Ganey, 2008). A national physician priority index was presented as the top five priorities for hospital administrators to improve relations with medical staff and increase physician engagement. These items included:

1. Responsiveness: “Responsiveness of the Hospital Administration to ideas and needs of medical staff members”
2. Ease of Practice: “Degree to which this facility makes caring for your patients easier”
3. Agility: “Degree to which Hospital Administration has positioned the hospital to deal with changes in the health care environment”
4. Trust: “Your confidence in the Hospital Administration to carry out its duties and responsibilities”
5. Communication: “Communication between yourself and the Hospital Administration”

The overall physician satisfaction score was 72.5 percent, with satisfaction with relationship with hospital leadership the lowest scoring items (63.2 percent). Specific comments from physicians included:

- Relationship with leadership is acerbic, accusatory, and simply not healthy. This is driving physicians away from the facility, along with driving away patients.

- I hope that hospital administration will start to involve the medical staff in decisions rather than continue making decisions and then letting us know after the fact.

- Work with physicians; don’t use them.

A follow-up survey was conducted in 2008 including 27,328 physicians in 283 facilities nationwide (Press Ganey, 2009). The priority index items’ order was slightly different from the previous year: 1) Responsiveness; 2) Trust; 3) Ease of practice; 4) Agility, and 5) Communication. Surprisingly, satisfaction for relationship with hospital leadership improved to 83.0 percent.

The 2010 survey conducted by Press Ganey included 39,598 physicians from 405 facilities (Press Ganey, 2011). The questions were slightly different as they focused on a “physician partnership priority index.” The results showed that the top five priorities for physicians were:
1. Administration seeks beneficial solutions
2. Treated as valued member
3. Responsiveness of hospital administration
4. Physicians involved in decisions
5. Patient care made easier

To our knowledge, the only results focusing specifically on physician engagement in the U.S. come from Morehead Associates. Data reported by the company in 2010 (sample size unknown) revealed that 30 percent of physicians were highly engaged with the healthcare organizations they are affiliated with, 54 percent demonstrated an average level of engagement, while 16 percent expressed low levels of engagement (Morehead Associates, 2010). More recent data which according to the company come from a survey of 1.4 million physicians showed a decrease in the overall physician engagement score from 4.17 in 2010 to 4.12 in 2011 (on a five-point Likert scale). The lowest scoring items on the 2011 survey included:

- I am satisfied with Ambulatory Services - efficiency of clinic (3.09).
- I have adequate input into decisions that affect my medical practice (3.30).
- Senior management is responsive to physician feedback (3.37).
- I am satisfied with the ease of the scheduling process for my patients (3.43).
- I can easily communicate my ideas and concerns to senior management (3.46).
- The amount of job stress I feel is reasonable (3.46).

Similar to results reported above, involvement in decision-making, responsiveness and communication are the major problem areas.

Results from the United Kingdom

Physician job satisfaction scores in the United Kingdom have constantly improved over time, with an average score of 7.4 (on a 1-10 scale) reported for the 2000-2005 time period (Sharma, Lambert and Goldacre, 2012).

Despite significant progress achieved in measuring physician engagement in the United Kingdom, there is relatively little data reported on overall engagement levels. According to NHS surveys, physicians have very high levels of commitment to and satisfaction with their jobs (NHS Employers, 2012). However, physicians perceive that they are not very involved with their organizations; for example, only 20 percent of physicians reported that they are able to suggest and implement changes to services, and less than 50 percent reported that senior managers seek to involve staff in decision making. These levels are considerably lower than levels for other clinical groups and managers.

The results reported in this section relate to physician satisfaction/physician engagement surveys from different healthcare systems using unstandardized and varied scales and measures. Despite the moderate evidence available, several similar themes emerge: regardless of where they are practicing, physicians are generally distrustful of hospital management, they feel uninvolved in major hospital decisions and strategies, and are disillusioned with the communication and support they get from hospital management. The next section explores strategies and activities that can help managers and hospitals address these problems and enhance physician engagement in their organizations.

“Strengthening medical engagement means ditching any notion of doctors following where managers lead in favor of managers and clinicians sharing power on the basis of mutual professional respect, united around the goal of improving quality. For some this will require a profound change in their mindset.”

—The King’s Fund, NHS, 2012
IV. Enhancing Physician Engagement

General Strategies and Activities to Improve Physician Relationships

The physician-hospital literature is saturated with recommendations to improve relationships with physicians. However, it is important to note that very few of these recommendations are based on empirical research and most are based on opinions of experts and consultants. In this section, we provide a few examples of these recommendations.

One important approach to overcome the barriers discussed earlier in this report is for managers to try to understand physicians’ perspectives and ways of thinking. McCarthy suggested that in order to involve physicians in quality improvement, managers should create an environment that enhances relationships by being personally and culturally involved with physicians (McCarthy, 1993). For example, the chief executive officer (CEO) should respect physicians; should feel comfortable working with them; should eat lunch with them in the cafeteria or physician lounge; should become involved directly in projects with them; and should not delegate this responsibility to other managers. Moreover, the CEO should demonstrate cultural involvement with physicians: he or she should genuinely appreciate physicians; should try to think like them; should strive to understand their perspective; and should try to see the hospital as they do in their daily practice (McCarthy, 1993).

Ashmos and her colleagues adopted a complexity theory approach to improve physician participation in decision-making (Ashmos, 2000). They argued that physicians enable hospitals to develop richer interpretations of what is happening and to better articulate strategies that are comprehensive and sensitive to the conditions of the moment. Therefore, they recommended that managers allow physician maximum participation in strategy design and involve physicians in decisions where they are more likely to make an impact (Ashmos, 2000).

Similarly, Edwards proposed several ideas to address the poor relationships between physicians and management (Edwards, 2003). He suggested that managers should show mutual respect for their differences with physicians; should have agreed rules of behavior that are based on integrity, keeping promises and avoiding personal attacks; should develop a mission, vision or goals that are aligned with physicians; should learn more about medicine; and should strive to find a common approach with physicians to managing resources, accountability and autonomy (Edwards, 2003).

In a 2004 book entitled Allies or Adversaries, Holm proposed several techniques to foster an effective working relationship with physicians (Holm, 2004). Involving physicians in hospital leadership in order to have them participate fully in crucial strategic and financial decisions is one major areas of focus. He suggested that managers and physicians should form a partnership, a cooperation and collaboration which can lead to a willingness to share control and work together to face strategic issues. Specific tactics to achieve that include involving physician leaders in formal and informal capacities; forming formal leadership positions for physicians, not figurehead slots; creating formal and informal forums for candid discussions and truth telling, such as physician advisory groups. Holm also stressed the importance of small details such as meeting with physicians in their own practices rather than in the executive suite, to demonstrate understanding of the value of a physician’s time and to show willingness to become acquainted with physicians on a personal level. He argued that physicians are not a homogeneous group, so managers should avoid a one-size-fits-all approach, and should instead offer physicians choices and build personalized relationships with them that fit their interest and comfort level according to their age and specialty (Holm, 2004).

Chervenak and McCullough took a slightly different approach and examined physician-manager relationships from an ethics perspective (Chervenak and McCullough, 2003). They contended that the solution is that managers and physicians should act as “co-fiduciaries” of patients by showing an unequivocal shared commitment for excellence to patient care. To achieve that, both sides should focus on promoting
“diffidence” and “compassion” through solicitation of each other’s input and holding each other mutually accountable for creating and sustaining an organizational culture of mutual trust (Chervenak and McCullough, 2003).

Larson (a physician) proposed several strategies to “calm the perfect storm” and achieve productive physician-hospital relationships (Larson, 2007). Many of these echo strategies mentioned above such as creating a culture of mutual respect; developing medical staff leaders; setting expectations; holding each other accountable; establishing clear and reliable lines of communication; and celebrating successes together (Larson, 2007).

Two interesting approaches have been used by some organizations in recent years to improve hospital-physician relationships. The first one is the development of a physician-hospital compact (Silversin and Kornacki, 2000). The compact is typically built around shared values and trust, and establishes “a consistent set of rules and behavioural expectations for hospitals and physicians within the construct of their working relationship” (Petasnick, 2007). In a typical compact, physicians commit to actively engage in quality improvement; select and empower leaders in synch with shared vision; treat all with respect; engage in collaborative practice; and promote the hospital through clinical innovation and outreach (Silversin, 2011). In return, the hospital commits to include physician leaders in significant decisions; be transparent regarding hospital finances and decisions; demonstrate appreciation for physicians’ contributions; ensure a well-run hospital; and improve access to clinical data and physician performance relative to benchmarks (Silversin, 2011). Clark reported the example of the Ottawa Hospital where a physician-hospital engagement agreement compact was recently put in place to define 14 commitments that physicians and hospitals make to each other. For example, “the hospital commits to fostering a culture of care within an academic environment,” while physicians commit to “championing the development and adoption of organizational processes, practices and policies that drive excellence in quality of care within an academic environment” (Clark, 2012).

The other approach is the development of physician-manager dyads where a physician leader is paired with a non-physician manager at each level in the organization. The physician leader may still practice medicine part-time in addition to performing his or her administrative responsibilities (Deane, 2009). In the dyad, the physician leader responsibilities typically include assuring quality; managing provider productivity; managing physician-driven clinical resource use; and minimizing inappropriate practice style variation across providers, among others. The non-physician leader responsibilities include financial management; accounting and reporting systems and methods; market share performance; competitor strategy analysis; and capital and resource consumption patterns, among others (Zismer and Brueggemann, 2010).

Best Practices to Enhance Physician Engagement

Examples of strategies and practices used by high-performing organizations with a strong record of successfully engaging physicians have appeared in the literature in the last five years. These examples have varied from enhancing physician engagement in general, to physician engagement in specific organizational domains or projects such as leadership or quality improvement.

The earliest evidence came from Mercy and Unity Hospitals in Minnesota, United States, where norms of physician culture were used to completely restructure the medical staff and improve physician engagement scores (O’Hare and Kudrle, 2007). Techniques such as extensive briefing materials paired with rapid-decision making deadlines; decision-making with a forcing function; aggressive dialoguing strategies and utilization of elected leaders were used to successfully improve physician-manager relationships in the long term (O’Hare and Kudrle, 2007).

As previously discussed, IHI made recommendations for engaging physicians in quality and safety, based on practices in five U.S. health systems and other organizations such as group practices and independent
medical staff in the NHS (Reinertsen, et al., 2007). These practices included:

1. Discover common purpose: improving outcomes and efficiency.

2. Reframe values and beliefs: making physicians partners in, not customers of, the organization, and promoting individual responsibility for quality.

3. Segment the engagement plan: fine-tuning engagement to reach different types of staff physicians, identifying and encouraging champions, educating leaders, developing project management skills and working with laggards.

4. Use “engaging” improvement methods: using performance data in a way which encourages buy-in rather than resistance and making it easy for doctors to do the right thing for patients.

5. Show courage: supporting physician leaders all the way to the board.

6. Adopt an engaging style: involving doctors from the beginning, working with real leaders and early adopters, choosing messages and messengers carefully, making physician involvement visible, communicating candidly and often, and valuing physicians’ time by giving management time to them.

Based on a study of hospitals in four U.S. communities in Detroit, Memphis, Minneapolis-St Paul and Seattle, Liebhaber and her colleagues suggested five strategies to increase physician engagement and involvement in quality improvement activities (Liebhaber, Draper, and Cohen, 2009). First, they suggested that employing physicians can help achieve economic alignment and reduce competing pressures on physician times. Second, they said, using credible data that is external, risk-adjusted and benchmarked and providing physicians with staff as data support are essential for securing physician participation. Third, providing visible commitment by hospital leadership can be achieved by involving the board; publicly demonstrating that quality improvement is important, supported and encouraged; senior leaders doing rounds; and committing adequate resources. Fourth, using physician champions who are highly respected in their areas of clinical expertise can ensure the same physicians are not the only ones involved and can bring in naysayers early in the process and convert them into supporters. Fifth, effective communication—such as effective messaging, educating physicians, framing quality improvement as advantageous to patients; and being strategic about using physicians’ time can help spur physician involvement (Liebhaber et al., 2009).

Also in the United States, Press Ganey Associates reported the case of the Hospital of Central Connecticut (HCC), where a comprehensive approach to physician engagement took the organization’s physician satisfaction scores from the 58th percentile in 2007 to the 99th percentile in 2009 (Press Ganey, 2009). The approach focused on improving communication with physicians and making the hospital a better place to practice medicine. Financial incentives were provided for managers who met benchmarks on physician satisfaction scores. The frequency of the physician newsletter was increased from three times a year to six; a publication called “From My Desk to Yours” to physicians from the CEO was created; minutes of key committees were sent to physicians to increase meeting attendance; and the hospital’s intranet site was improved to make it more relevant to physicians (Press Ganey, 2009).

Another United States organization where physician engagement has been key to quality transformation is McLeod Regional Medical Center in North Carolina (Gosfield and Reinertsen, 2010). Interestingly, the main goal at McLeod was to engage physicians with each other in improving quality, not with the organization per se. Six specific methods were used to engage and clinically integrate physicians with quality: 1) asking physicians to lead so that improvement efforts are “physicians-led, data-driven, and evidence-based;” 2) asking physicians to work on what they want to work on; 3) making it easy for physicians to lead and participate by not wasting their time; 4) recognizing physicians who lead; 5) backing up physician leaders with courage and 6) providing opportunities for physicians to lead and grow (Gosfield and Reinertsen, 2010).

Morehead Associates suggested three best-practice themes and potential interventions for each theme
based on its work with 300 hospital clients in the United States (Morehead Associates, 2010). The themes focus on communicating; building trust; and partnering and aligning with physicians. Specific best practices under each theme included:

1) Communicate with physicians:
   - “Build and implement a physician marketing and communication plan.”
   - “Break down the silo between the medical staff and the rest of the hospital.”
   - “Develop an administration rounding strategy to bring leaders face-to-face with physicians.”
   - “Share information and insights from the administrative rounding team in order to make communication more proactive.”
   - “Avoid spending too much time on the squeaky-wheel physician.”
   - “Measure and monitor physician engagement with physician satisfaction surveys, round tables, and comment lines.”

2) Build trust with physicians:
   - “Aim for complete transparency. Do not “spin” messages to physicians – they will see through it.”
   - “Identify and solve problems together.”
   - “Demonstrate responsiveness – tell them what you heard from them, what you are going to do about it, and then what you did.”
   - “Ensure physicians have a “seat at the table.”
   - “Involve physicians in strategic initiatives.”
   - “Listen to physician feedback objectively without getting defensive.”
   - “Instill evidence-based methodology in decision-making processes.”
   - “Engage administration with physicians through rounding.”

3) Partner and align with physicians:
   - “Hire and recruit the right physicians with effective hiring techniques.”
   - “Provide effective orientation and mentoring.”
   - “Use the 80/20 rule to ensure your first partner and align with the physicians you can’t afford to lose.”
   - “Develop a formal physician-retention program that includes a written plan.”
   - “Create profiles of your physicians with market intelligence to better focus on their ongoing needs.”
   - “Set expectations, give feedback, provide recognition, and listen.”
   - “Promote both system and individual responsibility with a culture of measurement.”
   - “Work with leaders and early adopters from the beginning.”
   - “Identify specific roles that need to be played by physicians, and develop a detailed plan to prepare individual physicians to play these roles.”
   - “Create councils and include physicians in leadership roles as well as in general and specialty roles.”
   - “Help physicians see the big picture and separate themselves from their personal agenda.”
   - “Assist physicians in focusing on win/win solutions that strengthen the hospital-physician partnership.”
   - “Help physician leaders nurture and evaluate developing leaders.”
   - “Train physicians to be leaders in the institution’s cultural transformation.”

At the international level, many have reported on the Danish healthcare system as an example of a system where physician involvement in leadership roles is an explicit aim (Ham and Dickenson, 2008; Chadi, 2009). For example, all hospital boards have medical directors and all clinical departments are required to have a physician as leader. Physicians are encouraged to take on leadership roles through required training at the postgraduate level, which includes a 10-day leadership course provided by the system, followed by a five-day leadership course after appointment as consultants (Ham and Dickenson, 2008). The training is based on demonstrating core competencies in seven roles: professional; communicator; scholar; collaborator; health advocate; and manager, and is derived from the CanMEDS (Canadian Medical Education Directions for Specialists) program (Dalhousie University, 2009; Frank, 2003). Using CanMEDS, Denmark underwent a major reform in postgraduate medical education in recent years, and improvement in leadership roles among physicians has been documented (Ringsted, Hansen, Davis, and
Scherpbier, 2006; Kodal, Kjær, and Qvesel, 2012; Mortensen, Malling, Ringsted, and Rubak, 2010). For example, the Danish healthcare system recently used the IHI framework to help better engage physicians in quality and patient safety initiatives focusing on strokes, gastric ulcers, lung cancer and diabetes (Jensen, 2012).

In Canada, Snell and her colleagues suggested several strategies to encourage physician engagement in their systems based on interviews with physician leaders (Snell et al, 2011). One main strategy is to recognize formally the role of the physician leader by sponsoring learning opportunities; implementing recognition programs; providing compensation for time spent on leadership activities; and developing meaningful roles for physician leaders. Other strategies include streamlining bureaucratic processes; managing physician meetings efficiently; supporting innovation; and ensuring that role expectations, deliverables and lines of authority are communicated when physicians are involved in managerial projects (Snell et al, 2011).

Based on their study of high-performing NHS trusts in the U.K., Hamilton and her colleagues recommended that CEOs adopt three specific actions that were statistically associated with higher levels of physician engagement: 1) participation of the CEO or other executives in physician induction programs; 2) regular formal meetings between physicians and the CEO or other executives to discuss quality, safety and performance; and 3) regular informal opportunities for physicians to meet with CEO or other executives to discuss quality, safety and performance. They also emphasized that engagement is a process of strengthened contribution from all physicians, not an isolated few, and that managers and physicians should be educated on that (Hamilton, 2008).

In a follow-up to that study, seven NHS Trusts that have achieved high MES scores were assessed (Atkinson et al., 2011). It was concluded that generating and maintaining physician involvement included first and foremost involving hospital leadership, and that senior managers should set expectations, lead by example and be visible and available. They should also work with physicians to create future-focused and outward-looking cultures where physicians are increasingly required to engage in the wider environment beyond their direct clinical areas. The results underscored the importance of selecting and appointing the right physicians to leadership and management positions based on ability, open competition and attitude, rather than seniority. Moreover, physicians should be provided with support, development and leadership opportunities through leadership development courses, ongoing training, project initiatives, talent spotting and succession planning. Several principles were advanced for generating an organizational culture where physician engagement becomes a reality: promotion of understanding, trust and respect between physician and managers by emphasizing shared common goals, openness and transparency; acknowledgment and acceptance of professional differences; setting expectations, enforcing professional behaviour and firm decision-making by balancing punitive measures with incentives, and addressing poor performance; and clarification of roles and responsibilities where managers and physicians have joint accountability but separate portfolios (physicians accountable for quality, managers accountable for finances) (Atkinson et al., 2011).

In a recent review of the evidence on leadership and engagement for improvement, the examples of Intermountain Healthcare in the United States and University College Hospital NHS Trust Find in the United Kingdom have been cited as organizations that have engaged physicians by uniting them with managers around improvement (The King’s Fund, 2012). The key to their success is a managerial culture where physician leaders are consulted and supported, while having explicit expectations of their performance.

Also recently, Clark drew on various national and international studies, frameworks and perspectives to propose a framework for organizations to create a culture in which physicians are more engaged in leading healthcare improvements (as discussed in a previous section) (Clark, 2012). The framework is based on the rationale that improving physician engagement is a cultural change, rather than a structural change, but structural changes may be needed. Moreover, this cannot be achieved overnight.
nor can it be imposed by introducing a new policy. Instead, a highly inclusive approach where different behaviour by executives is required and where physicians become more like shareholders than stakeholders is suggested. The specific strategies that will help lead to that include: establish focus groups for all physicians to establish vision; ensure focus is on what physicians want to contribute; measure current level of engagement and assess against benchmarks; create opportunities for physicians to lead quality initiatives; create opportunities for shared leadership at all levels; identify physician leader champions; support engagement with development and rewards; and sustain the engagement strategy (Clark, 2012).

One theme that is prevalent in the above-mentioned literature is the importance of effective communication, on both physicians’ and managers’ sides. It was suggested that “applying honest, factual and timely communication principles between hospitals and physicians will enhance relationships if there is an underlying competitive reality” (Howard, 2003, p. 28). In their book chapter entitled “Mending the gap between physicians and hospital executives,” Waldman and Cohn argued that physicians are not trained to communicate well and that their authoritarian style and limited listening skills hinder information exchange with managers. Therefore, managers should work with physicians to help them develop their communication and confrontation abilities. Skills and tools such as active listening; checklists; sensitivity and empathy; structured dialogue; appreciative inquiry; and positive deviance should be acquired and used by physicians (Waldman and Cohn, 2008).

In the above-mentioned study in NHS Trusts with high levels of physician engagement, Atkinson and her colleagues stressed the importance of communication as key to developing relationships and building trust. Recognizing that use of respective professional language by physicians and managers could be divisive, organizations that have improved communication have created a unifying language or narrative set in the context of organizational vision and issues. Moreover, those organizations communicated widely and effectively with physicians, using a variety of methods and persistence. Face-to-face communication especially from senior leaders was crucial. In addition, open, honest and frank discussions with physicians on a routine basis, with emphasis on listening, responding and closing the feedback loop were practiced (Atkinson et al., 2011).

The approaches discussed in this section have different focuses and hold some similarities. We summarize them in Table 2.

<table>
<thead>
<tr>
<th>Organization(s)</th>
<th>Main focus</th>
<th>Best practices</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td>Mercy/Unity Hospital, Minnesota (U.S.)</td>
<td>Norms of physician culture</td>
<td>Extensive briefings; rapid-decision making deadlines; aggressive dialoguing</td>
<td>O’Hare and Kurdle, 2007</td>
</tr>
<tr>
<td>Five U.S. health systems and other organization</td>
<td>Engaging physicians in quality and safety</td>
<td>Reframing values and beliefs; segmenting the engagement plan; showing courage; adopting an engaging style</td>
<td>Reinertsen, Gosfield, Rupp, and Whittington, 2007</td>
</tr>
<tr>
<td>Hospitals in Detroit, Memphis, Minneapolis-St Paul and Seattle (U.S.)</td>
<td>Engaging physicians in quality improvement</td>
<td>Employing physicians; using credible data; visible commitment by leadership; using physician champions; using effective communication</td>
<td>Liebhaber, et al., 2009</td>
</tr>
<tr>
<td>Location/Study</td>
<td>Action/Strategy Description</td>
<td>Outcome/Expectation</td>
<td>Source</td>
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<tr>
<td>Hospital of Central Connecticut (U.S.)</td>
<td>Improving physician satisfaction percentile scores</td>
<td>Improving communication; improving ease of practice</td>
<td>Press Ganey, 2009</td>
</tr>
<tr>
<td>McLeod Regional Medical Center, North Carolina (U.S.)</td>
<td>Engaging physicians with each other in improving quality</td>
<td>Asking physician to lead; asking physicians to work on what they want; making it easy to lead; recognizing physician leaders; backing up physicians; providing opportunities</td>
<td>Gosfield and Reinertsen, 2010</td>
</tr>
<tr>
<td>300 hospitals in the United States</td>
<td>Improving physician engagement and satisfaction</td>
<td>Communicating; building trust; and partnering and aligning with physicians</td>
<td>Morehead Associates, 2010</td>
</tr>
<tr>
<td>Danish healthcare system</td>
<td>Physician involvement in leadership</td>
<td>Building formal roles for physicians; requiring leadership training</td>
<td>Ham and Dickenson, 2008</td>
</tr>
<tr>
<td>Physician leaders in Canada</td>
<td>Physician engagement in systems</td>
<td>Formally recognizing the role of the physician leader; streamlining bureaucratic processes, ensuring effective communication</td>
<td>Snell et al, 2011</td>
</tr>
<tr>
<td>NHS trusts in (U.K.)</td>
<td>Physician engagement</td>
<td>Participation of CEO/other executives in physician induction programs; regular formal meetings; regular informal opportunities</td>
<td>Hamilton et al., 2008</td>
</tr>
<tr>
<td>NHS trusts in (U.K.)</td>
<td>Generating and maintaining physician involvement</td>
<td>Involvement of hospital leadership; selection and appointment of right physician leaders; providing leadership opportunities and support; effective communication; promotion of understanding and trust; acceptance of professional differences; setting expectations and enforcing professional behaviour, clarifying roles and responsibilities</td>
<td>Atkinson et al., 2011</td>
</tr>
<tr>
<td>Intermountain Healthcare (U.S.); University College Hospital NHS Trust (U.K.)</td>
<td>Physician engagement around improvement</td>
<td>Consulting and supporting physician leaders; having explicit performance expectations</td>
<td>Kings Fund, 2012</td>
</tr>
<tr>
<td>Various international studies</td>
<td>Physicians as shareholders</td>
<td>Establishing focus groups; ensuring focus is on what physicians want to contribute; measuring current level of engagement and assessing against benchmarks; creating opportunities for physicians to lead quality initiatives; creating opportunities for shared leadership; identifying physician leader champions; supporting engagement with development and rewards; sustaining the engagement strategy</td>
<td>Clark, 2012</td>
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New Integrative Framework

Building on the evidence provided in this report and on the above-discussed frameworks and examples, we propose a new integrative framework for enhancing physician engagement in healthcare organizations (Figure 9). The framework centres on engagement in general, not engagement in specific domains such as quality improvement or safety. We suggest three main general strategies and specific tactics/practices under each strategy. The strategies include communication, building trust and developing physician leaders. The evidence suggests that physicians in all healthcare systems are not satisfied with the effectiveness of the communication received from managers, are distrustful of managers, do not feel involved in important decisions and strategies, and are craving opportunities to become more involved in leadership roles. Therefore, organizations will not be able to effectively engage their physicians without developing clear and efficient communication channels; building trust, understanding and respect; and identifying and developing physician leaders that can help engage the rest of the physicians in the organization.

To improve communication with and from physicians, managers have to start by developing an overall physician communication plan. The plan should include specific written communication (such as newsletters, e-mail updates, Intranet); face-to-face communication in meetings (preferably in physicians’ office or lounges), especially by CEOs; and routine rounds by managers on clinical units to identify potential problems, discuss them, and work on solving them. In these communication methods, sharing information, using a unifying language and focusing on open, honest and frank conversations should be emphasized. Moreover, managers should work with physicians to help train them on developing and refining their communication and listening skills.

To develop and maintain trust, managers should start at the beginning by becoming involved in physician orientation programs. Moreover, executives and upper managers should strive to be visible, responsive and transparent as leaders of the organization. Inviting physicians to have a seat at the table; involving them in all major strategic decisions and plans; developing common goals; and listening to their input and following-up are necessary to earn their trust. But in order to work together, both managers and physicians should acknowledge and accept the many professional differences that exist between them. Also important is the consistent enforcement of professional behaviour standards. Developing a formal structure, such as a physician-hospital compact, outlining essential duties, expectations and responsibilities, can enable trust.

To help develop physician leadership, managers should start by creating new structures and roles for formal physician leaders. To fill these roles, the right physicians should be selected based on attitude, interest, abilities and potential. Once selected, physicians should be given clear directions on expectations and responsibilities, as well as ample opportunities to learn the skills needed and to develop their abilities beyond their current roles. It is important to have support, recognition and rewards for physician leaders in place, and to compensate them for their time. Succession planning and talent management programs can help feed the physician leaders’ pipeline in the long term.
Figure 9: Enhancing Physician Engagement Integrative Framework

**Communication**
- Developing a communication plan
- Written communication
- Rounds by managers
- Sharing information
- Formal/informal face-to-face meetings
- Open, honest, frank conversations
- Using a unifying language
- Developing physician communication/listening skills

**Building Trust**
- Visible leadership by managers
- Participating in physician orientation
- Transparency/responsiveness
- Developing physician-hospital compacts
- Involving physicians in decision-making and strategies
- Listening to physician input
- Developing common goals
- Acceptance of differences
- Enforcing professional behaviour
- Creating joint accountability

**Developing Physician Leadership**
- Creating formal physician leadership roles
- Selection/appointment of “right” physicians
- Training/development
- Recognition/support/rewards
- Compensation
- Clarifying expectations
- Succession planning/talent management

Enhanced Physician Engagement
V. Conclusion

Physicians are central to the operation of any healthcare organization. However, most physicians have traditionally had an ambiguous relationship with the organization, practicing in it but never actually feeling part of it. This, coupled with increasing external and internal pressures for efficiency, cost control, and improved quality and service have resulted in a strained relationship between physicians and managers. As a result, physician engagement has been anemic in most organizations. Recent efforts in several healthcare systems have resulted in moderate advances in understanding ways to enhance physician engagement. The integrative framework presented in this report is based on these efforts and aims to provide a specific plan for hospital managers to radically improve how they interact with their physicians.

We propose a new integrative framework for enhancing physician engagement in healthcare organizations that builds on several frameworks and examples (Figure 9). We suggest that in order to enhance physician engagement, organizations should focus on the following strategies:

- Developing clear and efficient communication channels with physicians
- Building trust, understanding and respect with physicians
- Identifying and developing physician leaders

Moreover, we propose specific tactics and practices under each strategy. These are meant as recommendations, rather than a prescriptive how-to manual. There is no one-size fits-all in physician engagement and organizations can choose to focus on some practices more than others. However, it is our opinion that organizations that want to affect physician engagement in the medium- to long-term should start by:

1. Holding formal and informal face-to-face meetings with all physicians to listen to their issues and address them (through appropriate follow-up), preferably in settings convenient for physicians.
2. Involving most physicians in the majority of managerial decisions and strategic plans and integrating their input.
3. Creating formal training and development opportunities for physicians to cultivate and refine their leadership skills.

Obviously, adopting these practices will require significant commitment of time, energy and money on the part of healthcare managers. However, we strongly believe that enhancing physician engagement is a worthwhile endeavour that will have far-reaching positive effects on the clinical, service, and financial outcomes of any healthcare organization, and should be given precedence by healthcare managers. Now is the time for healthcare managers to set aside traditional differences and historical conflicts and engage their physicians for the betterment of their organizations.
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