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Hospital/Physician Relationships: A Constraint To Health Reform

by Jeff Goldsmith

The evolving health reform scenario envisions weaving hospitals and physicians seamlessly into community-based networks that would assume economic responsibility for the cost and quality of care. Those who view the medical terrain from thirty thousand feet have a different view of how this “weaving” process might work than do those whose professional lives have been spent on the ground. Indeed, the hospital/physician relationship is at once rapidly evolving, widely variable from region to region, and extremely unstable. This unstable relationship will significantly constrain the implementation of health reform.

Historical Context

As historians and sociologists who have studied American medicine have observed, the relationship between hospital and physician has been fraught with conflict for most of this century. Paul Starr’s Social Transformation of American Medicine documented how American physicians were able successfully to resist hospital incursions into physicians’ autonomy. Rosemary Stevens’s In Sickness and in Wealth recorded the continual tensions between medical staff and management as the hospital adapted its mission to new social realities and technological possibilities. Both sides of the hospital/physician relationship were able to achieve remarkable economic growth without resolving the fundamental tensions between them. Odd hybrids such as the Mayo Clinic and the Kaiser health plans, where the hospital was a subsidiary to a larger physician business, managed to flourish without becoming “templates” for the larger medical enterprise.

As the health system entered the 1980s, the emergence of such industrial models of health care organization as the multihospital system and the growth of nonhospital services disturbed the relationship further. As managed care spread and pressures for economic accountability from diagnosis-
related groups (DRGs) injected tension into the relationship, antibodies rose within organized medicine to resist new incursions into physician autonomy. The American Medical Association (AMA) created a new section on Hospital/Medical Staff Affairs to respond to varied physician concerns about an unfavorable shift in the balance of power toward management.

Management during the 1980s became preoccupied with a new complexity in health services. Mergers, geographic expansion, new service development, aggressive capital expansion, and technology acquisition distracted managers from their relationship with physicians. Many senior managers removed themselves from day-to-day contact with physicians and believed that physicians would be far less important to the future health enterprise than in the past. Physicians correctly sensed both a loss of control over their institutions and a loss of importance. As a result, many hospitals and medical communities actually “disintegrated” during the 1980s sowing the seeds of mistrust and conflict in advance of a decade of reform.

Transiting The 1990s

It is difficult to describe adequately the level of ferment in most American physician communities today. Although the uncertainties of health reform and the arrival of a new administration in Washington have contributed to the turbulence, the unraveling of the private practice of medicine has been under way for more than a decade. Conventional private practice is coming to an ugly and abrupt end in many communities, even in conservative places such as Cincinnati and Indianapolis. Average physician incomes continued to rise nationally through 1992, but the averages conceal regional meltdown, in both primary care and many specialties.

Specialists now face a double threat-reduced incomes from Medicare’s resource-based relative value scale (RBRVS) and managed care discounts, and sharply higher personal tax rates-which will push many of them, already overleveraged and cash poor, into personal economic crisis. Many specialists spent 110 percent of what they earned during the “Roaring Eighties” and will not have the cash cushion to absorb the impending 30 percent increase in their marginal income tax rates, let alone the numbing prospect of a new 9 percent payroll tax for their health insurance. The prospect of 30-50 percent further reductions in specialty incomes under a managed care-based health reform strategy could mean that the future may be even darker.

On the primary care end, national averages conceal a steady deterioration in practice economics in many parts of the country. Although some general internists and family practitioners were able to augment their
incomes with laboratory tests and chest x-rays, many primary care physicians experienced steady reductions in their per hour compensation in private practice during the past decade. Unable to work any harder than seventy-five hours a week and unable to manage the proliferation of practice constraints imposed by health insurers, an increasing number of primary care physicians began searching for relief. Primary care physicians by the thousands are turning to the hospital, urging their administrators to provide them with subsidies or paid administrative roles, or simply to acquire their practices. The latter actions inflame the anxieties of specialists, who see the hospital moving into a position to control their referrals (and therefore incomes) from “hospital-owned” primary care physicians.

The result of these pressures has been a virtual land rush of practice acquisitions by hospitals. In some communities this has been a deliberate, thoughtful process of taking in primary care physicians in distress. In others it has become a mercantile process where physicians seek to cash out while their practices still have some economic value, placing themselves and their patient volume on the auction block like sides of beef.

For all of these reasons, the emotional state of many American physician communities is deeply unsettled and troubling. An economic franchise that took a century to build is coming unraveled with dizzying speed. Given the heritage of suspicion and mistrust between physicians and hospitals, it is a dangerous time for lay managements to be working with physicians. Mingled feelings of fear, rage, humiliation, suspicion, and greed make it exceptionally difficult to work with physicians at all, let alone to meld them into new “alliances” or “networks.” What was once a dynamic equilibrium has become an unstable, explosive mixture.

The Integration Business

Interest in building new “integrated” health care organizations from the matrix of private practice predates the current health reform initiatives by at least eight years. By 1993 a new legal and management consulting “franchise” has been born. The nation’s hospitals are spending tens of millions of dollars in legal and consulting fees, far in advance of any usable details of a new federal health policy, in creating integrated health care organizations. The arcane details of alternative structures and relationships have been dealt with by others. Most of these structures will fail. They will fail because of the inability of hospitals and physicians to set aside historic suspicions, and because of the poor interpersonal skills of the participants. Their failure will, in turn, compromise reform scenarios that are predicated upon a seamless melding of hospital and physician services, or else convey market power to health insurance firms and existing managed care actors.
Both sides of the troubled relationship between medical practice and management carry baggage into efforts to form an integrated health care system. Since neither side has had enough power in the past to control the other, passive aggression has been the principal emotional subtext.

Management resentments. Health executives bring long-simmering resentments against physicians—against their incomes, their intellectual prowess, and their capricious input into management. As a consequence, there are a lot of Walter Mitty-like fantasies of power being realized in the creation of integrated systems. Some executives believe that management is finally about to triumph over physicians. A few less-temperate administrators actually pop off in medical staff meetings about how different things will be “when all you bastards finally work for me.”

These tensions are compounded by the uncertainties created by health care reform itself and by the impending reduction in hospital capacity (and jobs) that reform foretells. Many health care executives correctly anticipate that they will be unemployed in a few years and are concerned about increasing the probability of job loss by angering their medical staffs. These fears, and the resentment many executives harbor toward physicians, will be difficult to reconcile with the leadership demands of the moment.

Physicians’ tactics. However, an even more difficult challenge presents itself on the physician side. My experience at the University of Chicago Medical Center taught me early on that physicians crave order but despise authority. Long deprived of their power to influence directly the operations of hospitals or medical schools, physicians have resorted to guile and guerilla warfare to win their battles. While many physicians fall prey to an illusion of omnicompetence and believe that their medical training endowed them with superior management judgment, most are incapable of submitting to the authority of anyone, even a fellow physician.

Many physicians selected their profession based upon their need for autonomy and individual achievement. As a consequence, many lack the interpersonal skills or civility to function as part of a larger enterprise. When physicians are unhappy, they whine-deafeningly. They passively resist initiatives that they cannot overtly oppose, often doing so with dazzling flair and elegance. They will agree in public meetings and subvert privately. They wait for temporary weakness in administrative personnel and savage them. They are easily swayed by the last angry man in their midst. In short, they are terrible employees; ask any medical school dean or group practice executive.

A sizable fraction of the current generation of private practitioners or medical school faculties are poor candidates for participating in any integrated health care enterprise. The fact that physicians are in economic distress does not mean that they are emotionally prepared to surrender their
autonomy or participate meaningfully in a larger enterprise. Fifteen years ago Mitchell Rabkin likened the physician response to change to Elizabeth Kubler-Ross’s grieving paradigm. Angry or depressed people make terrible business partners.

The current generation of health care executives, medical school deans, and physician leaders are caught in the transition from an atomized entrepreneurship to an organized, collegial physician culture. Fostering collegiality—a scarce commodity in the current clinical environment—is the essential task in creating an integrated health care enterprise. In the explosive climate of many medical communities today, the task of leadership is akin to driving a nitroglycerin truck along a bumpy road. Leaders without the political skills to sense the bumps before they hit them will never know what hit them.

The Deteriorating Moral Climate

As physicians responded to a tightening market during the 1980s, the result has been a palpable deterioration in the moral climate of medical practice in many communities. Communities crossed the “mercantile” threshold when physicians began trying to “harvest” the maximum economic value from their franchises before they became worthless.

As a result, mutual exploitation between hospitals and physicians became the norm in many communities (Los Angeles, Houston, and south Florida are examples), as physicians sought, and hospitals gave, substantial bribes in the form of perks or administrative allowances (directorships for nonexistent administrative duties) to physicians in exchange for moving their “business” to the hospital. In these communities the movement toward integration simply means moving from “renting” the physician’s loyalty to “owning” it. Hospitals still profit from growing their volume of nonmanaged care business, and the fact that they are straddling payment incentives only complicates the transactions with physicians.

In an overheated market, the underlying economics of practice acquisition is obscured. If the motivation of a physician in selling his or her practice is to cash out, purchasing the practice is one of those rare transactions where the act of acquisition markedly diminishes the value of the item acquired. By buying the practice, the hospital reduces the economic risk of the physician and acquires a difficult new worker in the same bargain. For these reasons I have advocated mergers of existing practices into larger economic units at arm’s length from the hospital as an alternative approach. This strategy is impossible to execute, however, in a climate where others are paying cash on the barrelhead.

Hospitals are not the only ones courting the private practitioner. Some
for-profit companies, such as Phycor and Caremark, are aggressively purchasing medical practices, typically large multispecialty groups. In some cases the apparent intent is to procure a captive physician channel for existing products (in Caremark’s case, home infusion therapy). However, all of these organizations anticipate the future managed care world in which possession of a nucleus of clinical practitioners will be the key to dominating a regional health care market. Health insurers are also moving aggressively in some markets to hire their own primary care physician cadre. The hospital is by no means the only potential integrator of clinical services.

There is a risk in the current climate that competitive practice acquisition could dissipate large quantities of scarce capital, as hospitals desperate for an adequate base of primary care physicians (the essential structural precondition of a managed care network) buy up what had been given to them free for generations. The legal constraints on a Casbah-like economic climate between hospitals and physicians are negligible (the last significant amendments to the Medicare Fraud and Abuse statutes took place in 1977). There are sufficient loopholes in the existing law to drive a fleet of Mercedeses through without scratching the paint. Tightened fraud and abuse laws are a vital ingredient of a successful transition to managed competition. Even those in Congress who follow these issues closely have no idea how rapidly the moral climate of medical practice is deteriorating.

### Health System Architecture

If the goal of the integrated enterprise is to manage the comprehensive health needs of an enrolled population for a fixed dollar amount, the organization must, at its core, reshape how its physicians practice and how they interact with their patients. Although most lay health care executives resist the ultimate logic of integration, it is clear that, eventually, integration will require conveying real power to physicians to manage their clinical futures.

There are not many truly integrated health care organizations in the United States, and most of the obvious examples (such as Kaiser and Mayo) are either owned or managed by physicians. There are exceptions, such as the Henry Ford Health System, which are run by lay managers. But it is ironic that many nonphysician managers who succeed in creating a new integrated enterprise out of the entrepreneurial remains of private practice may have worked themselves out of a job and conveyed power to a new generation of physician-executives.

Health care reform planners have wisely remained silent on the ownership structure of community-based health care networks, correctly anticipating a competitive process among multiple potential sponsors. The insta-
bility of physician/hospital relationships in many communities markedly increases the probability that outside forces, whether employer coalitions, for-profit firms, or network-building health insurers, will dominate “high-conflict” markets.

The architecture of health systems is not founded upon physical assets like hospitals or magnetic resonance imaging (MRI) machines, but rather on organizations of health professionals. The core enterprise of most existing integrated health care systems is a large multispecialty group practice. However, the increasing tendency of physicians to accept employment enables insurers or employers to directly hire primary care physicians and at least partially integrate physician services into their enterprises, controlling the downstream use of hospital and specialty physician services. CIGNA and Aetna among insurers, and some employers such as Southern California Edison and Goodyear Tire and Rubber, have already embarked upon this approach.

One thing becomes clear from studying the small number of existing integrated health enterprises. In them the hospital is truly an ancillary service—a capital-hungry, troubled cost center. The hospital is not the appropriate nucleus of an integrated health care system. In an integrated health care enterprise, rather, the hospital is a high-maintenance core asset whose use must be rigorously limited by managed care incentives. Outside the integrated enterprise, the hospital is merely a vulnerable vendor of a surplus commodity. Owning a lot of hospital beds in the emerging managed care world will be as advantageous as owning a lot of rubles in post-Soviet Russia.

Networks whose objective is to leverage existing assets will be vanquished by those that seek more efficient configurations of clinical service. Those who seek to organize these networks are, unwittingly perhaps, heralding a posthospital age of health care delivery.

The Prospects For Managed Competition

There is marked variation in the readiness of various parts of the U.S. health system to execute a reform strategy based on managed competition. The ability of providers to transform themselves from entrepreneurial units to entities capable of bearing and managing health care risk will be affected by the degree of trust that can be achieved within these organizations and the degree to which organizations can successfully redistribute incomes and economic responsibility within the physician community.

Managed care fundamentally rearranges economic flows in the provider community. Hospital dollars become physician dollars under managed care, and specialist dollars become primary care dollars. Organizations that suc-
ceed under managed care must have the organizational strength and leadership to withstand the inevitable conflicts that arise in this redistributive process.

**Need for leadership.** Organization capacity to make this transformation will vary according to the skills and leadership ability of lay managers and physicians. Some medical communities are so mired in conflict that leadership is not possible. The balance of risk and reward for potential physician “statesmen” is so unfavorable that they may not step forward. By the same token, health care executives burdened by the 1980s mind-set of empire building will be unable to engender sufficient physician loyalty and trust to create truly risk-bearing enterprises. While health insurers may have better luck imposing order from the outside in these places, they will still be constrained by the medical culture of the communities in which they work. Many insurers have markedly underestimated the difficulties they will face as employers or organizers of physicians.

**Regional differences.** There also are marked differences from region to region in readiness to move toward a network-based health reform strategy. In some parts of the country, as in the Pacific Coast and upper Midwest, most of the infrastructure is in place to absorb the tripling or quadrupling of managed care enrollment that would result from managed competition-style health care reform. There will be strains in these areas, though, particularly in securing a large enough primary care physician cadre.

In other parts of the country, such as the Mid-Atlantic states, the South, and large parts of New England, political, cultural, and economic forces have retarded the growth of integrated enterprises (Exhibit 1). The latter regions harbor the greatest potential for savings in reducing excessive hospital and specialty physician utilization. In these regions, frantic network development activity can be anticipated in the wake of health care reform, as can the potential for huge economic losses in the transition from fee-for-service to capitated payment. In the West and upper Midwest, experience in constructing and operating managed care networks spans almost three generations. Yet despite this lengthy history, operational experience has not diminished the widening periodic underwriting losses that have afflicted managed care plans.

Managed care growth in the East has been retarded by heavy regulation, by government policies that created health insurance monopolies for Blue Cross plans, and by the preponderance of large teaching hospitals in most metropolitan areas. In the South managed care has been held off by strong traditions in medical communities that have resisted changes in fee-for-service payment. In both areas loose network arrangements such as individual practice associations (IPAs) have been the norm for managed care plans. Many of these IPAs were organized by physicians with the explicit
Exhibit 1
Health Maintenance Organization (HMO) Enrollment
As A Percentage Of U.S. Population, By Region, 1980-1990

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<tr>
<th>Year</th>
<th>South</th>
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Source: InterStudy Edge: Managed Care: A Decade in Review, 1980-1990.

The objective of resisting more constraining forms of managed care. Group practice is rare in these regions, limiting insurers’ options for rapid deployment of physician networks. Capitated physician or hospital payment is a negligible fraction of total revenues.

Current organizational patterns. The preexisting state of organization of the medical community is a major source of variation in the ability to move toward a managed competition strategy. Group practices find it easier to make the transition to managed care than does an atomized physician community grounded in solo or partnership practice. Although more than a third of physicians in the country practice in groups, groups are a regional, not a national, phenomenon. And many physicians practicing in groups are actually members of medical school practice plans that no thoughtful individual would mistake for businesses.

Although many communities are attempting to create physician groups out of solo and partnership practitioners, such as the so-called groups without walls, there is yet no convincing evidence that these new organizations are strong enough to sustain the stress of income redistribution and clinical discipline. The early track record is not encouraging. Federal policies, such as fraud and abuse exemptions for physician groups and the potential for “enterprise liability” for malpractice, will greatly influence incentives for physicians to join groups. But again, merely creating a corporate enterprise does not assure that it will be strong enough to sustain the stresses of managed care economics.

Finally, as others have pointed out, geography constrains the ability to foster managed competition. Many rural areas have absolute shortages of
primary care physicians and decaying health care infrastructure. The ability
to offer alternative health plan choices in these areas is compromised by
these factors. However, these constraints are not, in my judgment, as
serious as are the others cited above. Compelling examples in Wisconsin
(the Marshfield Clinic) and Pennsylvania (the Geisinger Clinic) suggest
that multispecialty groups can manage care across widely dispersed rural
regions and offer health plan choice and a support structure for medical
practice at the same time.

Prospects for change. Do these constraints imply that managed compe-
tition will fail? Not by any means. Alternative strategies such as fee sched-
ules or price controls on physician services fail to address the volume and
intensity increases that are driving health costs today. Nor do they foster an
effort to plan more effectively how care is provided to the elderly or
high-risk populations who generate so much health cost. Meaningful cost
containment and improved health outcomes can be achieved only by
altering how physicians are paid, abandoning the fee-for-service framework
in favor of population-based payment, and by holding providers account-
able for improving the health status of their communities.

The point of this Commentary is that tremendous emotional and sym-
bolic energy has been invested in the current framework, and that the
demise of this framework will be neither pretty nor orderly. Many people
who have spent their professional lives working as their own bosses will be
unable to function in the new order. Many organizations, such as academic
health centers, that were able to function with almost complete diffusion of
authority and responsibility for resource use will be unable to bear or
manage economic risk and will experience catastrophic dislocation.

It may take a generation for the cultural and interpersonal factors that
constrain medical practice to align themselves to permit the emergence of
truly integrated enterprises. In the meantime, the management and leader-
ship challenge of fostering this transition will be daunting. Progress will be
slower than health reform “architects” expect.

Portions of this Commentary first appeared in “Driving the Nitroglycerine Truck,” Healthcare
Forum Journal (March/April 1993); reprinted with permission.

NOTE

1. For a conceptual treatment of the issue, see S. Shortell et al., “The Holographic
Organization,” Healthcare Forum Journal (March/April 1993): 20-26; for some of the
structural variations, see T. Hudson, “Three Major Models,” Hospitals and Health
Networks (20 June 1993): 31-34.