Is the Relationship Between Your Hospital and Your Medical Staff Sustainable?

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EXECUTIVE SUMMARY

Issues in the macro-environment are affecting the historic relationships that have existed between hospitals and their medical staffs over the last half century. Rising healthcare costs, deteriorating relationships, unexplained variations in clinical outcomes, transparency in healthcare outcomes, medical tourism, competition between hospitals and physicians, and reluctance by hospitals and physicians to change are among the issues challenging the sustainability of the current business model. This article highlights barriers to maintaining traditional relationships and concludes with strategies to preserve and strengthen relationships between physicians and hospitals.

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The business model that has worked for decades is clearly broken and is no longer sustainable" (Associated Press 2006). That conclusion was offered by William Clay Ford Jr. in 2006, before he stepped down as Ford Motor Company's chief executive officer. The same conclusion is an inescapable reality for the U.S. healthcare system. International management consulting firm McKinsey & Company concluded that "today's challenges demand nothing less than a fundamental rethinking of the health system in the United States" (Grote, Mango, and Sutaria 2007).

Macroenvironmental issues pose a threat to the business relationship that has existed between hospitals and clinicians for two generations. Healthcare executives, physician leaders, and hospital board members need to evaluate whether the traditional business model between hospitals and medical staffs is sustainable and determine what strategies should be implemented in response to threats from the macroenvironment.

EVOLUTION OF THE RELATIONSHIP BETWEEN PHYSICIANS AND HOSPITALS

Physicians began the twentieth century as entrepreneurs in a cottage industry, using hospitals as their workshop while fighting integration with and employment by hospitals (Starr 1982). The traditional business model between physicians and hospitals has been anchored by private physicians' appointment to hospitals' organized medical staff. Few explicit expectations existed regarding support by appointed physicians for the hospital's mission or values. Qualified physicians were granted privileges to admit and treat patients in return for serving on committees and agreeing to provide care to unassigned patients. For decades physician participation in non–patient care activities was *voluntary*, and physicians could choose whether or not to fulfill assignments without much concern of reprisal or consequences. Patient care was provided by private practitioners who balanced the needs of the hospital with the needs of their private practices. Quality was considered a given, costs were of little consequence, the relationship between hospitals and physicians was clearly understood by both parties, and relatively little strife existed.

Over the past two decades this bucolic arrangement has broken down to the point where many patient care needs are no longer uniformly met by private practitioners; emergencies are not voluntarily managed; and the medical-administrative work of the hospital is no longer performed by voluntarily elected (or appointed) officers, department chairs, or committee members. Most significantly, the financial requirements of the hospital and the patient care needs of the community have become too complex and competitive to be met through the well-meaning efforts of voluntarily appointed physicians who have private businesses to manage.

Economic, regulatory, and financial pressures as well as the complexity of medical practice have contributed to an acceleration of new relationships between hospitals and physicians. Hospital–physician relationships range from extremely loose affiliations to varying degrees of integration, including

full employment models (Cuellar and Gertler 2006). The historic independent relationship between hospitals and private physicians has been a major barrier to negotiating competitive contracts and improving service with insurers. Business tactics employed by managed care companies over the past two decades have motivated physicians and hospitals to work as partners to strengthen their negotiating position when seeking provider contracts. Hospitals and physicians that form integrated delivery systems are better positioned to effectively address the issues of cost, quality, and access that are becoming increasingly important in a transparent environment (Casalino, Devers, and Brewster 2003). A fundamental question is whether the current medical staff model can endure or whether a new model can better address the complex challenges facing the U.S. healthcare system.

ISSUES THAT THREATEN THE RELATIONSHIP BETWEEN PHYSICIANS AND HOSPITALS

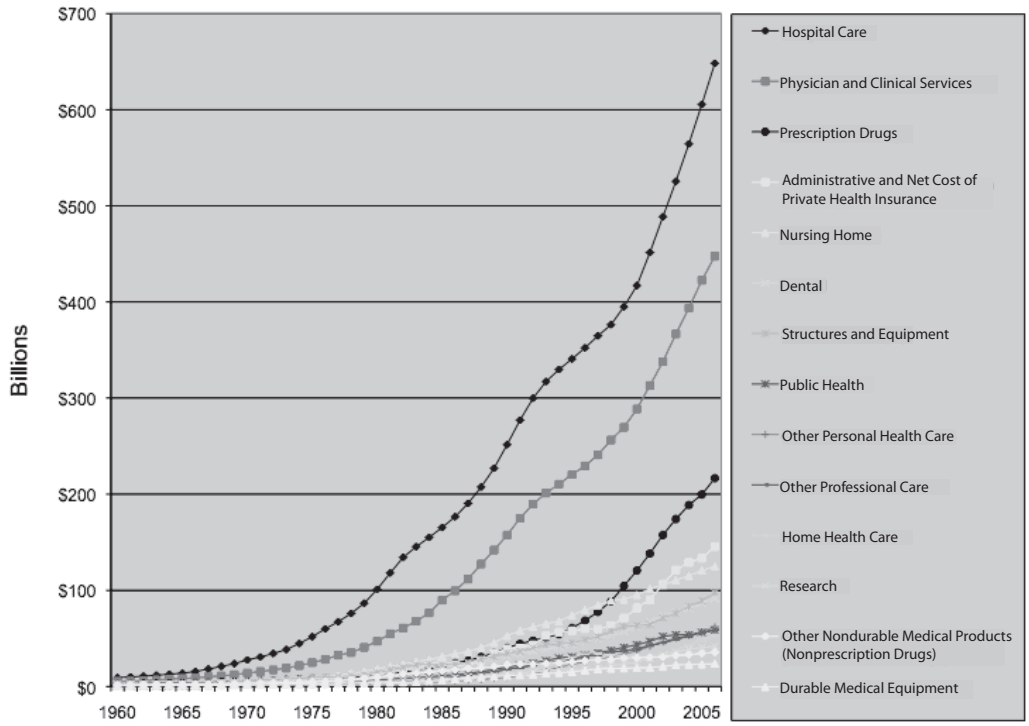
The Economics of the U.S. Healthcare System Are Not Sustainable

The United States spends more on healthcare than does any other nation (17 percent of gross domestic product), while the country's life expectancy ranks 41st in the world (Kaiser Family Foundation 2009). Per capita expenditures for private health insurance increased 39 percent between 1999 and 2003, two and one-half times faster than wages increased for hourly workers (Ginsburg 2004). Expenditures for hospital and physician services have been increasing for decades at an unsustainable rate that is approaching verticality (Hogan 2009) (see Figure 1). Despite the amount of money spent on healthcare in the United States, Thomson Reuters (2009) reports that 50 percent of U.S. hospitals were unprofitable in 2009, an increase from 2005, when one-third of the hospitals were losing money (American Hospital Association 2006, 2009). Total margins for hospitals fell to –7.8 percent in the fourth quarter of 2008 from 4.6 percent a year earlier (American Hospital Association 2009).

Administrative costs account for 31 percent of total healthcare costs in the United States, compared with 16.7 percent in Canada. Such high administrative costs in the United States can be attributed to healthcare organizations having to deal with the country's hundreds of insurance companies, compared with other industrialized countries that have centrally administered universal coverage (e.g., Canada, France). Reducing administrative costs to Canadian levels would save the United States $286 billion, enough to provide individual private health insurance policies to more than 41 million uninsured (Himmelstein, Woolhandler, and Wolfe 2004). With unemployment hovering around 10 percent in early 2010 and the U.S. deficit projected to exceed $9 trillion over the next decade, the present level of healthcare spending and inferior clinical outcomes is simply not sustainable. The U.S. health sector has been structured in favor of the quality of life of providers (and insurers) rather than the provision of care to all members of society (Reinhardt 2009).

Examples of how the complexity of the U.S. healthcare financing system contributes to higher healthcare costs are easy to find. Duke University Health

FIGURE 1
Hospital Cost Increases Are Not Sustainable



SOURCE: Data from Hogan (2009, 11).

System, in North Carolina, employs nearly 900 billing clerks to deal with multiple reimbursement systems established by hundreds of insurance companies. Likewise, Johns Hopkins Health System in Maryland files claims with 700 different insurance companies, each of which has its own reimbursement rules (Reinhardt 2009).

Deteriorating Hospital–Physician Relationships Lead to Dissatisfaction Among Physicians

Hospital–physician relationships have deteriorated markedly over the past decade, contributing to inconsistent service quality, the provision of care for purely economic gain, and disparities of care based on a patient's ability to pay (Goldsmith 2006). Our observation has been that a general dissatisfaction among physicians with the practice of medicine has contributed to the breakdown in relationships. Highlighted below are examples of negative outcomes associated with physician dissatisfaction:

- A survey of 1,077 physicians commissioned by the Connecticut State Medical Society reported that nearly one-third of those physicians are

dissatisfied with medical practice and are considering changing jobs or moving out of the state (Kaiser Health News 2008).

- The Agency for Healthcare Research and Quality (2009) reports that physicians who are dissatisfied with their profession are two to three times more likely to leave medicine than are satisfied doctors.
- The U.S. Department of Health and Human Services, as reported by e-healthsource.com (2008), documents that about half of 11,950 primary care physicians are dissatisfied with the practice of medicine and want to stop practicing or reduce their patient loads.

Strong, mutually supportive relationships are essential to delivering high-quality, cost-effective healthcare services, but physician dissatisfaction with medicine and the deterioration of hospital–physician relationships has affected the ability of the U.S. healthcare system to deliver such care.

Wide Variations Exist in Cost and Quality Outcomes at Hospitals

The *Dartmouth Atlas of Health*, as cited by Wennberg (2002), has documented that wide variations exist in the clinical outcomes realized in the U. S. healthcare system and that 50 percent of the care provided may not be clinically justified. Additional studies have confirmed that much variation exists in clinical outcomes and that appropriate care is provided only 54.9 percent of the time (McGlynn et al. 2003). Variations in clinical and financial outcomes for open heart surgery prompted the state of New York to publicly report clinical outcomes. Since 1989 the New York State Department of Health (2006) has published mortality outcomes that vary by 400 percent depending on the hospital selected and by 900 percent depending on the surgeon selected.

An article published in the *Wall Street Journal* reports that hospital charges (excluding physician fees) for chest X-rays varied from $120 to $1,519 in a select group of California hospitals (Lagnado 2004). The Institute of Medicine (2001) and the Kaiser Family Foundation (2009) have concluded the United States must realize improvements on the magnitude of 50 percent to achieve health outcomes attained by other countries for quality, access, and economic efficiency. Empirical studies have documented that patient treatments are often not evidence based, preventive care is routinely underutilized, and preventable errors are unacceptably high (McGlynn 1997; McGlynn et al. 2003; Schoen et al. 2006).

HealthGrades and Thomson Reuters are commercial companies that rate healthcare providers based on clinical and cost data abstracted from millions of Medicare cases. A report from HealthGrades (2009; Figure 2) compares total knee replacement surgery at two hospitals in a major metropolitan city with the following outcomes:

- Hospital A's complication rate was 2.7 percent, which was better than expected when compared with the comparison hospital's complication rate of 13.7 percent, 6.3 percent worse than expected.

- Hospital A's length of stay was 3.1 days versus 5.9 days for the comparison hospital.
- Hospital A's estimated cost was $11,029, compared with $15,026 for the comparison hospital, a difference of $4,000.

In this example, the lower-performing hospital charged 36.2 percent higher fees, experienced a 234 percent higher complication rate, and documented an average length of stay that was almost twice as long as the higher-performing hospital.

In no other industry do consumers (payers) routinely pay more for products or services of low or questionable quality. Healthcare consumers are typically not aware of whether they are purchasing care from a high- or low-quality hospital or physician and often do not know the costs (or charges) for the healthcare they receive (Advisory Board Company 2006). This *lack of transparency* is due in part to the reluctance of healthcare providers to share and compare outcomes data. Patients are generally too ill or too timid to request information concerning healthcare services and may be unable to make informed decisions even if such data were available.

Because most consumers do not directly pay for healthcare services, few seek or demand cost information beyond their copayment or deductible. Furthermore, most do not compare the price of elective healthcare services prior to receiving care. The inability to effectively address healthcare's cost paradigm is largely due to the reality that patients are not price-sensitive consumers of healthcare. However, as deductibles and copayments increase, consumers will become more prudent purchasers of healthcare services.

In turn, when consumers have easy access to meaningful data that allow them to select providers based on cost and quality (i.e., value), hospitals will begin to align themselves with efficient physicians who can consistently deliver quality outcomes. Likewise, physicians will select hospitals that have demonstrated their ability to partner with physicians whose quality outcomes are the primary objective.

Transparency Creates Consumer Awareness

So when consumers have a vested interest in the cost of healthcare services and have access to comparative data on cost and quality, they will be expected to make rational decisions and seek care based on value. The historic lack of transparency in healthcare has prevented consumers from making informed decisions based on cost and quality. Hospitals and private physicians are increasingly being forced to operate in a transparent environment, prompting payers to select providers based on cost, quality, appropriateness, and service. In a transparent environment, hospitals will no longer be able to subsidize losing services on the backs of profitable services and commercial payers (Goldsmith 2009).

Transparency in the marketplace pressures underperforming providers to improve performance or risk losing market share. Physicians who do not achieve acceptable outcomes will find

FIGURE 2
Comparison of Total Knee Replacement Surgery at Two Competing Hospitals

Hospital A	Hospital B
(five stars)*	(one star)*
Avoiding complications:	Avoiding complications:
Predicted without 93.2%	Predicted without 92.6%
Actual without 95.9% (+2.7%)	Actual without 86.3% (–6.3%)
Average length of stay: 3.1 days (shorter than average)	Average length of stay: 5.9 days (longer than average)
Procedures performed over 3-year period: 1,194	Procedures performed over 3-year period: 168
Estimated cost: $11,029	Estimated cost: $15,026

*As rated by HealthGrades.
SOURCE: Data from HealthGrades (2009).

it difficult to retain privileges at high-quality hospitals and may have difficulty renewing contracts with insurance companies.

Payers, predominantly the Centers for Medicare & Medicaid Services (2007), have begun to differentiate payments based on the quality of a provider's outcomes. Medicare is testing a "bundled" payment system whereby hospitals and physicians are reimbursed a single payment for an entire episode of care, rather than separate payments to the facility and physicians (RAND Corporation 2009). Pay-for-performance and bundled payment programs are receiving close attention during the health reform debate taking place in Congress at the time of this writing and will likely increase in scope and degree. The current practice of reimbursing providers for each unit of service cannot be sustained and will decline in the near future. Healthcare executives and hospital board members should ask themselves the following question: What would we do if our clinical outcomes and healthcare costs were publicly available and were published regularly in our local newspaper?

BARRIERS TO SUSTAINABLE RELATIONSHIPS BETWEEN HOSPITALS AND PHYSICIANS

Resistance to Change to Preserve the Current Healthcare Model

Many hospitals are looking to the past when they allocate capital to build replacement facilities instead of improving the technological infrastructure of their organizations or investing in integrated delivery systems with members of their medical staff. Continuing to invest in today's "cash cows" at the expense of investing in the future could undermine the entire U.S. health system (Shortell et al. 1993).

Executives and board members often are unable to imagine or accept the fact that the acute care hospital should no longer be the center of the health system. Hospitals' reliance on acute inpatient care as their primary source of business and revenue has been declining for years (Goldsmith 2006). Health systems in the future will be designed around a patient information system, integrated physician groups, ambulatory care, and wellness and prevention, with a reduced emphasis on inpatient care.

A persuasive case can be made that a patient information system, designed to provide clinical data to facilitate improved quality and cost efficiencies, should be the foundation for tomorrow's healthcare system. For example, cloud computing is an innovative concept that accesses data from a vast array of interconnected databases and organizations, making it possible for people to be connected almost anytime and anywhere. The challenge for healthcare providers is to adopt new technologies, like cloud computing, where medical records are readily accessible to the patient and his or her caregivers, regardless of the provider's location (Hamm 2009).

Competition Between Hospitals and Their Medical Staffs

Independent physicians have little incentive to be concerned about how their clinical and financial decisions affect the performance of the hospital (Madison 2004). Competition between physicians and hospitals, reductions in physician reimbursement, changing demographics, and physicians' emerging desire for a more predictable lifestyle have resulted in demands that physicians be paid for work previously performed voluntarily (e.g., leadership, committee attendance, emergency department call). One hospital executive stated: "The current confluence of forces threatens the long-standing assumption that physicians and hospitals share common goals. We are in competition with our own medical staff" (Berenson, Ginsburg, and May 2006).

Physicians who are not employed or not directly aligned with a hospital are more likely to compete with that hospital. Physicians are naturally more cost conscious when they have a vested interest in the financial outcome of the care they are providing (Burns and Wholey 1992; Fisher et al. 2006; Shortell et al. 2001).

Independent physicians, who are nominally part of integrated systems, often compete with hospitals where they have privileges by offering a wide array of office-based ancillary services, including physical therapy and diagnostic testing, and by having ownership in a freestanding surgery center or another facility (Casalino, Devers, and Brewster 2003; Shortell et al. 1993; Shortell, Gillies, and Anderson 1994). The effect of competition between hospitals and their medical staffs often results in misapplication of resources and an underutilization of capital, which results in duplication of equipment and facilities and higher costs for patients. Another outcome of competition between physicians and hospitals has been that the overall percentage of healthcare spending for hospital services has fallen from 40 percent in 1980 to 30 percent in 2006 (Goldsmith 2006).

Competing with the organization that grants the provider privileges and shares the resources needed to charge professional fees does not occur in most other businesses. Commercial airlines do not allow pilots to fly for other airlines or operate their own boutique airlines; automobile manufacturers do not allow their mechanics to establish competing repair shops across the street from the auto plant; and lawyers employed by large firms are not permitted to supplement their income by moonlighting for a competing firm. That physicians have been allowed to compete with hospitals where they have privileges to practice is clearly the result of a fatally flawed reimbursement system (Berenson, Ginsburg, and May 2006).

The absence of physician leadership often prevents physicians from being effective partners in an aligned health system. Physician leaders must effectively advocate for the needs and values of physicians without losing sight of the overall goals of the hospital. Both the hospital and its medical staff must adopt a systems approach. Failing to make tough decisions for the good of the organization wastes resources and prevents organizations from fulfilling their mission to serve their communities.

Cross-Subsidization of Services and Payers

A study by McKinsey and Company concluded that "few hospitals have more than a general sense of their competitiveness by service lines and even fewer have the ability to track profitability by service line, patients, or by individual physicians" (Grote, Mango, and Sutaria 2007). Hospitals and physicians historically operated in a "cost-plus" environment where the business model included all of the costs and a reasonable profit for new or existing services. If a specific service had a "poor payer mix," the hospital (or the physician) simply raised charges to commercial and self-pay patients to cover losses incurred from the provision of charity care and for services provided to Medicare and Medicaid patients.

Hospitals cannot continue to cross-subsidize losses from one payer or service by increasing charges to another payer or service. Hospitals must figure out how to operate profitably across all payer lines. A proactive strategy is for hospitals to prepare their operating budgets assuming all payers will reimburse at a level that is 5 percent lower than their existing payment rate from Medicare.

Medical Tourism

In 2009 an estimated 3 million Americans sought less expensive medical care in other countries, a number projected to grow to 6 million by 2010, potentially costing the U.S. healthcare system billions of dollars (Keckley and Underwood 2009). Projections indicate that global medical tourism will grow to $100 billion by 2012. Medical tourism, international and domestic, is challenging the status quo of the traditional U.S. healthcare system as consumers seek quality care and greater access at lower costs. Top U.S. healthcare providers are aggressively advertising to recruit

domestic and international medical tourists (Herrick 2007). Every medical tourist who travels out of his or her service area for healthcare is taking money out of that person's local economy and away from the local healthcare providers.

STRATEGIES TO PRESERVE AND STRENGTHEN THE RELATIONSHIPS BETWEEN PHYSICIANS AND HOSPITALS

Understand the Value Proposition of Your Hospital and Your Medical Staff

What is the value proposition of your hospital? Healthcare executives and board members need to clearly understand the business model and the value proposition their hospital and medical staff are offering to their communities. Simply stated, healthcare executives and board members need to know how the cost and quality of the services offered at their institutions compare internally and externally. Not knowing the value proposition of your hospital and medical staff may put your community at economic risk and your patients at clinical risk.

Internal analysis should inform healthcare executives and board members on the degree of variation that exists in the provision of specific services. For example, does the mortality rate for open heart surgery vary by 900 percent depending on the surgeon, as documented by the New York State Department of Health (2006)? Does the length of stay for total knee replacements vary by one day or by four days? How often do complications occur by physician, and what is the range in costs/charges for the same service among individual physicians?

External analysis should use the same metrics as internal analysis and should inform executives and board members how their institution compares with local and regional competitors and with the benchmark for the procedure at the best hospitals in the country. These metrics should be used to guide healthcare leaders when they consider which physicians to partner with if they choose to pursue integration strategies. And medical staff members should know how organizations perform in key areas before contemplating an integration strategy with that organization.

Build Collaborative Cultures with a Shared Vision and Shared Values

Among all of the factors contributing to quality outcomes and lower costs in healthcare, a key determinant is the degree of *alignment* that exists between physicians and hospitals (Shortell et al. 2001). Alignment occurs when organized delivery systems share the same mission, vision, goals, objectives, and strategies.

A key to building strong, values-based cultures is to seek input on clinical and operational issues from medical staff members and make decisions in a collaborative, not authoritarian, manner (Denison 1990; Shortell et al. 2005, 2001). Decisions that benefit from physician input include establishing the mission statement, organizational values, and strategic plan and operating and capital budgets. Reaching

agreement on the priorities of the organization is critical to garner the support of key physicians. However, members of medical staff who seldom support the hospital and who, in fact, may compete with the facility should not have the same level of input as those physicians who support the institution's mission and values.

One of the biggest barriers to creating sustainable relationships is the absence of shared values, vision, and goals. Organizations that do not have a shared vision and values with their medical staff will struggle in a competitive and transparent environment.

The strength and structure of aligned relationships are significant determinants of performance outcomes. Physicians who are philosophically and economically aligned with an organization are more likely to make decisions that are in the best interest of the organization and, therefore, the patients served by the organization. Physicians are also more likely to support a hospital or health system when decision making is not centralized or dominated by the system (Budetti et al. 2002; Fisher et al. 2006; Shortell et al. 2001).

Hospitals desiring to create alignment with physicians on their medical staffs understand that cultural alignment precedes economic alignment, and economic alignment precedes clinical alignment. Furthermore, hospitals pursuing the employment model as a strategy to align the hospital's interests with the interests of the medical staff should be aware that tying physician compensation to productivity alone may have a negative effect on the attitudes of employed physicians (Budetti et al. 2002).

Consider Integration as an Answer to the Challenges Facing Physicians and Hospitals

Economic trends coupled with inferior clinical outcomes suggest that the current U.S. healthcare system is not sustainable. Competition between hospitals and members of their medical staff is a recipe for failure. Lack of integration and alignment results in a lack of service rationalization and capital inefficiencies between hospitals, their medical staff, and the communities they serve (Zismer 2006). Independent physicians, including some multispecialty groups, do not have the scale to achieve the capital and operating efficiencies required in a competitive market where prices and quality are transparent. Transparency and global competition are putting pressure on prices and utilization, placing healthcare providers at financial risk. Structural changes are needed to create a business model whereby healthcare is affordable and the goals of hospitals and physicians are aligned with the healthcare needs of patients.

One solution to the challenges facing many hospitals is to integrate with physicians. *Integrated healthcare* is a unified business model whereby the goals and objectives of both parties are aligned (Zismer 2006). In a properly integrated hospital, physicians assume either full or shared responsibility for physician leadership, governance, physician recruitment, clinical quality, professional and appropriate behavior in the practice of medicine, a values-based culture, and a physician compensation

model that supports the goals and philosophy of the healthcare system. In properly integrated hospitals, clinical services are well capitalized, appropriately sized, and scaled to the demands of the market. Moreover, economic fragmentation, duplication, and competition between physicians and hospitals are minimized or eliminated (Zismer 2006). Variations in clinical practice style can be reduced, with the benefits accruing to the health system and the patients being served.

Because physicians are not a homogeneous group, hospitals are well advised to develop multiple integration strategies that appeal to a wide diversity of physicians. Having multiple strategies reflects the realities that no two physicians are alike, no two specialties are the same, physicians representing various age cohorts have different needs, and female physicians have different goals and views than their male counterparts. There is clearly not a "one size fits all" model for hospitals and their medical staff. Sailing in these uncharted waters may be difficult due to the limited amount of research linking hospital–physician alignment with hospital performance (Grumbach and Bodenheimer 2004).

Physician diversity also applies to the employment of physicians. While many mid-career physicians may have no desire to be employed by a hospital, younger physicians may be more motivated to be employed by a hospital. Millenial generation physicians, coming out of medical school with high levels of debt, typically want a soft landing into the profession and may achieve it by seeking the security employment provides (Merry 2008; Zismer 2008). A survey conducted by the American College of Physician Executives found that more than 40 percent of employed physicians rated their relationship with their hospital as going well compared with only 16 percent of private-practice physicians (MacNulty and Reich 2008).

One strategy to align the interests of hospitals and physicians is to employ physicians using a compensation model focused on quality, service, cost, productivity, profitability, and the values of the integrated system. Although well-managed integrated hospitals can fundamentally improve their operating efficiencies and the performance of their physician practices, healthcare leaders need to be aware of the risks and the degree of integration that a given culture will tolerate. Proceeding slowly into such arrangements may be wise for many organizations eager to integrate with their medical staff. A question healthcare leaders should ask themselves when evaluating an integration strategy is, what would your hospital do if a competing health system offered desirable employment contracts to your top-performing physicians, particularly those who have high contribution margins?

Although physician employment is growing at a rapid pace, we caution that employment is not the silver bullet for all hospitals, and certainly not for all physicians. Employment of physicians is a strategic option to create alignment between hospitals and members of their medical staff, but success will depend on the cultural fit between the two parties. We believe multiple structures and strategies will emerge to address

hospital–physician relations. However, it is worth repeating that a foundation for building sustainable relationships must include an alignment of mission, vision, and goals.

Members of a hospital's medical staff typically fall into one of three major groups: private (appointed), employed (full or significantly part time), and contracted (exclusive or otherwise). These broad categories can be further broken down as follows:

1. Physicians who work outside the hospital and refer to hospitalists and other hospital-based physicians or specialists
2. Physicians who perform the majority of their work within the confines of the acute care facility
3. Physicians who by nature of their specialty have little need for the hospital (e.g., dermatologists, allergists)
4. Physicians who actively compete against the hospital through alignment with other hospitals or ownership in surgical centers, gastroenterlogy centers, outpatient diagnostic centers, and so forth
5. Physicians who are on staff at many facilities and split their inpatient work among them

Physician relationship strategies need to be tailored for each major group and for each subgroup. Most hospitals cannot and will not have a single relationship model with physicians but rather will have multiple, varied relationships with members of their medical staff. The structure and terms of the relationships should quantitatively and qualitatively define the outcomes both parties expect from the relationship. A goal of this process is to create alignment among the needs of the community, the mission of the hospital/health system, and the goals and objectives of each physician or physician group. A key to a successful relationship is the ability of both parties to effectively articulate, define, and prospectively agree on the metrics to measure and differentiate successful performance.

Evidence is mounting that the traditional business model between hospitals and physicians is not sustainable and has been a barrier to improving health outcomes. Voluntarily appointed medical staffs are often not aligned with the mission and values of the hospitals where they practice. Members of a hospital's medical staff often compete directly with the hospital where they have privileges. The historical relationship between the organized medical staff, as defined in the medical staff bylaws, and the hospital has little relevance in today's environment. The challenges facing the U.S. healthcare system are simply too complex and important to be managed in a system that was designed to permit self-governance by a collection of private practitioners who were often more concerned with their own practices than the medical staff as a whole, the hospital, the community's health status, or the healthcare needs of individual patients.

CONCLUSION

Future success will depend on the ability of healthcare leaders to craft new structures and strategies while simultaneously shedding structures and strategies

that do not contribute to the healthcare needs of our communities. Successfully integrated health systems will find it necessary to establish mutually beneficial relationships with physicians who are aligned with and support the values and mission of the organization irrespective of whether the physicians are private, employed, or contracted. Physicians who choose to compete, or who are struggling to assert their independent authority and autonomy, will find it difficult to remain part of the organization unless they possess a needed skill or knowledge base that is in extremely scarce supply.

In the future, physicians seeking appointment to a hospital's medical staff will be required to articulate how they will assist in the fulfillment of the hospital's mission. Physicians with privileges at a hospital or health system who fail to support the mission of the organization may experience consequences related to their nonsupport. This situation is no different from the consequences an employee may experience if he or she fails to support the organization where he or she is employed.

Additionally, a number of forces are in play to create educated consumers who will purchase healthcare based on cost, quality, and the appropriateness of the services needed. An increase in the transparency of services regarding cost and quality and initiatives by insurance companies to differentiate payments based on clinical outcomes will forever change the relationships among hospitals, their medical staff, and the patients they serve.

While it is impossible to forecast the political will of the U.S. Congress regarding healthcare legislation, healthcare in the United States will no longer continue as "business as usual." Hospitals and physicians must redefine their relationships, with an emphasis on alignment of interests, placing patients and the communities served centermost.

REFERENCES

Advisory Board Company. 2006. *An Emerging Market for Value-Based Payment.* Health Care Advisory Board.

Agency for Healthcare Research and Quality. 2009. "AHRQ Quality Indicators." Washington, DC: AHRQ, U.S. Department of Health and Human Services. [Online information; retrieved 4/28/09.] www.qualityindicators.ahrq.gov.

American Hospital Association. 2009. "Fast Facts on US Hospitals." [Online information; retrieved 10/28/09.] www.aha.org/aha/resource-center.

American Hospital Association. 2006. "Fast Facts on US Hospitals." [Online information; retrieved 10/28/09.] www.aha.org/aha/resource-center.

American Hospital Association. 2009. "Hospital Margins Sink with Economy." [Online article; retrieved 3/31/09.] ahanews.com/ahanews_app/jsp/display.jsp? dcrpath =AHANEWS/AHANewsArticle/data/AHA_News_090316_Report_hospital &domain=AHANEWS.

Associated Press. 2006. "Ford Names Alan Mulally as New CEO." *New York Times*, September 5. [Online article; retrieved 9/7/10.] www.nytimes.com.

Berenson, R. A., P. B. Ginsburg, and J. H. May. 2006. "Hospital–Physicians Relations: Cooperation, Competition, or Separation?" *Health Affairs* 26 (1): 32–34.

Budetti, P. P., S. M. Shortell, T. M. Waters, J. A. Alexander, L. R. Burns, R. R. Gillies, and H. Zuckerman. 2002. "Physician and Health System Integration." *Health Affairs* 21 (1): 203–10.

Burns, L. R., and D. R. Wholey. 1992. "Factors Affecting Physician Loyalty and Exit: A Longitudinal Analysis of Physician-Hospital Relationships." *Health Services Research* 27 (1): 1–10.

Casalino, L. P., K. J. Devers, and L. R. Brewster. 2003. "Focused Factories? Physician-Owned Specialty Facilities." *Health Affairs* 22 (6): 56–67.

Centers for Medicare & Medicaid Services. 2007. "Research, Statistics, Data and Systems." [Online information; retrieved 5/10/09.] www.cms.hhs.gov/home/rsds.asp.

Cuellar, A. E., and P. J. Gertler. 2006. "Strategic Integration of Hospitals and Physicians." *Journal of Health Economics* 25 (1): 1–28.

Denison, D. R. 1990. *Corporate Culture and Organizational Effectiveness.* New York: John Wiley & Sons.

E-healthsource.com. 2008. "Nearly Half of Primary-Care Docs Dissatisfied: Survey, November 19, 2008." [Online article; retrieved 11/ 21/09.] news.e-healthsource.com.

Fisher, E. S., D. O. Staiger, J. Bynum, and D. J. Gottlieb. 2006. "Creating Accountable Care Organizations: The Extended Hospital Medical Staff." *Health Affairs* 26 (1): 44–57.

Ginsburg, P. B. 2004. "Controlling Health Care Costs." *New England Journal of Medicine* 351 (16): 1591–93.

Goldsmith, J. 2009. "Beyond Health Reform." [Online article; retrieved 4/8/10.] www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/10OCT2009/091013HHN_Online_Goldsmith&domain=HHNMAG.

Goldsmith, J. 2006. "Hospitals and Physicians: Not a Pretty Picture." *Health Affairs* 26 (1): W72–W75.

Grote, J., J. Mango, and S. Sutaria. 2007. "Transforming U.S. Hospitals." [Online article; retrieved 4/8/10.] mkqpreview2.qdweb.net/ Transforming_ US_hospitals_1937.

Grumbach, K., and T. Bodenheimer. 2004. "Can Health Care Teams Improve Primary Care Practice?" *Journal of the American Medical Association* 291 (10): 1246–51.

Hamm, S. 2009. "How Cloud Competing Is Changing the World." *Business Week*, June 15, 42.

HealthGrades. 2009. "Comparative Hospital Quality Data." [Online information; retrieved 4/28/09.] www.healthgrades.com.

Herrick, D. 2007. *Medical Tourism: Global Competition in Health Care*." Dallas, TX: National Center for Policy Analysis.

Himmelstein, D. U., S. Woolhandler, and S. M. Wolfe. 2004. "Administrative Waste in the U.S. Health Care System in 2003." *International Journal of Health Services* 34 (1): 79–86.

Hogan, N. C. 2009. *The End of the Third Bubble*. Miami, FL: BDC Advisors.

Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press.

Kaiser Family Foundation. 2009. "Comparing U.S. Healthcare Spending with other OECD Countries. [Online information; retrieved 4/28/09.] www.kff.org.

Kaiser Health News. 2008. "Survey Finds Nearly One-Third of Connecticut Physicians Dissatisfied with Work Conditions." *Kaiser Daily Health Policy Report,* September 25. [Online article; retrieved 10/22/09.] www.kaiserhealthnews.org/daily-reports/2008/september/25/dr00054670.aspx?referrer=search.

Keckley, P., and H. Underwood. 2009. *Medical Tourism: Consumers in Search of Value*. Deloitte Center for Health Solutions.

Lagnado, L. 2004. "Medical Markup: California Hospitals Open Books Showing Huge Price Differences." *Wall Street Journal,* December 27, p. A.1.

MacNulty, A, and J. Reich. 2008. "Survey and Interviews Examine Relationships Between Physicians and Hospitals." *Physician Executive* 34 (5): 48–50.

Madison, K. 2004. "Hospital-Physician Affiliations and Patient Treatments, Expenditures, and Outcomes." *Health Services Research* 39 (2): 257–78.

McGlynn, E. 1997. "Six Challenges in Measuring the Quality of Health Care." *Health Affairs* 16 (3): 7–21.

McGlynn, E. A., S. M. Asch, J. Adams, J. Keesey, J. Hicks, A. DeCristofaro, and E. A. Kerr. 2003. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine* 348 (26): 2635–45.

Merry, M. 2008. "Shifting Sands for Medical Staffs." *Physician Executive* (May/June): 20–25.

New York State Department of Health. 2006. *Annual Report on Cardiovascular Care*. Albany: New York State Department of Health.

RAND Corporation. 2009. "Overview of

Bundled Payment Policy Options." [Online information; retrieved 11/09.] www.randcompare.org /bundled _payment.

Reinhardt, U. E. 2009. "Way Too Much for Way Too Little!"[Online article; retrieved 4/8/10.] whatmatters.mckinseydigital.com/health_care/way-too-much-for-way-too-little.

Schoen, C., K. Davis, S. How, and S. Schoenbaum. 2006. "U.S. Health System Performance: A National Scorecard." *Health Affairs* 25: W457–W475.

Shortell, S. M., J. A. Alexander, P. P. Budetti, L. R. Burns, R. R. Gillies, T. M. Waters, and H. S. Zuckerman. 2001. "Physician-System Alignment: Introductory Overview." *Medical Care* 39 (7): 130–145.

Shortell, S. M., R. R. Gillies, and D. A. Anderson. 1994. "The New World of Managed Care: Creating Organized Delivery Systems." *Health Affairs* (Winter): 46–64.

Shortell, S. M., R. Gillies, D. Anderson, J. Mitchell, and K. Morgan. 1993. "Creating Organized Delivery Systems: The Barriers and the Facilitators." *Hospital and Health Services Administration* 38 (4): 447–66.

Shortell, S. M., J. Schmittdiel, M. C. Wang, R. Li, R. R. Gillies, L. P. Casalino, T. Bodenheimer, and T. G. Rundall. 2005. "An Empirical Assessment of High-Performing Medical Groups: Results from a National Study." *Medical Care Research and Review* 62 (4) 407–34.

Starr, P. 1982. *The Social Transformation of American Medicine*. New York: Basic.

Thomson Reuters. 2009. "Thomson Reuters Launches Campaign to Reduce Healthcare Costs by $4 Billion." [Online information; retrieved10/23/09.] www.save4billion.com.

Wennberg, J. E. 2002. "Unwarranted Variations in Healthcare Delivery: Implications for Academic Medical Centres." *British Medical Journal* 325 (7370): 961–64.

Zismer, D. 2008. "The 'Physics' of Market Consolidation and the Likely Effects on Private Medical Group Practice." *Perspective.* Duluth, MN: Essentia Health Consulting.

———. 2006. "Integration as an Answer to the Challenges of the 'Legacy' U.S. Not-for-Profit Community Health Systems." *Perspective*. Duluth, MN: Essentia Health Consulting.

PRACTITIONER APPLICATION

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Carlson and Greeley have written a well-researched article that does a very good job presenting the past, the present, and the future of physician–hospital relations. First, the authors briefly review the history of hospital–physician relations—in short, traditionally physicians were completely independent and the hospital existed to serve physicians' practice and patients' needs. Next, Carlson and Greeley lay out a clear argument for why this historical system cannot continue. They believe that the cost of the current delivery system, the viability of hospitals, and the ability of the consumer to shop for the best value (including medical tourism) means that new alignment models must be established. Finally, the authors suggest new ways of working with physicians under the many and accelerating pressures for physicians and hospitals.

Two themes are woven throughout the three areas of focus: economic viability and culture. The economic dynamics affect the practicing physician and the hospital in similar ways. Both groups want to maximize their gain after expenses. The physician is "cherry-picking" those high-margin tests and procedures that can be

completed in his or her office. And the hospital is managing staffing patterns and inventory to minimize expenses while encouraging physicians to admit patients to the hospital. The authors do a good job of discussing why the similar but mutually exclusive goals of creating the most financial gain makes the historical and current hospital–physician relationship model impossible to manage in the future.

Adding to the complexity of the economic dynamics are the cultural differences between hospitals and physicians. Hospitals are complex social communities, whereas the physician culture is characterized by the absolute protection of the individual prerogative.

The authors deserve a lot of credit for introducing the concept of culture as a critical success factor. Too often, physician–hospital alignment strategies are based solely on the economic benefits to each party. Then the execution of the strategy is weakened by the hospitals' belief that physicians' decisions about their patients will be made in ways that benefit the hospital and physicians' belief that they will not be bound by any policy or process that interferes with the way they practice medicine. These fundamental, hard-wired differences between hospitals and physicians are real and universal. The authors believe that physician employment presents the best hope for bridging the cultural-economic chasm.

Physician employment was first tried in the late 1980s and early 1990s. It is fair to say that most arrangements were not successful. The underlying reason for the dismal outcome of physician employment was misunderstanding the motivation of the parties involved in the contract, driven once again by their very different cultures. And while Carlson and Greeley do a fine job of repositioning physician employment as a viable model for the future, they recognize that the employment of physicians is simply one means to align the interests of physicians with the interests of the hospital for the benefit of the patient.