



CHAPTER TWO

HISTORY OF PHYSICIAN-HOSPITAL COLLABORATION

Obstacles and Opportunities

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Introduction

Management theory teaches that successful innovation requires concomitant changes among the system's components to achieve congruence or *fit*.¹ Similar thinking has been applied to changing the U.S. health care system.² In recent years, there has been growing recognition that payment reform of the U.S. health care system must be accompanied by corresponding reforms in the delivery system. Proposed payment models such as bundled payment and gainsharing require new models of physician-hospital relationships to make them work.

Policymakers and researchers who advocate payment reform commonly recognize the need for hospitals and physicians to link together in various organizational models, coordinate their efforts, and achieve three types of integration: economic, clinical, and cultural. Indeed, the Federal Trade Commission (FTC) and Department of Justice (DOJ) have issued guidelines that require providers to demonstrate these different types of integration if they wish to consolidate their practices and jointly negotiate with commercial payers.

Such collaboration is not easy to achieve. For providers, the twentieth century has been characterized as a century of conflict.³ Much of this conflict stems from the classic problem of trying to integrate professionals into bureaucracies.⁴ Such conflict has also been shaped by public and private sector forces specific to the

health care industry, forces touching on issues of payment, competition, cost containment, managed care, professional prerogatives, and medical liability.

At the same time, there has been a shift in the relationship between hospitals and physicians throughout the past century. This shift involves the demise of the dual hierarchy of the old hospital (separate medical and administrative spheres), the eclipse of the hospital as the *physicians' workshop*, the rise of corporate forms that envelop physicians, the rise of substantial capital and management support for complex ambulatory practice independent of the hospital, and, at the most general level, the ascendancy of management authority over professional power.

Some of these shifts have occurred with the explicit goal of fostering economic, clinical, or cultural integration in physician-hospital relationships. Nevertheless, it is not clear that integration has changed the care experience in a way that patients and their families actually notice. As a direct consequence, most physician-hospital integration has had limited impact on health care costs or quality.⁵ Thus, it is not yet clear whether the ascendancy of management in physician-hospital relationships is beneficial and, if so, in what ways.

This chapter first reviews the changes in physician-hospital relationships across the twentieth century and the industry forces that prompted the arrangements observed. The chapter then argues that the major provider-based competencies called for in health care reform may best be satisfied by hospitals rather than physicians. Despite these advantages, and despite the shift in power to institutions over professionals, hospitals will still encounter problems in collaborating with physicians, and both parties may still encounter problems in working together to improve patient care. Subsequent chapters in this book explore those problems and potential solutions.

Historical Development of Physician-Hospital Relationships

The historical development of physician-hospital relationships necessarily flows from the development of both the hospital industry and the medical profession. The following sections describe these relationships during several major eras in the histories of these two sectors.⁶

1870–1930: The Rise of the Hospital Industry

The rise of the hospital industry took place largely between the years 1870 and 1930 and primarily in the wealthier states and larger cities of the eastern United States.⁷ During this period, there were several major technological and therapeutic breakthroughs in medicine, as well as remarkable population increases and

economic growth, which together increased demand for hospital services. At the same time, a growing economy and base of philanthropists and trustees supplied the capital to build the infrastructure needed to meet the demand. Although they were historically institutions of care to shelter the poor sponsored by the trustees, hospitals evolved into institutions of cure that attracted wider economic classes of patients. Middle-class (paying) patients were needed to help finance the growing costs of technologically and institutionally based medicine. As Starr writes, the hospital evolved during this period into the physicians' workshop, which the physician both required technologically and controlled economically.

Such an arrangement served physician interests well. Physicians were given access to hospitals and their support staffs without having to deal with managing costs, raising capital, or administering operations—amounting to a huge social subsidy of their private incomes. Physicians were accorded this access in exchange for donating services where needed (for example, taking call in the emergency room, participating on hospital committees) as part of a *quid pro quo*.

Physician incomes also grew during this period, while hospitals often incurred losses or just broke even. Years later, Clark would criticize hospital tax-exemption as a screen for “for-profit” activities on the part of physicians, who made use of the community’s capital on a risk-free and cost-free basis to expand their professional franchises.⁸ However, hospitals also benefited from physicians’ patronage, because they brought in more paying patients as well as helping the hospital compete with other hospitals being built. This encouraged hospitals to open their medical staffs to community physicians. The majority of physicians had hospital privileges by the end of the period; only a fraction of physicians were either employed or practiced full time in the institution.

Physician access to the institution was coupled with professional autonomy. According to Stevens, nonprofit boards viewed their institutions as valuable instruments of professional expertise and viewed their own roles as supporting rather than controlling that expertise. Trustees thus yielded control over clinical decision making to physicians, who monopolized the scientific knowledge and ability to use the new technologies being developed.⁹

Physician autonomy and control received institutional endorsement in 1912 when the American College of Surgeons (ACS) formed to pursue hospital standardization, and again in 1918, when the ACS adopted minimum standards for well-equipped surgical environments. The minimum standards encompassed five quality criteria, including the presence of hospital laboratory and radiology departments under physician supervision.

Hospitals felt compelled to adhere to these requirements for several reasons. Surgery was the central craft in most hospitals. Surgical management was important to reduce infections. The industrial standardization movement begun by Frederick Taylor was well under way. Hospitals also sought to avoid external regulation. As part of the ACS requirements, hospitals had to develop formal medical staff structures, committees, meetings, and policies to supervise standards within the hospital. These requirements were consistent with state hospital licensure statutes, which granted the medical staff semiautonomous status with formal bylaws distinct from the hospital's bylaws.

The hospital was thus assumed to be a physicians' workshop whose clinical affairs were overseen by the medical staff; the physician hierarchy and organization was separate from the administrative hierarchy and organization.¹⁰ Governance arrangements guaranteed physician clinical autonomy, which served both as the bedrock for and constraint on future efforts to improve physician-hospital relationships in the remaining decades of the twentieth century and the beginning of the new century.

Thus, since the early decades of the last century, the American community (or nonteaching) hospital was defined by open access to physicians, use of the hospital as the physicians' workshop, quid pro quo relationships governing the exchange between the hospital and physicians, professional autonomy of the private practitioner, and dual hierarchies of administration and medicine.

In teaching hospitals, by contrast, medical staff membership was tied to faculty appointment in an affiliated medical school or employment by an affiliated university (not necessarily by the hospital). Moreover, there was in these institutions as well an ethical presumption, with legal backing, that faculty physicians would be left alone by the hospital to make patient care decisions.

Stevens does note that a handful of organizational models diverged from the norm: for example, the large private medical groups that directed most of their patients to one hospital. The American Medical Association (AMA) opposed these closed-practice models as the corporate practice of medicine. Likewise, the aforementioned university hospitals were attacked by state medical societies for having closed-staff arrangements. Statements published in the 1930s in the *Journal of the American Medical Association* espoused the profession's key tenets, including solo practice (not group), fee-for-service payment (not salaried), medical professional control of all medical services, and the conviction that medical institutions are but logistical extensions of physician practice.¹¹

During this early period, physician-hospital relationships were still occasionally challenged by conflict between the two parties. One source of conflict was hospitals' development of outpatient departments to recruit patients for teaching

purposes as “interesting material.”¹² Such departments became more critical sources of patients during World War I, when many physicians served in the armed forces, and local physician supply decreased.

Another type of tension was caused by rising hospital expenses and thus rising hospital rates charged to patients. Hospitals expected patients to pay them before the physician was paid. Rapidly rising hospital expenditures meant that a growing share of national health expenditures were now going to institutions (23 percent in 1929) rather than to medical professionals (30 percent).

1930–1965: Third-Party Payment and Dual Hierarchies

The next thirty-five years witnessed major changes in provider payment that strengthened and reaffirmed the principles governing physician-hospital relationships established in the earlier period. At the same time, this era witnessed the rise of several countervailing forces to the professional power of physicians that exacerbated the tensions between hospitals and physicians.

The Great Depression in the 1930s threatened the incomes and survival of both hospitals and physicians. Patients did not have the ability to pay for the care they received from either party. As a result, hospitals were not able to finance the new technologies and therapies being developed. On separate fronts, the hospital industry and the medical profession pushed for a voluntary—rather than a government—solution to health insurance coverage through Blue Cross and Blue Shield plans, respectively. Blue Cross plans needed local physician support to succeed.

Blue Cross plans were careful to not cover physician services or to intertwine hospital with physician payment. Hospitals preserved open staff models for physicians, kept specialist billing separate from the hospital, maintained fee-for-service and physician autonomy, placed physicians in charge of ancillary clinical departments (compensating hospital-based practitioners in a variety of ways), and reaffirmed the hospital’s status as the physicians’ workshop.

Nevertheless, professional powers were now counterbalanced by several new organizational realities. First, the voluntaristic solution to health insurance coverage traded the possibility of government funding of, and control over, the hospital for local control by the hospital’s administration and board.¹³ Financial issues, as well as the need to manage the institution’s growing operations, required a new class of professionals: hospital administrators. Training programs for this new professional class developed in the 1930s and subsequent decades; professional textbooks and associations followed.

Physicians delegated control over nonclinical functions to this new class, leading to an uneasy balancing of power between the medical and administrative hierarchies.¹⁴ Along with the original hospital founders—the trustees—hospitals

now had a triumvirate, or *three-legged stool*, model of governance.¹⁵ Power was shared among the three groups, with conflict avoidance or conflict resolution through growth as two primary ways of muddling through.

Conflicts nevertheless continued to characterize physician-hospital relationships. Starr describes frequent divisions over such issues as further expansions to the hospital's outpatient department, the addition of lay managers to run specialized services, and hospital hiring of full-time physicians to oversee these services. Stevens notes that the major ancillary areas (radiology, pathology, and anesthesiology) had developed powerful technologies and large staffs of non-medical technicians that the hospital now employed despite their supervision by physicians. These technical staff members heavily outnumbered the physicians in these areas. As the clinical division of labor became more complex, the idea of the hospital as exclusively the physicians' workshop was hard to sustain.

Physician resistance to hospital employment was further exacerbated by the growing number of nonmedical hospital employees who (as in other charitable institutions) were not allowed to unionize under the Wagner Act—a countervailing force to corporate control in other sectors of the economy. Stevens writes that hospitals enjoyed greater control over their workforce for other reasons as well, including their voluntary character and the philanthropy of trustees.¹⁶

Studies conducted during this period repeatedly cite the management of relationships with physicians as a major problem area for hospital administrators. For example, the 1948 Prall report, which advocated curriculum requirements for university programs of hospital administration, identified physician-hospital relationships as administrators' number one problem.¹⁷ A Cornell University study conducted in 1963 identified these relationships as the number four problem, a finding affirmed in a 1978 study.¹⁸

According to Stevens, conflicts were natural due to (a) the growing concentration of physicians' practice within the hospital and (b) the lack of clarity of the medical staff's role and authority. Because there was no formal decision-making structure of physicians, administrators lacked a clear party to deal with. Conflicts over issues such as *corporate practice of medicine*, the hospital's involvement in ancillary and outpatient services, and payment of hospital-based practitioners continued to fester. As a result, there was a "smoldering distrust, antagonism, resentment, and even hatred" in physician-hospital relationships.¹⁹

Two legal rulings at the end of this period chipped away even more at physician autonomy. In 1957, *Bing v. Thunig* established hospital liability for contractual relationships with community physicians and responsibility for their behavior inside the institution. In 1965, *Darling v. Charleston Community Memorial Hospital* affirmed and extended the hospital's legal responsibility.

Physicians could no longer claim complete freedom from the hospital's jurisdiction; hospitals now had a direct corporate responsibility to supervise the care rendered by physicians within the institution. Hospitals began to ask or demand cooperation from the medical staff for quality assurance. Hospitals also had to exercise care in the selection of physicians who practiced inside and take corrective action when deficient medical practice surfaced. More importantly, these rulings began to establish hospital accountability for patient outcomes.

1965–1990: Medicare and the Consolidation of Hospital Authority

The passage of Medicare and Medicaid in 1965 widened access to health insurance coverage, escalated health care spending, and reaffirmed some historical patterns.²⁰ Medicare Parts A and B replicated the separate payment silos of hospitals and physicians established under Blue Cross and Blue Shield, respectively, and also outsourced claims management to these private plans. Medicare also continued the practice of fee-for-service reimbursement and free choice of provider, and it explicitly guaranteed clinical autonomy. Medicare was statutorily forbidden to interfere with the practice of medicine.

By the end of the 1960s, some reformers called for concomitant changes in both payment methods and provider organization to cope with the explosive growth in health costs after the enactment of Medicare. These reformers, among them Paul Ellwood, advocated for a model of private group practices affiliated with a primary hospital developed in the 1930s or the emerging prepaid group practice model developed during the 1920s and 1930s on the West Coast. Their objective was to expand the footprint of organizations such as Kaiser Permanente and the Group Health Co-operatives, which combined salaried medical practice and capitated health insurance payment.

The reformers' proposal eventually resulted in new federal legislation, the HMO Act of 1973, signed into law by President Richard Nixon. The provision of federal planning grants enabled medical groups and hospitals to experiment with the creation of new risk-bearing organizations (prepayment plans) coupled with tightly linked physician groups (either employed or contracted) to help manage the risk. There were numerous community-based health plan start-ups, many of which survive to this day. The Marshfield Clinic developed its Community Health Plan in 1971; the Geisinger Clinic and its hospital established its health plan in 1972; the Presbyterian/Lovelace system in Albuquerque established its health plan in 1973; and Michael Reese Hospital in Chicago set up its plan in the early 1970s.

In addition to new payment and provider models, hospitals began to respond to growing challenges by embracing the language of management.

New management structures emerged, such as the investor-owned hospital chains in the late 1960s, which entered the market to take advantage of Medicare's favorable payment model, and to consolidate and strengthen a sector of physician-sponsored hospitals. These chains pioneered horizontal consolidation of facilities, the pursuit of scale economies through more centralized management (for example, centralized support services and supply-chain management), capital fundraising through the equity markets rather than philanthropy, the use of consultants, and the pursuit of efficiency.

Nonprofit hospitals were threatened by the growth of investor-owned hospitals and responded by developing their own regional chains, as well as national purchasing organizations such as the Voluntary Hospitals of America. They also began to access tax-exempt bond markets to finance system-building efforts. Hospitals thus faced the need to keep up with new payment and provider models, new capital financing models, growing Medicare regulation, and the details of Medicare politics. All of these developments served to place even greater power and responsibility with hospital administrators.

Hospitals borrowed ideas of modern management from sources outside the hospital industry as well as inside. Hospitals developed complex corporate structures in which holding companies oversaw a diversified array of businesses, some not even focused on health care. Hospitals also began to develop joint ventures and strategic alliances with one another (for example, through shared services), with their physicians, and with insurers. Hospital administrators and assistant administrators became chief executive officers and chief operating officers. Hospitals began to invest in strategic planning and marketing activities. All of these developments served to transform what used to be a community institution into more of a business enterprise.²¹

Whereas the 1970s was the era of increasing regulation in health care, the 1980s was the era of market forces and market competition. The federal government abandoned the certificate-of-need regulation passed in 1974 and embraced antitrust enforcement and extended it to the health care professions; and many states abandoned the public-utility-style rate regulation of hospitals that was established in the 1970s. Providers' pursuit of management efficiency and the adoption of management strategies were consistent with this new approach. Entrepreneurial efforts, in the form of equity joint ventures and new business models, were similarly encouraged.

The push for modern management reached a high point in 1983 with the passage of a new Medicare Prospective Payment System (PPS) using diagnosis-related groups (DRGs). DRGs reintroduced the idea of standardization first suggested by the ACS reforms of 1918. Rather than standardizing hospital equipment and governance, however, the focus now was on standardizing hospital patterns of

treatment. DRGs capped payments for an entire hospitalization, rather than continuing to pay for hospital inpatient services à la carte. This forced hospitals to analyze and then manage care patterns and the intensity of resource use within a hospital stay to avoid ruinous losses under the new payment system. This was impossible without the active support of the medical staff.

Because PPS affected only Part A payments to the hospital, administrators now approached physicians for the first time for their help in operating within a budget constraint—a very stressful moment for both parties. Administrators had an incentive to try to educate physicians about the need for cost containment, to engage them in integrative partnerships such as building joint physician-hospital delivery networks, and to scrutinize physician practice patterns as part of money-making or money-losing services. DRG payment pressures were reinforced by hospital contracting with the burgeoning sector of managed care organizations, which likewise called for hospitals to ask their physicians to work within (sometimes capitated) fiscal limits. Private insurers replaced open-ended, after-the-fact “reimbursement” for hospital services with negotiated rates determined in many cases on a per diem or even per case basis.

Physicians were not accustomed to, and thus not quite ready for, such conversations, which inevitably bred more distrust in their hospital “partners.” Hall notes that much of the cost containment effort of the 1980s focused on institutional payments (DRG payments to hospitals and capitated payments to health maintenance organizations [HMOs]) because it was more efficient to target and motivate larger organizations than individual professionals.²² This effort likely had the effect of indirectly motivating institutional control over physicians to limit the institution’s risk under these new reimbursement methods.

A new payment methodology for physicians was developed for Medicare Part B in 1992 and implemented in the late 1990s. Physician payment under the resource-based relative value scale (RBRVS) attempted to create a more scientific basis for paying for physician care, but it did not address aligning physicians’ financial incentives under Part B more directly with hospitals’ incentives under Part A.

Hospitals now focused on cost management in their dealings with physicians, reviving old physician complaints about diminished clinical autonomy and the corporate practice of medicine. Hospitals also engaged in *product line management*, often a disguise for cultivating profitable clinical services and jettisoning unprofitable ones. A decade later, some hospitals would extend this approach from the clinical services to the physician level by imposing *economic credentialing*, evaluating physicians’ privileges based in part on their contribution to hospital profit.

Rather than being an open workshop, hospitals began cutting back on some services and uses of technology on campus, while developing networks of remote

facilities and services. Hospital forays into the ambulatory care market represented an extension of the outpatient department strategy developed earlier. Hospitals developed freestanding ambulatory services such as imaging, emergency or urgent care, surgery, and rehabilitation and occupational medicine, as well as remote physician office complexes. In some cases, aggressive ambulatory development brought hospitals into direct competition with the community-based physicians on their medical staffs.²³

At the same time that physicians faced growing incursions from hospitals into their traditional markets, they also faced growing competition from other physicians and other types of practitioners. In response to impending shortages of practitioners, the number of medical schools had expanded, growing from 88 schools in the mid-1960s to 126 schools by 1980. This expansion was encouraged by federal funding for health professions education. Concerns over physician shortages and favorable immigration policies in the 1960s and 1970s also led to growing competition from an influx of international medical graduates, who accounted for nearly one-quarter of all active physicians and filled residency positions by the end of the century.

Finally, as part of the 1970s expansion of homeopathy, osteopathy, and herbal medicine (a return to medicine's nineteenth-century roots), physicians faced growing competition from what are now termed *complementary* and *alternative* medicine practitioners, who increasingly sought membership on the hospital's medical staff. Some physicians blamed the hospital for fomenting part of this new competition. By the 1980s, physicians no longer enjoyed a monopoly over professional services provided to the hospital.

Three legal rulings during this period further exacerbated physician-hospital tensions by increasing the power of hospitals and health plans over physicians. The U.S. Supreme Court, in *Goldfarb v. Virginia State Bar* (1975), struck down the learned professions exemption to the Sherman Act—meaning that physicians could now be subject to antitrust scrutiny and charges of restraint of trade in their dealings with hospitals. The 1982 *Arizona v. Maricopa County Medical Society* decision blocked independent physicians in the Phoenix area from collectively negotiating prices and froze the physician consolidation movement—at a time when hospitals and health plans continued their horizontal integration into local, regional, and national systems.²⁴

The resulting uneven playing field gave rise to a growing sense of injustice among physicians and to the growing ability of hospitals to develop local monopolies with leverage over disorganized physicians. In *Jefferson Parish Hospital District No. 2 v. Hyde* (1984), the U.S. Supreme Court allowed exclusive hospital contracts with specialist physician groups (for example, for coverage of hospital ancillary services). Such contracts did not violate federal antitrust laws, yet they served to

block free access to hospital privileges by some community physicians. These contracts prompted several lawsuits brought by excluded physicians and heightened conflict between hospitals and physicians.

Physician-hospital issues were a major reason for the formation of a new section within the AMA: the Hospital Medical Staff Section. This section was formed to help physicians collectively voice their concerns about incursions of the hospital's administration into traditional areas of physician discretion, as well as to create a non-hospital-controlled framework for medical staff leadership development. Three professional associations issued reports in the 1980s emphasizing the growing importance of hospital-physician conflict. These associations included the AMA and the American Hospital Association (AHA),²⁵ the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),²⁶ and the AHA's Office of Legal and Regulatory Affairs.²⁷

One technique used by hospitals to deal with medical staff conflicts was physician inclusion on the board of trustees (see Chapter Seven). Another was the development of salaried roles such as the chief medical officer and vice president for medical affairs. Hospitals also began to seek alignment or partnerships with segments of the physician community. The physicians thus targeted became customers and feeders to the hospital's outpatient and inpatient service lines.

As the decade drew to a close, the federal Medicare program proposed to include Part B fees of hospital-based specialists (radiologists, pathologists, and anesthesiologists) as part of the inpatient DRGs, effectively capping the Medicare payments for these specialties and giving the hospital explicit control over these income streams. This 1987 proposal was enormously threatening to the independent status and incomes of these powerful specialists, and it engendered sufficient political controversy to be abandoned after widespread congressional opposition.

1990–2009: Managed Care and Market Consolidation

The trends observed during the 1980s accelerated during the 1990s due to several environmental forces. The managed care movement reached its zenith in the mid-1990s, when HMOs penetrated one-third of the large commercially insured market. Such managed care models combined capitated payments with group and staff model clinics, as well as risk-sharing arrangements with physician-based independent practice associations (IPAs).

Capitated plans now included global capitation, in which providers assumed risk for inpatient, outpatient, and sometimes pharmaceutical use and costs. Federal pressures intensified this push to risk sharing in 1993, with the health

reform proposals of President Bill Clinton and his wife, Hillary Clinton. The Clinton plan called for regional health insurance purchasing cooperatives to negotiate with accountable health plans composed of integrated provider networks in local markets.

The rise of HMOs and the threat that the Clinton plan would convert the rest of the provider market into risk-bearing entities induced hospitals and physicians to form a variety of integrated delivery networks. Research shows that 1994 was the modal year for hospitals to develop horizontally integrated networks of hospitals and vertically integrated networks of hospitals and physicians (for example, physician-hospital organizations [PHOs]) and sometimes health plans.²⁸

These integrated delivery networks were developed for several purposes. First, they represented a collaborative effort by hospitals and physicians to confront the threat of managed care and develop contracting vehicles for joint bargaining. Hospital consolidation and physician practice acquisition often was explicitly directed at limiting health plan bargaining power. Second, they represented a generic provider response to an uncertain future whose underlying assumptions included closed panel networks, global capitation, and downsizing of provider capacity (number of hospitals, beds, specialists, and so on). All of these assumptions eventually proved to be erroneous. Though the formation of integrated delivery networks accelerated in the early 1990s, it slowed by the end of the decade due to the diminishing number of hospitals yet to be aligned with systems, as well as financial pressures from the Balanced Budget Act of 1997.

It is ironic that strategies that originated in a *procompetition* political environment had explicitly anticompetitive consequences. Hospital consolidation resulted in many metropolitan areas being dominated by a handful of hospital systems that also owned extensive physician practices and related health services. These systems eventually achieved significant bargaining leverage over health plans in the early 2000s.

Consolidation was the mantra of the decade. Nearly every player in the health care value chain—insurers, hospitals, group purchasing organizations, wholesalers, product manufacturers—consolidated its operations through mergers and acquisitions.²⁹ Integrated delivery networks were a vehicle for providers to pursue this strategy. Such collaborations were initially compelling to physicians because they believed global payments under health reform would be made only to large institutions, not to individual providers, who were constrained from organizing into larger economic units by antitrust laws. In turn, physicians, especially primary care physicians, were now more attractive to hospitals due to the shift to managed care, as hospital systems sought to become sole source contractors with broadly accessible proprietary physician networks.

Hospitals were not the sole consolidators of primary care physician practices. Publicly traded physician practice management (PPM) companies in many

markets bid competitively to acquire local practices, seeking to step between hospitals and health plans in risk contract negotiation. Many of these PPM firms did little to improve quality or reduce costs; rather, they were vehicles for executing roll-up strategies designed to quickly build up scale with the hope of garnering managed care contracts and exert bargaining leverage under them.

Research shows that these practice acquisition strategies largely failed to achieve anything, except consume a great deal of hospital and investor capital.³⁰ The large integrated delivery networks that developed included more levels of bureaucracy, corporate offices separated from the facilities that treated patients, highly paid system executives, greater dependence on expensive external consultants, slower decision making, an emphasis on the front-office mentality over the frontline mentality, little effort to make system changes meaningful to frontline staff, and no real efforts to reduce costs or improve quality.

Health plans found employers reluctant to accept *closed panel* models that relied only on a subset of providers in a given local market. Employees did not want to be forced to switch physicians or hospitals because their employers chose a different health plan. Broad-based health plans, such as preferred provider organizations (PPOs) and point of service (POS) plans, triumphed over closed panel HMO plans. This meant that integrated delivery networks could not offset their development expenses and physician practice acquisition costs and operating losses with additional patient enrollment.

As the 1990s wore on, many health plans wound down capitated contracts and hired disease management firms to carve out troublesome subsets of cost risk—particularly mental health and prescription drugs. New pharmacy benefits management (PBM) firms emerged to manage prescription drug costs, contract with pharmaceutical companies, and impose protocols on health plan members. Health plans also developed their own disease management programs or delegated them to new companies such as COR Solutions and American Healthways. These activities had the effect of bypassing the doctor-patient relationship and attempting to manage cost risk directly.

Many integrated delivery networks experienced both economic and organizational stress, and at least one major bankruptcy ensued from this strategy, that of the Allegheny Health Education and Research Foundation in Pittsburgh and Philadelphia.³¹ Despite predictions that they would dominate many health care markets,³² an entire industry of publicly traded PPM firms such as MedPartners and PhyCor collapsed in less than two years, taking nearly \$12 billion in investor equity with them.

The failure of hospital-sponsored primary care physician networks and the PPM companies left a bad taste in physicians' mouths and increased their cynicism and suspicion of the corporate practice of medicine. Despite the rhetoric about

aligned incentives, these efforts failed to improve physician-hospital relationships. Though some larger systems retained their provider networks, the late 1990s were characterized by dissolution of many physician-hospital contracts. As a result of the failed 1990s experiment with global capitation, few providers (except for isolated IPAs and some group practices) wanted to assume risk.

After this period of divestiture of owned practices, however, hospitals returned to employment of physicians less than a decade later, this time employing specialists as well as primary care physicians. With the impending retirement of the baby boom generation of physicians and falling or stagnant physician incomes, hospital employment offered physicians a buffer from market competition, an avenue to cope with declining skills, and a float until retirement.

Hospitals were not seeking hegemony over physician practice or health plan negotiating leverage in this new wave of practice consolidation. Rather, they responded (in a largely defensive manner) to spreading economic distress in their physician communities. The employment packages developed during the 2000s avoided some of the common mistakes committed during the 1990s, including fewer practice buyouts, less generous compensation packages, shorter income guarantees, and more incentives for clinical productivity and revenue metrics. Still, there is no solid evidence that hospitals have yet learned how to make physician employment profitable; it does not appear to be a core hospital competence.

Two remarkable changes have occurred in the current decade, separating the hospital of the mid-2000s from the hospital of the early 1900s. First, an increasing number of practitioners across the specialty spectrum withdrew from the hospital. More primary care physicians now focus their attention on office-based and ambulatory practice. Many surgical specialists, such as ophthalmologists, urologists, plastic surgeons, and gastroenterologists, have developed completely hospital-independent practices, using freestanding surgical facilities for their practices.

Second, a growing number of physicians are now salaried employees of, or contractors to, the hospital. State medical societies now report that 70 percent to 80 percent of primary care physicians are hospital employees. Hospitals have also begun, with considerable controversy, to employ specialists required to cover the hospital's 24/7 services (such as cardiology and orthopedics). Increasingly, community-based physicians no longer wish to spend time rounding or treating patients in the hospital, and they ask that full-time staff perform these functions at the hospital's expense. Hospitalists, intensivists, laborists, and so on have appeared as full-time employees of the hospital or contractors employed by outside firms or physician groups.

Thus, at the same time as a diminishing percentage of the community's practitioners need to use the hospital, an increasing percentage have become dependent on the hospital for a portion of their incomes. These countervailing forces—the diminished use of the hospital but increasing economic dependency—will create yet new stresses in physician-hospital relationships, as well as exposing hospitals to increasing economic risk.

The 1990s also saw two public sector initiatives to increase care coordination and prepare the economic groundwork for further provider consolidation. First, the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services [CMS]) developed the Medicare Participating Heart Bypass Center Demonstration. This program paid a small set of hospitals a bundled payment of Part A and Part B fees for coronary artery bypass graft (CABG) procedures to be split with their physicians. Hospitals participating in the demonstration succeeded in developing new methods of collaborative decision making with their physicians and new approaches to cost containment (see Chapter Five for a case study of one hospital's participation in this program). Nevertheless, HCFA encountered opposition in Congress to extending bundled payment to other procedures, and the demonstration quietly ended. In 2008, CMS announced a return to bundled inpatient payments through the Acute Care Episode Demonstration, which covered an extended set of cardiac and orthopedic procedures. In January 2009, CMS announced that five hospitals in the southwestern United States would participate in this new demonstration.

Second, the DOJ and FTC developed antitrust guidelines for combinations of health care firms that would be procompetitive (although some have argued that these guidelines actually provided insufficient guidance to allow firms to act on them—see Chapters One and Six). These guidelines outlined the types of financial or clinical integration that must be present in physician-hospital collaborations and physician networks in order for provider groups legally to engage in collective contracting with managed care organizations. The latter half of the 1990s and the first nine years of the 2000s saw the DOJ and FTC prosecute several provider networks for their failure to adhere to these guidelines.³³ Government agencies prevailed in nearly all of the early prosecutions: physician-hospital associations and IPAs were found to have engaged in price fixing without offering any compensatory economic or clinical integration that might lower costs or improve quality. Two exceptions—Advocate HealthCare and Greater Rochester IPA—were allowed to continue based on a demonstrated ability to motivate physicians toward cost and quality goals.

In part to deal with DOJ and FTC requirements and guidance, in part to foster closer relationships with physicians, and in part to generate greater revenues, hospitals began to develop an array of noneconomic, economic, and clinical

integration arrangements with their physicians. This array has been described elsewhere in the literature.³⁴ In some cases, hospitals embarked on new strategies such as using proprietary electronic medical record systems to link community physician offices and hospital sites.

In other cases, hospitals revisited older strategies and repackaged them under new names such as *hospital service lines* (formerly *product lines*). As in the 1980s with DRGs, hospitals pursued growth of those service lines that were “winners” (specialty areas such as cardiology, orthopedics, neurosurgery, and oncology), or that generated significant revenues and margins for the hospital. This approach served to divide the medical staff into “home run” physicians versus “singles” physicians, as well as to divide the various specialties into fiefdoms with physician service line chiefs as their feudal lords.

Another development of the 2000s further segmented physician markets. Specialists in a given community began to aggregate into large single-specialty medical groups to gain bargaining leverage with managed care organizations. This strategy was particularly popular with technology-dependent specialists such as radiologists, urologists, gastroenterologists, and cardiologists, who could not only leverage their bargaining power with health plans but acquire their own imaging equipment under the in-office ancillary service exemption to the Stark laws concerning self-referral (see below and Chapter Six). Such groups have faced growing scrutiny by the DOJ and FTC. These governmental bodies have looked for economic and clinical integration benefits to justify the higher reimbursement that the groups have sought from payers.

The development of large single-specialty groups ran against the grain of the integrated, multidisciplinary clinics such as Kaiser Permanente, Mayo, and Geisinger, which were held out by policymakers as exemplars of how physicians ought to consolidate. Unfortunately, large multispecialty clinics (100-plus physicians) represent only 1 percent of all group practices, leaving few such practices upon which to build new Kaisers and Mayos.³⁵ Today, single-specialty groups constitute the single largest block of group practices. Their formation did not solve many problems faced in physician-hospital relationships but rather served as a vehicle for stripping away ancillary services that contributed significant hospital profits. These groups also leveraged their bargaining power to demand subsidies from the hospital for performing hospital-related services, such as covering emergency room call.³⁶

Investor-owned companies such as MedCath encouraged physician entrepreneurial efforts by taking on “profitable” physicians such as cardiologists and orthopedic surgeons directly as investors in their hospitals. Surgeons also invested in such facilities, as well as freestanding surgical centers, to augment their incomes and capture a portion of the facility fees generated by moving their patients.

The facilities served as new competitors for hospitals, particularly the smaller community hospitals that depended more heavily on outpatient surgical volumes and lower-severity patients. McKinsey recently estimated that physician dividends from partnerships with ambulatory surgical and imaging companies amounted to \$8 billion in 2006.³⁷

At the same time, the spread of physician-owned ambulatory surgery centers and office-based surgery and imaging continued the long-standing duel between hospitals and physicians for control over outpatient services, while the freestanding specialty hospitals threatened to strip away from general hospitals the more profitable and lower-severity inpatient cases. These developments directly threatened the core profitability of hospitals, which was increasingly focused in elective outpatient care. McKinsey estimated that a remarkable 75 percent of hospital profits in 2008 came from elective outpatient care, and only 12 percent from inpatient hospitalization.³⁸ Hospitals threatened by these potential competitors often felt compelled to create physician joint ventures that helped retain some of their profitable outpatient volume and keep physicians from leaving the hospital campus (at the price of giving away half or more of those services' profits).

In addition, pharmaceutical and medical device companies developed an array of financial arrangements—real or sham consulting agreements, “lecture fees,” and so on—that sometimes constituted thinly disguised bribes to both primary care physicians and specialists. These economic inducements sought to lock in physician use of their products and prevent hospitals or PBM firms from achieving bargaining leverage through group purchasing that would have lowered manufacturer margins. Such arrangements, struck by firms with very deep pockets and aimed at influential physicians whose incomes had stagnated, also served further to divide physicians from their hospitals.³⁹

To respond to the flourishing *moral hazard* opportunities created by physician ownership or control of lucrative technology, the Omnibus Budget Reconciliation Acts of 1989 and 1993 included the famous Stark laws, which forbade physicians from profiting from self-referral of Medicare patients to facilities or services they owned. These laws were riddled with loopholes, however. The most controversial safe harbors for physicians were exemptions for ownership of entire hospitals (as opposed to a specialty center within a hospital) and referral to so-called ancillary services in physicians' own offices, which applied not only to group practices but to technology housed in their office buildings and even to individual physicians who purchased their own computed tomography (CT) or magnetic resonance imaging (MRI) scanners.

The Stark laws marked the beginning of efforts to clamp down on physician self-referrals and business development.⁴⁰ They led to a wave of consolidation in the imaging center business, as imaging centers that relied on physician partnerships

were forced to restructure their business arrangements and consolidated into two large firms. When the Balanced Budget Act of 1997 brought reductions in payments for imaging services, these companies, in turn, ran into economic difficulties and were forced into bankruptcy.⁴¹

A new cycle of consolidation was launched in 2005 when the Deficit Reduction Act reduced payments to freestanding imaging facilities for high-technology scans such as MRI and CT, and in 2007 when CMS decided to reduce payments to freestanding ambulatory surgery centers to 65 percent of the fees paid to hospital outpatient departments. It is still too early to tell how significant an effect these changes have had, but radiologists who relied extensively on technical component (or facilities) income as opposed to professional fee income saw significant reductions in their incomes from the Deficit Reduction Act.⁴² These changes had the effect of tilting the playing field back in the direction of hospital-sponsored ambulatory services, whose payment levels were not affected.

Overall, the entrepreneurial efforts of physicians seem to have come up short. During the early 2000s, CMS imposed a temporary moratorium on the development of new specialty hospitals, pending an analysis of their performance effects and impact on general hospitals. That analysis showed that these hospitals cream-skimmed patients and did not offer lower-cost, higher-quality care.⁴³ However, there was also no significant impact on the financial health of general hospitals. The evidence for physician-owned ambulatory surgery centers paralleled these findings.⁴⁴

It is possible that further restrictions on physician entrepreneurship will be included in health reform legislation. A recent article in the *New Yorker* magazine, by Atul Gawande, shined a harsh light on a single Texas community where physician entrepreneurship appears to have dramatically affected Medicare spending in the area.⁴⁵ The negative climate developing around physician entrepreneurship may motivate even more risk avoidance among physicians and lead them to seek hospital employment and other relationships.

However, as physicians' income growth has faltered so has the formerly voluntary compact with hospitals under which physicians traded medical staff privileges for covering medical service needs of patients after hours and on weekends. These demands are particularly acute for surgical coverage of the emergency room and coverage of the intensive care units that operate twenty-four hours a day, seven days a week. As fewer physicians, particularly procedure-oriented physicians, need to use the hospital, physicians in critical care disciplines demand and receive stipends for covering call, dramatically increasing hospital costs.⁴⁶

The situation differs in the larger academic medical centers (see Chapter Ten). Their medical staffs consist of a group of physicians—the clinical faculty of the affiliated medical school—employed by the parent university rather than by

the hospital. Depending on the institution, these staffs may or may not be organized in the manner of large multispecialty groups; at a minimum, they do aggregate physician billing and payer-bargaining functions. As employees, physicians are protected from the day-to-day productivity requirements of the medical practice market.⁴⁷ Being organized in practice plans, faculty physicians can usually negotiate together with the hospital for better payments in the commercial insurance market; teaching hospitals also receive enhanced Medicare payments and, in many states, better payments from the state Medicaid program.

Medical schools often receive significant additional subsidies from their affiliated hospitals in exchange for faculty supervision, which cannot be billed directly to Medicare or other payers. Finally, because they are organized under common governance, these hospitals and faculty practice plans are able to share revenues through means such as gainsharing that avoid some of the conflicts that community hospitals face when physicians split off profitable practices from the hospital (for example, ambulatory surgery centers and imaging facilities) as a means to access facility payments (for example, Medicare Part A or Part B technical).⁴⁸

2010 and Beyond

By the end of the first decade of the 2000s, physicians appear to have lost the battle to retain their autonomy from the hospital and maintain the professional prerogatives developed one hundred years earlier. However, because their practices are, traditionally, small economic units and fragmented along specialty lines, physicians have also failed to organize themselves effectively. They have also been actively inhibited from doing so by federal antitrust law.

Medical staff organizations consist of a confusing matrix of officers, committees, and departments with no strong, central leadership or clear lines of authority. In larger institutions, at least, real power lies in the specialty departments and their chiefs. Hospitals are left with the responsibility to organize physicians and work out patterns of collaboration within and across specialties (service lines, collaborative care models) and distribution of shared fees (bundled payments) and shared savings (gainsharing).

At the same time, physicians have become increasingly dependent on the hospital for incremental income. As baby boom primary care physicians retire, their practices are increasingly absorbed into the hospital, and new primary care physicians become hospital employees. Dependence is evident from the gradual demise of solo practice,⁴⁹ the rise in hospital employment, the use of productivity systems to reward employed physicians for their inpatient work, and an increasing emphasis on physicians' production of relative value units in their clinical

practice. The physicians' workshop is evolving by degrees into more of a hospital sweatshop (or at least a hospital dependency).

Community-based physician groups are also becoming more reliant on the hospital to help recruit and finance new members. Many specialty groups found their practices did not throw off enough cash flow to replace existing practitioners, and they turned to hospitals for subsidies to maintain their current physician complements. Hospitals witnessed rising levels of admissions from the emergency department (upward of 40 percent in many institutions) not directed by any community practice. These patients were increasingly managed by hospitalists, who were hospital employees or contractors. Thus an increasing fraction of the hospital's admissions and costs are no longer controlled or even affected by community physicians.

These trends are being reinforced by generational changes taking place within the medical profession. As Goldsmith has noted, as the 1960s generation of physicians began to gear down their practices or retire, many have sought hospital employment as either salaried practitioners or medical staff officers.⁵⁰ Younger physicians are more diverse along racial, ethnic, and (especially) gender lines. The growing number of younger and female physicians desire more balance between professional and private lives, fewer hours, and more shift work. An increasing percentage of the physician workforce wishes to work part time.

However, younger physicians benchmark their income expectations based on the eighty-hour-a-week work norms of the older physicians they are replacing, placing the hospital in a difficult economic position. They also raise complex questions of equity—whether the hospital is dealing in an aboveboard and evenhanded fashion with physicians who are not receiving economic subsidies or are not employed by the hospital—the very issues that caused so much grief during the 1990s.

The Hospital's Growing Responsibility for Clinical Risk and Cost

The current policy environment in health care may compel major changes in how providers are paid and organized. These new (or not so new) ideas all have a common theme: the expansion of the hospital's responsibility for clinical risk and costs that the hospital cannot manage without active physician collaboration. They will require fundamental changes in how physicians and hospitals collaborate in making decisions, even as the physician community fragments and fewer physicians use the hospital on a daily basis.

As described in Chapters Three and Four, new or proposed payment methodologies will require hospitals and physicians to work together in ways for

which they have little historical preparation or a poor historical track record.⁵¹ *Accountable care organizations* (ACOs), described in Chapter Three, call for providers in a wide geographic catchment area to be clinically and fiscally accountable for the entire continuum of care that patients may need. *Bundled payments* likely require providers to coordinate care and distribute payments across all of the in-house specialties involved in a surgical procedure (for example, cardiovascular and orthopedic), or across various types of providers over time. *Pay-for-performance* in the hospital setting requires providers to convene specialists and ancillary staff across many departments to reduce infection rates and other categories of clinical risk. *Incentive payments for reduced readmissions* require providers to improve discharge planning and community-based follow-up of patients. *Incentive payments for clinical integration* require providers to invest in (among other things) electronic medical record systems and implementation spanning inpatient areas, outpatient areas, and community physician offices. Finally, growing calls for *comparative clinical effectiveness* will require providers to screen and evaluate more carefully the new technologies being brought into the hospital by physician advocates and product sales representatives on both quality and cost criteria.

By virtue of their fragmented and silo-based practice organization, the constraints placed on entrepreneurship, their lack of access to capital, and increasing isolation from hospital practice, physicians in many communities are not well organized to accomplish these tasks and may not be inclined to take them on. Just as most physicians shied away from running their own hospitals at the beginning of the twentieth century and delegated these tasks to administrators, many contemporary physicians may prefer that lay managers attempt to organize responses to these new demands for collaboration.

Subsequent chapters provide examples of where physician-led entities have assumed these responsibilities. With the exception of some physician-led organizations (for example, Kaiser Permanente and Mayo Clinic), however, calls for improved care coordination and accountability for cost and quality may be answered more effectively by hospitals, their managers, and their paid clinical directors. As organizations used to being regulated and accredited, hospitals and their managerial cadre have some structural advantage over less-organized physicians in the majority of practice settings in coordinating multiple clinical services, developing models of multidisciplinary care, taking accountability for outcomes, developing care networks, assuming economic risk, managing large provider organizations, managing bundled payments, and doing technology assessments.

This comparative advantage does not necessarily translate into actual competence, however. Hospital and system executives still face a steep learning curve themselves, particularly after the sobering and costly failures of the 1990s.

The present situation thus presents both the opportunity for greater collaboration between hospitals and physicians and challenges in fostering good relationships. In contrast to the early historical dominance of physicians and then the later uneasy balance of power between physicians and hospitals, hospitals now appear to have a constitutional and functional advantage in being organized.

Research on mergers and acquisitions in industry shows that mergers of equally large and powerful firms have difficulty in resolving the difficult political issues of “who is in charge” and “who is being acquired by whom.”⁵² In such mergers, the extraordinary efforts needed to manage the politics and conflicts of integration drain the energies needed to extract synergies from the combination. Here, however, what is being contemplated is not a merger between like organizations, but rather between a solid and a gas, that is, between a hospital organization and an amorphous *medical community* that has been dispersed both geographically and economically.

These problems were illustrated by the experiences of the 1990s movement toward integrated delivery networks, when hospitals developed a menu of alignment options for physicians (for example, PHO, IPA) who did not necessarily want full integration with the hospital (in other words, employment). Such pluralistic alignment models were almost always failures (with an occasional success story).⁵³ These failures should chasten advocates of joint physician-hospital risk management, including some of the models that have been called accountable care organizations, which appear to be a reemergence of a troubled 1990s idea, the physician-hospital organization (PHO).

The only alignment model from the 1990s that appears to have persevered and developed is the employment model. Hospitals that retained their employed physicians from this period have spent the ensuing decade attempting to meld acquired practices into a coherent clinical enterprise, with the capabilities of established multispecialty medical groups. How many have actually achieved this coherence will be a subject of future health services research interest.

Thus, from a mergers and acquisitions perspective, the current asymmetry in power between hospitals and physicians might bode well for extracting value from relationships between hospitals and physicians, because it might lessen the political struggle over who is in charge. This is not meant to suggest that asymmetry in power, rather than power sharing through common incentives, is the desired goal. However, the history of physician-hospital relationships described in this chapter evinces persistent, longstanding conflicts between the two parties that inhibit power sharing and common incentives. These conflicts include hospital incursions into outpatient care, control over referrals to the hospital medical staff, control over the technology base in the hospital (and who

generates monies from it), physician concerns over commingled reimbursement, physicians' concerns over hospital domination and control (especially through employment relationships), physician concerns over the corporate practice of medicine, and conflicts over covering call for emergency patients. Such conflicts are not likely to disappear quickly, but may attenuate as new generations of physicians replace older generations.

Managing physician-hospital relationships is likely to continue to be a key priority among hospital executives, as it has been since the 1940s. The management skills required here include bargaining and negotiation, conflict resolution, interdisciplinary team building, physician leadership development, management infrastructure development, communication, managing professional-bureaucracy relationships, managing "stars," as well as managing coalitions and politics. Such skills are not well taught in health administration programs and are only recent additions to the curricula of many business schools.

Conclusion

Those responsible for managing physician-hospital relationships might also consider new opportunities for hospitals to add value to their physicians' practices. One major opportunity is improving physician cash flow.⁵⁴ Hospitals should invest in digital real-time systems for processing physician billing and collections, and invest in upgrading office systems and staffing to enable better operations.

A second opportunity is developing physician teamwork and collegiality (for example, through executive education and colocation of specialists). These are the features that distinguish and unite physicians at Kaiser Permanente, Mayo, and Geisinger—not how they are paid or who owns what (issues that themselves took generations to resolve at these organizations). According to Freidson, collegiality is also how physicians control the quality of each other's work and thereby minimize the need for outside surveillance and interference.⁵⁵ Collegiality also addresses the principal challenge of uniting a physician network: the political struggle of coordinating different specialties with different needs, including renewed attention to professionalism.

Professionalism is also fostered by regulatory oversight of conflict of interest behaviors by physicians (for example, payments from device manufacturers, self-referral, and so on). External oversight may spur greater provider efforts at self-policing of behaviors. Other areas of opportunity include using clinical information systems to develop online clinical communities, assisting primary care physicians and specialists with quality improvement activities as they adapt to pay-for-performance incentives, helping the medical staff to reorganize itself

and reengineer its processes, and helping primary care physicians develop new operational models.

The regulatory focus of the Obama administration, compared to the market orientation of the previous Bush administration, will push more physicians into relationships with hospitals. What will these look like? Can hospitals and their managers develop the skills, leadership, and organizational capacity to manage all these conflicting crosscurrents? There will probably be more restrictions on physician self-referral, conflicts of interest that compromise the physician-patient relationship, physician entrepreneurial activities that drive up costs, medical practices that are not cost effective, and capital investments by physicians. It is not clear whether and how physicians will respond to these developments.

It is also unclear whether hospitals' differential ability to handle the potential changes identified in this chapter will help to improve health care's cost and quality issues. In the past, hospitals have relied heavily on structural mechanisms to collaborate with physicians: salaried employment, leadership roles, contracting vehicles, modes of integration, and so on. There is little solid evidence that the use of these mechanisms in hospital settings has helped the pursuit of value. Hospitals might consider other approaches in the future, such as behavioral change skills and rules-based integration.

The next decade of physician-hospital relationships appears to be fraught with new challenges and opportunities to improve the quality of clinical medicine. These challenges will take the form of real and perceived legal barriers, differences in culture between hospitals and physicians (and among physicians), and major differences in governance structures, among others. Each of these topics is explored further in the chapters that follow.

Notes

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12. Stevens, *In Sickness and in Wealth*, 87.
13. Stevens, *In Sickness and in Wealth*, chaps. 6 and 7.
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15. R. L. Johnson, "Revisiting 'the Wobbly Three-Legged Stool,'" *Health Care Management Review* 4 (1979): 15–22.
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17. C. Prall, *Problems of Hospital Administration* (Chicago: Physicians' Record Co., 1948).
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