FIRST RULE OF WING-WALKING
The first rule of wing-walking: Never let go of where you're standing now until you have firm grasp of where you're going next

By Marc A. Bard, MD

A popular attraction in the 1920s, wing-walkers were aviation acrobats who performed their stunts outside the cockpit of an airplane while it was flying. According to the U.S. Centennial of Flight Commission (1), the original wing-walker, Ormer Locklear, first entertained his colleagues in the U.S. Army Air Service during WWI, stepping onto the wings of his biplane to check for ground signals or make minor adjustments to the craft. Eventually he perfected the "transfer", in which he stepped from one aircraft in flight to another, or from a speeding car up a rope ladder into a flying plane.

Wing-walking below 1,500 feet was outlawed in the US in 1936, making it far less visible to spectators, and although a few continued to practice the art through the 1950s and 1960s, it has largely disappeared as a public amusement. Nonetheless, many of today's healthcare leaders face a dilemma that Ormer Locklear might have found familiar: "How do I move forward without letting go?" The traditional relationship between hospitals and their physicians, based on a private voluntary medical staff, has become outmoded. Most hospital executives acknowledge that if current trends continue, the future medical staff is likely to be made up of hospital-based, employed physicians. But the path from here to there is not clear. And attempting to move forward to what's new without letting go of the past has generated great tension between hospital systems and among the physicians themselves.

In healthcare, the answer to the wing-walker's dilemma may be: "You can't." To survive the transition, hospitals will have to let go of their current position before they have a firm grasp of where they are going. The divide between today's voluntary medical staff and tomorrow's employed one is simply too great to cross in a single step. And finding the right future structure for any particular organization will require trial and error, a process of evolution rather than a single drastic change. The only way to get to that future is to begin letting go of the past.

So healthcare leaders must work with one foot in each world: accommodating the voluntary staff model while building and preparing for a very different future. It's tempting to avoid the anxiety and tension of transition by settling upon a future model and rushing to implement it. But experience counsels a more measured and gradual approach. In the 1980s, hospitals rushed to buy up physician practices, in aggregate spending hundreds of millions dollars and often alienating their independent physicians—squandering both financial and relationship capital. They believed that managed care would dictate a future in which they would need to "own" the channels of patient referral. They were wrong. More precisely, their prediction was wrong—payers retreated from that model of managed care. The legacy of rushing to implement the wrong future vision, in terms of money wasted and damaged physician–hospital relationships, is still felt today. It's not enough to pick a model, any model; the right model for most systems must be achieved through a culture of change and continuous but moderate redesign.

Physicians have their own wing to walk: they must find a way to preserve autonomy while acknowledging the increasing role of employed colleagues. The independent physicians who make up voluntary medical staffs often regard hospitalemployed physicians as competition for patients, income, and facilities, in a game that is at best zero-sum, and at worst rigged against them. But sustainable solutions don't arise by fighting over every threat to "the way things have always been done"; they come when hospitals and physicians—independent and employed—together focus on the needs and interests of patients and the larger community.

"The way things have always been done" is itself an artifact of an earlier period of change. By 1913, the number of hospitals in the US had grown from fewer than 200 in the 1870s to more than 6,000, fueled by the advances in science and the professionalization of both medicine and hospital administration.(2) The familiar, bylaw-structured relationship between an independent, self-regulated, voluntary medical staff and its hospital workshop is very much the product of the American College of Surgeons' campaign for hospital standardization that began in 1917. The economic independence of hospital physicians has its roots in one of the first goals of that campaign: eradicating fee-splitting between hospitals and doctors. (3) And for nearly 100 years, both sides of the equation have enjoyed a relatively comfortable customer–supplier relationship. But the situation has become more complex, and although government regulators still frown upon fee-splitting, hospitals and physicians now share a broad portfolio of relationships that go far beyond customer–supplier, including vendor, contractor, and business partner as well as employee.

A number of trends suggest that the future physician is more likely to be an employee than an independent practitioner. As hospitals come under increased pressure to "de-fragment" care, making it more systematic, continuous, and consistent; and to guarantee the overall quality and outcome of treatment, one logical response is to employ physicians. Increasing the use of hospitalists and hospital-based primary care can improve access, continuity, and quality of care; employing specialists is one way to complete the care continuum in communities that may not otherwise be able to guarantee the patient volumes to support an independent specialty practice. On the other side of the coin, younger doctors are more willing than their predecessors have been to accept the tradeoffs of employment—less workplace autonomy and possibly lower income in exchange for predictability, security, and better work–life balance.

Most hospital executives, and physician leaders as well, see these trends accelerating, increasing the likelihood that in the future, the majority of physicians will be employed—though not necessarily by the hospital itself. Single-specialty or multispecialty groups and faculty group practices experience many of the same pressures, and are increasingly turning to employed physicians in response. The transformation is not the result of any Machiavellian master plan; contrary to the common physician perception, very few hospital executives actually want to employ doctors. But employing physicians is one response to converging demands from payers and patients as well as from physicians themselves. It is also a form of succession planning to provide continuity in key specialties.

In the current situation, hospitals and their medical staffs may accept the need for both voluntary and employed physicians, but often grudgingly, and in ill-adapted structures that lead to competition and resentment. For some, the issues are ideological, focusing on traditions of the past and concerns about the future. For others, the issues are pragmatic, focusing on today's economic needs, clinical autonomy, and the question of equity for all parties. But those who cast the conflict in ideological terms are likely to find themselves increasingly isolated and marginalized, for it is their own peers and successors who are pursuing employment options. Those who see the issues as pragmatic must recognize the pragmatic necessity of working together during this period of transition in order to assure access, continuity, and de-fragmentation of the healthcare system.

Hospitals seem to be approaching this challenge from one of two perspectives. Some seek a tactical resolution that will diminish contemporary turf battles and reduce the noise, disruption, and angst associated with unresolved tension. Others are searching for a more strategic solution based on long-term goals. Organizations that have made progress on the journey have done so through noble experimentation, trial and error, and strategic evolution. That evolution is an ongoing process involving adaptive responses to local conditions; the leadership capabilities and attitudes on their governing boards and among their executives and physician leaders; local competitive market dynamics; attrition, supply, and demand of specialties; and local, regional, and national economic and social forces, whether directly related to healthcare or not. It is unlikely that any two markets will face identical circumstances, and therefore the right solution for one hospital may not be a good fit for another.

Furthermore, in most systems, it would be difficult to say when or where they began the process of change in which they find themselves, and hard to reconstruct the specific factors to which they responded. But one point is clear: Hospitals and healthcare systems at the beginning of the journey cannot simply borrow a highly-evolved model and expect to adapt it successfully to their own environments. Trying to introduce a highly evolved model at the beginning is like trying to start a car in fourth gear: The ride will be unnecessarily bumpy and it will be very easy to unintentionally kill the engine. So while you can't stay still, you may have to go forward without knowing exactly where you will end up. You have to break the wing-walker's first rule.

There is no best model; there is only a best practice. Start simple and encourage the initial model to evolve over time. The truth is that you are already out on the wing, and more than likely, without realizing it, you've already let go. Which leads us to the second rule of wing-walking: Put one foot in front of the other, and try to keep your balance.

And don't forget the third rule: Always wear your parachute.