While the majority of this book is designed to provide guidance for the future, there is value to beginning with a lightning-fast overview of modern medicine in the United States. Many of today’s issues concerning hospitals and their physicians are rooted in the last century and need to be understood to make sense of current struggles and appreciate the forces and values that will impinge on any change initiative.

The Evolution of Hospital–Physician Relationships Through the Twentieth Century

Doctors and hospitals have always needed one another, especially since the early twentieth century, when the chances of benefitting from a hospital stay rose above the breakeven point. As the sophistication and efficacy of hospitals grew, they became essential workshops for physicians. The hospital became the most visible symbol of the dramatic scientific advances of twentieth-century medicine, and physicians enjoyed the prestige that accompanied affiliation.
with a reputable institution. In 1916 the influential American College of Surgeons advocated a selection process to ensure that only qualified doctors were admitted to the staffs of U.S. hospitals. \(^1\)

In 1919 this same group, driven by concerns over quality and a desire to support hospitals committed to professional standards, instituted a formal requirement that hospitals seeking its approval organize the physicians affiliated with them into a “definite medical staff.” Organized medical staffs as we know them today were developed as a result, designed to help doctors and hospitals meet common quality goals. In later years, government regulatory bodies cemented this arrangement by requiring that every hospital participating in federal insurance programs have an organized medical staff. \(^2\)

For much of the early twentieth century, physicians were intimately involved in the management of hospitals and, in some cases, were outright owners of these facilities. Financially, the interests of doctors and hospitals were aligned, and what satisfied the needs of one generally satisfied the needs of the other. When the Great Depression threatened the economic well-being of healthcare providers, two companies—Blue Cross and Blue Shield—were created to ensure cash flow to hospitals and doctors. The expansion of federal health programs in the 1960s (Medicare and Medicaid) offered doctors and hospitals retrospective, cost-based reimbursement. Both hospitals and physician practices thrived under this payment arrangement. For the most part, incentives were aligned.

The explosion of medical specialties after World War II anchored the position of the hospital as the center of the medical practice community. The rapid development of expensive medical technologies required that new cohorts of specialized physicians spend most of their time close to their new tools. Cost-based reimbursement supported long hospital lengths of stay, and most physicians had large numbers of hospitalized patients to attend. The professional lives of most doctors were spent in hospitals or nearby offices.

A strong sense of professional community was fostered as a result, and with it physicians developed a feeling of loyalty to their “medical home.” In general, hospital medical staffs were open to all appli-
cants as long as they met minimum quality criteria. Growth in the number of medical school graduates in the 1960s and 1970s prompted expansion of hospital medical staffs. A community physician without at least one hospital affiliation was a rarity, and membership on multiple medical staffs became more common.

The growing complexity of hospitals not only required physician staffing in a range of specialties but also a new breed of healthcare administrator better prepared to manage the expanding and more complex institutional bureaucracies. Initially, hospital administrators simply served the physicians working in their facilities. The postwar economic expansion and excellent reimbursement climate of those times made these jobs much less challenging than they would become in the last quarter of the twentieth century. Administrators in the 1950s through the 1980s rarely needed to confront or challenge physicians and largely deferred to their “professional authority.” This era was considered a golden age of harmony and mutual success for doctors and hospitals.

The inflation of medical costs that followed the initiation of the federal Medicare program challenged those halcyon days. In 1983, to rein in runaway healthcare costs, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA), which instituted a new prospective payments system for hospitals. Diagnosis-related groups (DRGs) fixed reimbursement for a given episode of illness to incent hospitals to control costs, but doctors continued to be paid on a fee-for-service basis. While hospitals searched for ways to reduce patient resource utilization and lengths of stay, doctors practiced as usual, having no economic incentive to support their efforts.

DRGs introduced a significant fault line between doctors and hospitals. For the first time, economic incentives were unaligned, if not in direct conflict, causing an unaccustomed disharmony to spread throughout U.S. hospitals. Institutions hired physicians as utilization advisers, whose job was to pressure colleagues to discharge patients quickly and reduce costs per case. Most doctors were uncomfortable in this role, and the positions were hard to fill. Hospitals ramped up utilization departments and began to second-guess the
clinical decisions of their attending doctors. Hallway meetings between administrators and doctors became increasingly tense as the latter complained about the growing infringement on their clinical autonomy. Threats of “economic credentialing” motivated organized medical groups to rail against these new hospital efforts to manage costs.

Events in the last two decades of the twentieth century further alienated doctors and hospitals. Faced with difficult economic realities, many not-for-profit community hospitals were sold to for-profit hospital chains. Comfortable relationships between doctors and local management teams evaporated as corporate management asserted itself in these takeovers. While not all of these transitions were rocky, they heightened physicians’ concerns that economics would trump patient care considerations—that management’s commitment to shareholder return on investment would interfere with the need to invest in hospital infrastructure. Physicians, perceiving that their places of work were being run for the benefit of shareholders, began to feel less loyal to the hospitals they formerly considered their professional homes. Such feelings became even more prevalent as hospitals began to be bought and sold multiple times to successive investor-owners.

Another major development of the late twentieth century was the emergence of managed care as the economic model du jour. While many physicians were quick to adapt their practices to a capitated payment system, hospitals were not so easy to convert. To ensure they received an adequate number of “covered lives,” hospitals began to link themselves to physicians through a variety of mechanisms, including physician–hospital organizations, physician practice management companies, and outright purchase of practices.

These relationships were seldom harmonious. Hospitals had difficulty collaborating with physicians, who usually lacked formal management training and were brought up in the “culture of the expert” that emphasized personal autonomy (Atchison and Bujak 2001). Hospital administrators felt they were “herding cats” in their new relationship with physicians. Doctors observed with derision
the failure of most hospitals to run newly purchased physician practices without incurring huge deficits, often in excess of $70,000 per doctor annually. Forced by these losses to divest the practices they had just acquired, many hospitals hesitated to continue physician employment. Some even jettisoned the practices they had purchased at a premium only a few years earlier.

INTO THE TWENTY-FIRST CENTURY

The wreckage left in the wake of the stormy 1990s includes widespread suspicion among physicians regarding hospital administrators’ intentions and competence. In tandem, many hospital managers entered the twenty-first century perceiving doctors as their adversaries or as major obstacles to achievement of their organizational goals.

The volatile relationship between doctors and hospitals continues, and a variety of healthcare trends are exacerbating the friction. One trend is the changing locus of physician practice. At the start of the twentieth century, doctors clamored for admission to hospital medical staffs because healthcare institutions were an essential locus of medical work. Hospitals today do not enjoy such status. Many primary care doctors no longer deliver inpatient care. Technological change is also allowing increasing numbers of specialists to practice primarily in their offices or other ambulatory sites. As a result of this decentralization, physicians are becoming less loyal to their community hospitals and less motivated to deliver on the historic citizenship requirements of medical staff membership.

The rapid growth of competition between doctors and hospitals is another trend fraying physician–hospital alignment. As reimbursements decline and overhead costs increase, many physicians are taking over sources of revenue that hospitals have historically claimed. Doctors are investing in outpatient medical facilities and technologies that deliver diagnostic and therapeutic services previously provided by hospitals. Because doctors control patient referrals, they can direct
more profitable patients to their own facilities, leaving underinsured or uninsured patients to hospitals. In some parts of the country, doctors are investing in boutique specialty hospitals to divert lucrative revenue streams from local full-service community hospitals. Even when physicians are interested in joining with hospitals to pursue economic goals, they are impeded by huge statutory barriers, including the Stark laws and various anti-kickback statutes at the federal and state levels (see Chapter 12).

Yet another trend aggravating hospital–physician relations is third parties’ demands for greater transparency regarding hospital performance. Patients, regulators, politicians, employers, and payers want a safer, higher-quality product from hospitals. These demands are being reinforced by pay-for-performance reimbursement formulas, refusals to pay for “never” events (i.e., preventable quality mishaps), an increasing number of lawsuits claiming hospital negligence, and threats of exclusion from payer networks if performance lags established benchmarks. Hospitals can achieve and publish excellent results only when physicians collaborate with them vigorously. As a result, hospitals are putting ever-increasing demands on their voluntary medical staffs. Physicians, busy and burdened by their own frustrations about the increasingly complex regulatory environment, tend to resent these pressures. As a result, many hospitals are finding that their medical staff members don’t have the time or inclination to assist meaningfully in hospital-driven efforts to achieve regulatory compliance or performance targets established unilaterally by payers.

The changing demographics of the physician population add further complexity. Younger physicians are flooding the healthcare workplace, many of whom have different values than their older mentors and eschew the excessive work hours that have long been a hallmark of the medical profession. Greater numbers are looking for part-time options or intend to take leaves of absence for some part of their careers to pursue other interests. The growing number of women practicing medicine may be prompting this trend. Nearly 50 percent of medical school students are female, a notable change from the historic gender ratios in medical education.
If the desire for a more flexible lifestyle is a significant point of friction between physicians and hospitals, so is the consternation of doctors who believe their professional autonomy is under attack. These physicians’ angst is palpable as they become increasingly subject to scrutiny and criticism regarding the adequacy of their performance. They feel unreasonably constrained when hospitals push the adoption of clinical pathways, enforce codes of professional conduct, demand that they act as team players, require the use of computerized order entry systems, insist on compliance with national patient safety goals, or urge them to improve performance on core measures promulgated by the government.

The hostility that this “assault” on professional autonomy engenders in some practitioners infects all of their interactions in the hospital. These individuals inflame their colleagues at medical staff meetings in an attempt to get everyone to oppose even the most reasonable efforts by hospitals to gain physician cooperation. Many of these individuals seem to be auditioning for the part of “last angry man” on the medical staff.

Hospitals are not the only targets of this cantankerousness; physicians’ sense of alienation is widespread. Some leaders in the field are concerned that the love of practice and commitment that marked previous generations of physicians are eroding, as evidenced by new attitudes toward work; demands for reimbursement for services that used to be uncompensated; and the rise of questionable economic relationships with drug companies, medical device manufacturers, and other industry players. These concerns have prompted the Medical Professionalism Project of the American Board of Internal Medicine (ABIM) Foundation (see Exhibit 1.1).

These factors are only some of the dynamics shaping the healthcare environment as we near the second decade of the twenty-first century. Hospitals are responding with a variety of tactics to shore up their relationships with physicians, many of which are discussed in Chapter 2. Despite the failures of physician employment in the preceding two decades, the most significant response has been the growing employment of physicians by health systems. Physicians,
hospitals, and communities believe this arrangement is an answer to many of their needs. We will explore their rationale in Chapter 3. Despite all of the turmoil described above, tight integration of hospitals and doctors is critical if we are to deliver the high-quality, efficient, affordable healthcare this country desperately needs. The proposals unveiled in the following chapters address many of the challenges summarized in Exhibit 1.2 and offer the most promising means of effectively integrating physicians with modern healthcare institutions.

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**Exhibit 1.1 Medical Professionalism in the New Millennium: A Physician Charter**

“Perhaps the principal statement of the ethical code that defines the profession is the Hippocratic Oath—a document authored circa 4th century BC. Given the phenomenal change in medical practice since then, the ABIM Foundation, in collaboration with the ACP Foundation (American College of Physicians) and the European Federation of Internal Medicine (EFIM), published ‘Medical Professionalism in the New Millennium: A Physician Charter.’

“The Charter sought not to replace the Hippocratic Oath, but rather to consider the ethical principles that are relevant today, in an environment in which medicine’s commitment to the patient is being challenged by external forces of change within our society. The Physician Charter on Medical Professionalism lays out three principles—related to the primacy of patient welfare, to patient autonomy, and to social justice—which are the foundation to the ten commitments that are proposed to guide ethical behavior.”

*Source: ABIM Foundation (2009).*

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**Exhibit 1.2 A Review of the Forces Straining the Relationship Between Hospitals and Doctors**

- The growing migration of physician practice from inpatient to outpatient settings
- Increasing competition between hospitals and private physician practices, especially the development of specialty hospitals, ambulatory
surgery centers, outpatient diagnostic centers, and other ambulatory health facilities

• Demands by payers and the public for greater transparency in healthcare regarding hospital/physician performance
• Pay-for-performance and bundled-payment reimbursement arrangements
• Encroachment on physician autonomy
• Growth of regulatory requirements for hospitals that can be met only through collaboration with physicians
• Decline of physician interest in the organized medical staff
• Stark laws and other anti-kickback statutes that prevent hospitals from sharing revenues with physicians
• Doctors’ increasing interest in manageable lifestyles that are not centered solely on professional work
• Ill will lingering from failed joint ventures, unsuccessful practice acquisitions by hospitals, shared-risk managed care collaborations that were not durable, and short-lived physician–hospital organizations
• Growing use of exclusive contracts by hospitals, which angers some members of the physician community
• Hospitals’ efforts to make credentialing and peer review programs more rigorous
• New requirements for hospitals to address disruptive physician behavior

NOTES


2. A description of the current Medicare Conditions of Participation can be found at www.cms.hhs.gov/CFCsAndCOPs.
3. *The Last Angry Man* is a 1959 movie about a cantankerous elderly doctor in Brooklyn. He upholds a lot of values that the present generation in the film seems to have lost.