

In the eye of the beholder: Mutual obligations and areas of ambiguity in the hospital-physician relationship.

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Internationally, many countries are increasing provider accountability for cost and quality of the delivered care. In this challenging environment hospital executives struggle to build effective hospital-physician relations. However, despite the importance of the hospital-physician relationship there has been little research which has examined how physicians and hospital executives describe the terms of their working relationship. This paper seeks to fill this gap by reporting findings of a qualitative study in which we explored the psychological contract between physicians and the hospital they practice at. In-depth interviews with physicians and executives (n=30) of three Belgian hospitals were performed. Our analysis of the transcribed interviews yielded a rich understanding of how physicians and hospital executives interpret and experience mutual obligations and areas of ambiguity within their psychological contract. We found that a distinction should be made between on the one hand administrative obligations (adequate operational support, responsive decision making processes and attractive facilities) and on the other hand professional obligations (clinical excellence and physician autonomous medical decision making). In addition, two areas of ambiguity could be identified reflecting both dimensions of the psychological contract. Firstly, physicians act as independent caregivers generating professional fees. A trade-off exists in their day-to-day interaction with the hospital. Therefore the interpretation about the way the care should be organized differs between executives and physicians. Secondly, hospital prospective financing systems lay the accent on cost-effective care from a societal perspective. In contrast, physicians are remunerated mainly by fee-for-service. The extent to which physicians should take into account the impact that their medical decisions have on the hospital bottom line varies. Our aspiration is that the findings of this study will assist in

supporting hospital executives and physicians to build cooperative relationships needed to improve the quality and cost-effectiveness of current health care delivery.

Highlights

- Qualitatively explores how physicians and hospital executives perceive obligations within the hospital-physician relationship;
- A distinction should be made between administrative and professional obligations;
- An operational trade-off exists and the extent to which physicians should consider the impact their medical decisions have on hospital performance differs.
- Shifting the attention in health services research towards the theoretical lens of social exchange theory is a promising line of research.

Keywords

Hospital-Physician Relationship, integration, psychological contract, mutual obligations, ambiguity

Introduction

Hospitals and physicians have been working together for years in providing specialized health services to the community. In general, physicians provide the medical care while the hospitals provide the resources by which the care can be managed and delivered (Schramko, 2007). Within this working relationship the physician acts as a professional, independent decision maker who has considerable control over the resources of the hospital. Their relationship was historically labelled as a ‘workshop model’ in which both parties had compatible incentives to increase the volume of care using the latest technology. They worked relatively independent of each other, maximizing the professional autonomy of the physician (Harris, Hicks, & Kelly, 1992; Pauly & Redisch, 1973). However, many western countries are seeking ways to increase provider accountability. These efforts reflect stakeholders’ expectations of improving performance in response to two important evolutions. On the one hand, there is recognition that healthcare systems are fragmented and suffer from unexplained variability and gaps in quality of care (Institute of Medicine, 2001). On the other hand, rising healthcare expenditures are a global phenomenon and the share of the gross domestic product attributed to healthcare in developed countries is continuously increasing (OECD, 2011). The confluence of these forces makes it unlikely that hospitals or physicians will be able to meet these challenges without closer integration which encompasses the extent to which functions and activities are appropriately coordinated across operating units (Gillies et al. 1993; Budetti et al., 2002). More specifically, the increased integration varies in terms of the degree to which financial risk, governance, revenue, planning and management are shared (Burns & Thorpe, 1993). It is important that in this view, integration is not seen as an end in itself but rather as a means for improving cost-effective performance of secondary care and as a precondition for the creation of added value for the patient and society. The aim of this paper is to provide insight into the relationship between hospital and physician by building on psychological contract theory. Our analysis of the transcribed interviews yielded a rich understanding of how physicians and

hospital executives interpret and experience mutual obligations and areas of ambiguity within their psychological contract. Our aspiration is that the findings of this study will assist in supporting hospital executives and physicians to build cooperative relationships needed to improve the quality and cost-effectiveness of health care delivery.

Physician-Hospital Integration

To deal with these challenges hospitals have tried to integrate with physicians. Burns and Muller (2008) identified three approaches to achieve greater integration. The first approach is rooted in economic literature, building on the model of the homo economicus, in which alignment is realized by financial means (economic integration). The second represents the sociological perspective, emphasizing the cooperative nature of the relationship (noneconomic integration). The third focuses on the clinical dimension of the relation, namely the coordination of patient care (clinical integration). It has been argued that noneconomic integration lies at the very basis of alignment. It contributes directly to alignment through the norm of reciprocity and indirectly by building trust with the medical staff, laying the foundation for alignment of financial incentives (Trybou et al., 2011). It aims at making the hospital more attractive for physicians by improving the hospital's working environment and addressing physicians' related concerns (Berenson, Bodenheimer, & Pham, 2006; Berenson et al., 2007). Yet, despite its importance, only few studies have focused on noneconomic integration (i.e. Morrisey et al., 1999 and Bazzoli et al., 2000). Previous research has focused primarily on the various contractual models as an indicator of physician-hospital integration. Although this type of data is readily available and relatively easy to capture, there is some concern regarding the true measurement of integration. Moreover, these integration efforts are mostly limited to contracting vehicles with the sole purpose of joint bargaining in a managed care environment without realizing true integration and added value for patient and society

(Cueller & Gertler, 2006). Given the difficulties concerning the measurement of integration by means of contractual arrangements between physicians and hospitals, the alternative approach of concentrating on noneconomic integration can be considered as a promising and important line of research. Therefore our research can be considered to be important. Our analysis of the transcribed interviews builds on psychological contract theory. It focuses on the individual's belief regarding terms and condition of the exchange between the individual and his or her organization (Rousseau, 1989). Accordingly, our study yields a rich understanding of how physicians and hospital executives interpret and experience mutual obligations and areas of ambiguity.

Psychological contract theory

There has been a plethora of research on psychological contracts in the last 20 years inside and outside the healthcare sector. This research has led to a large body of empirical research that demonstrated the explanatory power of the psychological contract to a variety of work-related attitudinal and behavioural outcomes (Conway & Briner, 2005). The psychological contract refers to the way the working relationship is interpreted, understood and enacted by individuals at the interface between themselves and their organization (Rousseau, 1989). Moreover, it has been shown repeatedly and consistently that individuals seek to enter and maintain a fair and balanced exchange relationship with the organization they work at, described as the norm of reciprocity (Cropanzano & Mitchell, 2005). This norm is based on the belief that organizational members tend to reciprocate beneficial treatment they receive with positive work-related behaviour and tend to reciprocate detrimental treatment they receive with negative work-related behaviour (Blau, 1964; Gouldner, 1960). In this respect, the management of the psychological contract has important implications on the hospitals'

ability to attract, retain, motivate and align highly skilled physicians. Accordingly, we define physician's psychological contract as the individual physician's own beliefs regarding the unwritten agreement about the reciprocal element of exchanges existing between the physician and the hospital. Surprisingly, previous research on noneconomic integration of physicians and hospital has not used the psychological contract framework to explain the hospital-physician relationship. A shortcoming also recently noted by Burns & Muller (2008). Following Bunderson (2001) and building on the large body of evidence of psychological contract research, we use the psychological contract theory as our dominant theoretical framework to examine the exchange relationship between physicians and the hospital they practice at.

Methods

The purpose of this study is to develop a robust understanding of the lived experience of the psychological contract between physicians and the hospital they practice at through the analysis of data obtained from transcribed interviews. Using a qualitative approach, our analysis focuses on the understanding of how physicians and hospital executives interpret and experience mutual obligations and areas of ambiguity in their psychological contract. Previous research has generally focused on capturing only the organizations' obligations to the individual, thereby neglecting the measurement of the individuals' obligations and failing to study adequately the content and mutual character of psychological contracts. Following Winter & Jackson (2006), to capture both the hospital and physician perspectives of the psychological contract, managers were treated as agents of the organization and in a position to convey promises or future commitments to physicians as actions of the organization itself

(Kotter, 1973). This approach is consistent with Rousseau's (1995) viewpoint that organizations become party to psychological contracts through agents who represent them.

Interviews were performed at three Belgian hospitals. In accordance to qualitative research methodology, the hospital choice was based on the principle of variation. Specifically, the selected hospitals varied in size (350 – 850 beds) and ownership type (public or private). Because our research focuses on independent physicians (non-employees), all hospitals were not-for-profit hospitals with an independent medical staff. We conducted interviews with both physicians and members of the executive committee. Within the executive committee the Chief Executive Officer, Chief Financial Officer, Medical director and Chief Nursing Officer were chosen because of the difference in responsibilities within the hospitals and the difference in their day-to-day interaction with the medical staff. In addition, because of the central role of the medical board in the structured negotiation between the medical staff and the hospital executive committee, the president of the medical board was also interviewed. The different specialties were chosen based on differences in operational linkages with the hospital (i.e. the use of the operating theatre and supporting personnel) and differences in their remuneration and associated incentives (medical fees). Within each hospital we conducted an interview with a paediatrician, geriatrician, cardiologist, orthopaedist and a general surgeon. All interviews were performed by the first author lasting between 30 and 60 minutes. The 30 interviews satisfied the number necessary to reach data saturation for this study.

An initial set of categories for coding the data based on the available definition of noneconomic physician-hospital integration (Burns & Muller, 2008) was used. Interview questions were of an open-ended, semi-structured nature designed to allow participants to address issues which they believed to be most significant. The final question asked the participant to articulate his or her own obligations towards the other party (the felt obligations

of the physician towards the hospital and those of the hospitals towards physicians). This provided the opportunity to assess the mutual character of the felt obligations and the possibility to compare the perceived obligations by executives and physicians. During the interviews probing questions were used to ensure the participant's experiences were grounded in concrete situations to increase the validity of the interview. All interviews were transcribed in full and analysis began whilst the data were still being collected. This made it possible to explore each theme that emerged in further detail in the next interviews. The transcripts were read repeatedly, categories were applied to the data and changes to the categories were made according to what the data revealed (Miles, 1979). Finally, the results were read by all co-authors to discuss the reproduction and interpretation of the analysis.

Findings

We asked study participants about their beliefs about the hospital-physician relationship and their perceptions of the obligations that exist within their relationship. Although physicians operate as independent practitioners with a distinctive revenue stream, they need organizational support that enables them to practice medicine. Consequently hospitals' obligations typically consist of issues related to organizing and planning the hospital care. Different obligations related to supporting physicians in building and maintaining their practice can be identified. A distinction can be drawn between administrative obligations (adequate operational support, responsive decision making processes and attractive facilities) and professional obligations (clinical excellence and physician autonomous medical decision making). In addition, within these main themes several sub-themes emerged. These findings are discussed in the following paragraphs. The results are presented through the use of the participants' words.

Beliefs about effective hospital-physician relationships

The interviews started with a direct question that inquired about beliefs what an optimal, effective hospital-physician relationship consists of. In addition to their responses to this question, respondents mentioned the characteristics of *'a good relationship'* also in response to other questions during the interview. The vast majority of the respondents reported that *'an open, constructive relationship'* and *'mutual respect, communication and trust'* are foundation building features that are crucial to realize effective relationships and ultimately crucial to improve hospital performance. Related to this, one physician reported *'understanding the viewpoint of physicians'* and another participant stressed the importance of *'taking into account the interests of the other party'* as prerequisites to constructive cooperation. The belief that interests of the hospital and the medical staff are not fully aligned is illustrated by these comments.

Adequate operational support

This theme describes the interviewees' experiences of obligations related to providing adequate support to physicians. Physicians rely on hospital resources to deliver medical care. The way the care is organized has an influence on their day-to-day activities. Related to this obligation, three subthemes emerged from the data. Firstly, participants stressed the importance of efficient and convenient operations. Furthermore, adequate and competent supportive staff is considered crucial. Finally, attracting and retaining talented, skilled physicians is important.

A majority of the respondents believe that assuring efficient and convenient operations to physicians is one of the primary obligations of the hospital. As one physician commented, *"The way the care is organized has a direct impact on my personal efficiency. When I need to wait for results or needed support, I'm losing valuable time, time that can be spent to patient*

care". Related to this, respondents stressed the financial importance of well-organized operations from a physician perspective. As an independent practitioner with a distinctive revenue stream they are responsible for generating their own income. Efficient operations limit the opportunity cost of time spent away from their own practice and maximize the time available for remunerated patient care. A physician clarified that *"considering the fee-for-service payment system of medical fees, the way the care is organized has also important financial implications"*.

Hospitals deliver integrated secondary care. Whereas the care is coordinated by physicians, a lot of supporting staff with specific expertise and experience is invoked. Nurses are responsible for the bed site nursing care (i.e. wound care and the administration of drugs), technicians assist them in performing medical procedures (i.e. imaging, interventional and surgical procedures) and other professionals like physiotherapists and pharmacists provide other specific care. As one respondent reported: *"An adequate number of nurses to monitor my patients is a basic requirement to realize high quality care. This is equally important at night. Next to the staffing level; their competence is of the utmost importance"*. However, physicians are ultimately responsible for the quality and coordination of the delivered care. A physician clarified this aspect as follows: *"It is a well-known fact that a lot of errors are made for instance with the administration of drugs. As a physician, I'm legally responsible for the care to my patient. However, I can't monitor the patient care 24 hours a day. To realize high-quality care I need competent supporting staff that can be relied on"*. Providing adequate as well as competent supportive staff can therefore be considered as an important obligation of the hospital and a key concern of physicians.

Additionally, the medical field is characterized by specialization and interdisciplinary dialogue between different specialties is increasingly important. Attracting competent physicians that contribute to the realization of high quality care is considered to be an

important obligation of the hospital. Besides providing adequate supporting staff, it is also important for physicians that the hospital attracts and retains competent physician-colleagues. As one physician puts it: *“Practicing medicine is increasingly complex and patient care has evolved from a mono- to multidisciplinary model ... given the shortage of certain specialties, cooperation with other, competent specialists is a major concern”*. Another respondent clarified the financial dimension of this concern: *“An important referral pattern within the hospital exists; this generates additional patient care for colleagues with other (sub)specialties”*.

Participative and responsive decision making

Physician involvement in hospital decision-making processes could be identified as a central theme in the interviews. Physicians frequently stressed the importance of decisions made by executives to their own day-to-day practice. Accordingly they expect participative and responsive decision-making processes. This aspect is related to their need of hospital resources to deliver medical care but are managed by hospital executives. Specifically, resource allocation and budgeting decisions were perceived as crucial to develop further their medical practice and clinical field. Likewise, respondents believe that participative and responsive decision making processes are crucial to the individual medical staff members: *“The core business of the hospital is to deliver medical care. Therefore, besides the patients, physicians are the most important stakeholders of the hospital. The medical field is complex and is highly specialized; consequently clinically related choices can only be made in close cooperation with the medical staff.”*

Justice and equal treatment of physician(group)s were expressed as a central concern by physicians. The participants asserted that fairness of the procedures used in hospital decision making is an important aspect. Additionally, the explanation provided to physicians, which

conveys information about why procedures were used in a certain way or why decision outcomes were distributed in a certain fashion, is considered an obligation of hospital management. While different committees that defend the interests of the medical staff as a whole are present in the hospital, participative and responsive decision making processes are also important at the level of individual medical staff members: *‘the composition of these committees is often determined by elections. At first sight, this seems fair but it is important to realize that the medical staff is not a homogenous group and is composed of different groups of specialties with different needs. Consequently, the specialties that are greater in number are elected and the smaller specialties like paediatrics are strongly underrepresented.’*

Attractive and accessible facilities

Infrastructure emerged in a lot of the interviews as a primary obligation of the hospital. Two different reasons could be identified. Firstly, attractive and accessible facilities are important to the external image of the hospital. In this sense, it is important to have such facilities to attract patients and to support physician practice growth. A physician referred in this context to the hotel services within the hospital: *‘it is important to me that ambulatory patients can have a coffee or a nice meal in the cafeteria. It contributes to a positive external image of the hospital’*. Another respondent expressed concern about parking facilities: *“There is insufficient parking space. This is a major problem to both the hospital staff and the patients who lose valuable time by driving back and forward, desperate to find one of the few available parking places”*.

Secondly, attractive and accessible facilities were described as important from a human resource perspective. A nice working place, especially the physician office where ambulatory visits take place, is important to physicians: *“An ambulatory office with basic comfort is a must have for each physician. We spend a lot of time in our offices, not only to see our*

patients but also to do the growing amount of registration and paperwork. We spend more time at the hospital than at home; a pleasant space of our own with the needed dedicated equipment present is very important. It contributes to our well-being.”

Professional obligations

Physicians enjoy a monopoly in several major decision areas (i.e. admit and discharge patients, the decision to perform a certain procedure). In the past, this professional autonomy was reinforced by the financing system by which physicians were paid on a fee-for-service basis and hospitals were paid on the basis of costs incurred. As such, the financial incentives were aligned. However, the financial relationship between hospitals and physicians has changed. Hospitals have evolved from a physician workshop to accountable organizations, charged with the development of internal organizations where quality and cost effectiveness go hand in hand. Hospitals bear the associated financial risk of DRG-payment systems (and sometimes pay for quality initiatives) creating a greater need for managing the delivery of care. Consequently physician autonomy has eroded in recent years. In the interviews, the safeguarding of physician autonomy was expressed as a central concern and primary obligation of hospital management by a vast majority of the interviewed physicians. One respondent commented: *‘Medical decision making, for instance the choice of an implant, is purely a medical matter. Hospital management has no business with those decisions and I must be able to make this choice independently. Physician autonomy has to be respected’*. Another one clarified that *‘As physicians we can interact and cooperate with for instance the development of clinical pathways and efficient admission and discharge policies, however we have to draw the line between interactive delivery and purely medical decisions made between patient and physician.’*

Executives' view on the HPR: mutual obligations and areas of ambiguity.

At first sight hospital and the medical staff members have clearly the same objective: the improvement of the health of individuals by providing excellent hospital care. Since the medical professional plays a central role in realizing high quality care, it is not surprising that hospital executives perceive '*excellent medical care*' or '*meeting the high standards of clinical practice*' as the primary obligation of the medical staff members. Furthermore, the majority of the obligations described by the physicians were acknowledged by the hospital executive team. Specifically, organizing the care and corresponding activities (i.e. invoicing) efficiently, joint decision-making and assuring the attractiveness of facilities were perceived as important responsibilities and obligations to the medical staff members. However, two related but distinctive reasons inducing areas of ambiguity could be identified.

Firstly, physicians need the organizational support and resources to deliver the care (i.e. supporting staff and the operating theatre). In this working relationship, the physician acts as independent caregiver generating his or her own income (professional fees). In this day-to-day interaction between both parties an economic trade-off exists. The way the care is organized may be very efficient for the physician but from a hospital perspective it can be inefficient and even wasteful. An executive pinpointed: '*Modern hospital care is characterized by multidisciplinary. Physicians appeal to a lot of supporting staff (i.e. nurses). Whereas it can be considered efficient to delegate certain tasks to a nurse from a physician practice perspective, from a hospital perspective this might be inefficient and increase labour costs. Similarly, when nurses regularly have to wait for a delayed physician (i.e. to begin the medical round at the nursing ward) hospital costs increase*'.

Secondly, the dual split in payment between physicians and hospitals creates different incentives. Hospitals are incited to provide cost-effective care induced by prospective payment systems but also have to persuade physicians whose fee-for-service incentives

remain the same. In these fee-for-service payment systems, physician fees encourage the physician to continue providing services. In contrast, hospital prospective financing systems put the focus on cost-effective care from a societal perspective. This creates a greater need for managing the delivery of care. This type of reimbursement forces executives to pay attention to the whole population (or enrollees in a health plan). This introduces considerable financial risk on an organizational level and potential conflict of interest into the triangular relationship hospital-physician-patient. There is clearly a tension between the need for independent medical decision making, focusing on the individual patient interest, and the adversarial payment system of hospitals that concentrates on an aggregated level (i.e. the mean length of stay). In response to these financial incentives installed by the payment system, hospital management responds by the use of a variety of techniques intended to reduce the cost of secondary care (i.e. length of stay) and improve the quality of care (i.e. clinical pharmacy). Guidelines, formularies, profiling and financial agreements are used and force physicians to consider not only the needs of the individual patient but also those of the hospital. While the improvement of the health of his or her individual patients still is the primary responsibility of the physician, this is no longer his or her exclusive responsibility. Modern health care delivery forces physicians to consider not only the needs of the patient but also those of the hospital:

“Of course our physicians need to take into account the financial impact their medical decisions have on the hospital. Modern care delivery is characterized by budgetary constraints and hospitals are held accountable for the assigned public means. Pharmaceutical prescriptions, length of stay and performed technical examinations have an important influence on the hospital bottom line. This economic reality should be taken into account by physicians to realize cost-effective, sustainable hospital care“.

Discussion

Internationally, physician-hospital integration has emerged as an important strategy in response to increased pressures to improve cost-effectiveness of hospital care delivery. However, while previous research has focused almost exclusively on the contractual arrangements between both parties we have shown that physician-hospital integration encompasses more than just strengthening the economic ties between both. Using the theoretical lens of psychological contract theory, our findings draw attention to the importance of noneconomic integration. Moreover, the majority of the participants in our study stressed the importance of an open, constructive relationship characterized by respect, communication and mutual understanding. Trust emerged as a foundation-building characteristic of the hospital physician relationship. This finding is also supported by the large body of evidence that consistently found trust as an outcome of cooperative behaviour (Zhao et al. 2007) and a key element of effective work relationships between managers and physicians (Succi, Lee & Alexander, 1998).

The results of our study have some important policy and management implications.

Firstly, it is clear that the policy-framework has a great influence on the working relationship between executives and physicians. More specifically, the dual split in payment and the alignment of incentives poses serious challenges to the hospital-physician relationship. This conflict of interest challenges physician autonomy and tends to fuel conflicts. Therefore, it is perceived as an obstacle to effective collaboration between hospital and the medical staff and a more integrated model of hospital finance is highly needed.

Secondly, hospital executives should involve physicians in their decision making processes. Hospitals have evolved from a physician workshop with an accent on the recovery in a nursing ward to a highly technological care facility characterized by increased complexity, multi-disciplinary interaction and a limited length of stay. This modern setting

requires more intense aligning of activities to increase the efficiency of secondary care delivery. Taking in consideration and weighting the interests of both hospital and independent physician is a difficult balancing act that characterizes the physician-hospital working relationship. This finding stresses the importance of involving and informing physicians in decision making processes and is consistent with the large body of evidence focusing on organizational justice (Colquitt et al., 2001). Moreover, it has been shown that responsive and participatory decision making processes enhance trusting relationships with executives and enables effective work relationships (Succi et al., 1998).

Thirdly, the need and importance of human resources management was articulated. The Healthcare sector is characterized by a chronic shortage of healthcare workers (i.e. Chen et al. 2004). A trend that is likely to increase given the continuing increase in demand of care due to the growing ageing population and the rapid evolution of medical technologies. Attracting and retaining skilled healthcare professionals poses therefore a major challenge to hospital executives. Given the importance of adequate and competent supporting staff and physicians-colleagues to the quality of delivered care and the efficiency of the independent physician, human resource management is very important to the hospital-physician relationship.

In addition, our findings raise a number of important questions for future research. One important avenue for future research is to focus on the importance of social exchange and reciprocity in the hospital-physician relationship. Moreover, physician response to perceptions that the hospital is not fulfilling its obligations (psychological contract breach) would be insightful. Specifically, the sensitivity to unmet professional obligations compared to unmet administrative obligations can be considered interesting. Furthermore, given recent efforts to reform the financing and delivery of health care, the degree to which the perceived medical autonomy by physicians is preserved can be valuable information from a policy perspective.

Our research demonstrates the usefulness of the concept of the psychological contract in understanding and improving hospital-physician relationships. This analysis should inform physicians and executives how to build constructive and effective relationships. We hope that this study, and any further work which arises from it, will inform and challenge current debate about physician-hospital alignment.

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