The Hospital-Physician Relationship
Past, Present, and Future

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The traditional hospital-physician relationship in the United States was an implicit symbiotic collaboration sheltered by financial success. The health care economic challenges of the 1980s and 1990s unmasked the weaknesses of this relationship as hospitals and doctors often found themselves in direct competition in the struggle to maintain revenue. We recount and examine the history of the largely implicit American hospital-physician relationship and propose a means of establishing formal, explicit hospital-physician collaborations focused on delivering quality patient care and ensuring economic viability for both parties. We present the process of planning a joint hospital-physician ambulatory surgery center (ASC) at a not-for-profit academic institution as an example of a collaboration to negotiate a model embraced by both parties. However, the ultimate success of this new center, as measured in quality of patient care and economic viability, has yet to be determined.

Historically there has been a largely implied and amicable relationship between hospitals and physicians. This relationship did not often entail a formal binding agreement or compact; rather, hospitals and physicians had an implicit agreement to work in concert to provide quality patient care. Buoyed by strong reimbursements for both parties, the traditional hospital-physician relationship usually did not involve difficult financial choices.

However, changes in health care economics, particularly in reimbursement, have strained this relationship. Physicians and hospitals compete for a slice of a shrinking health care economic pie. Although recent health care shifts have stressed the traditional hospital-physician relationship, there are opportunities for new partnerships based on shared goals, open communication, and evolving trust.

We explore the past and present relationships between hospitals and their physician staff and propose that more thoughtfully constructed, explicit hospital-physician partnerships can be designed to be more durable and synergistic than their predecessors.

Hospital-Physician Interdependence

A hospital is not simply a static physical entity constructed, staffed, and equipped for the care of patients suffering from various diseases and injuries. Rather, it is a dynamic vehicle of health care delivery driven by relationships between administrators and physicians and fueled by the efforts of a team of nurses, medical doctors, surgeons, anesthesiologists, and other staff.

While patients are attracted to hospitals because of various services offered, physicians themselves also attract patients to the hospital, and their knowledge and skill sets are used primarily in the diagnosis and treatment of patients. Physicians are the primary consumers of hospital institutional resources because they order and/or schedule the tests, medications, operations, and other diagnostic and therapeutic interventions for their patients. Supply costs constitute about 20% of a typical hospital’s overall expense; 40% of this consists of physician preference items. The costs of total joint implants, for example, can represent 70% of the reimbursement amount for the procedure.6 The cost (efficiency), quality (medical outcomes), and appropriateness (utilization management) of patient care are critically dependent on physician attitudes and actions. We believe the propensity of physicians to guard their autonomy in deciding what patient care resources to utilize can be justified given physicians bear ultimate medical, ethical, and legal accountability for patient outcomes.

To reverse perspectives, the dependence of any given physician on any given hospital is not so clear. Certain
surgical and medical specialties are completely dependent on the physical, technologic and organizational resources of the hospital. Physicians treating acutely or critically injured patients must practice within the hospital structure. Clinicians in other specialties, such as ophthalmology and dermatology, see patients and perform procedures in an outpatient setting often separate and distinct from a hospital. The increase in physician owned and operated outpatient surgical centers and specialty hospitals is further evidence of this independence.4

The Traditional Hospital-Physician Relationship

Historically, there has been an implied “social contract” between hospitals and their physicians. In this social contract it was assumed physicians would care for patients, follow the bylaws of the medical staff organization associated with a given hospital, and fulfill particular medical staff organization requirements (eg, take emergency room calls, attend meetings, and treat a certain number of “free care” patients). Physician responsibilities also included important patient-related issues such as physician credentialing, peer review of patient care, and assurance of patient care quality and safety. Physicians generate patient admissions to a hospital, thus creating revenue for their hospital so the hospital has the resources to fulfill their part of the implicit agreement.

In return, the hospital’s responsibilities included the provision of necessary resources (eg facilities, supplies, equipment and staff) at no cost to the physician. Administrators bore the responsibility for both day-to-day operations and strategic planning in terms of the direction of institutional commitments and resources.21

Strains on the Traditional Hospital-Physician Relationship

During the late 1980s and through the 1990s, the health care industry confronted major challenges. Traditional cost-based reimbursement shifted to a more competitive market-based approach. For hospitals, with the introduction of diagnosis-related groups (DRGs) and variations on this theme, most inpatient care was paid largely on a case rate basis. Physician compensation was highly scrutinized, and the resource-based relative value scale reimbursement system was instituted throughout the country. Surgical reimbursement rates declined considerably. For example, between 1995 and 2005, the Medicare reimbursement rate for the 25 most commonly performed orthopaedic surgical procedures declined both in absolute and inflation-adjusted terms at a rate of 5% and 26% respectively.

Despite declining reimbursement rates and immense pressure to manage costs, an increasing demand for inpatient and outpatient services necessitated the building of additional capacity and associated infrastructure. Increasingly informed patients and payers demanded higher quality and safety standards and the acquisition of expensive new technology. In addition, several unfunded federal mandates (eg, Health Insurance Portability and Accountability Act, ie, HIPAA) were imposed.21 These challenges strained existing capacity and resources. For example, in 2003, the deadline for HIPAA compliance, 45% of hospitals with between 100 and 400 beds spent between $30,001 and $250,000 to comply with regulations.10 In 2005, 33% of hospitals were still spending this amount annually to maintain compliance.9 In addition, physicians also had to train each employee in their practice in HIPAA compliance, rearrange their offices to minimize the occurrence of HIPAA violations, and both develop and keep track of privacy notices that must be signed by each patient on their first office visit.13 As a result of these multiple changes in the health care environment, the income streams and basic economic viability of both hospitals and physicians were strained.

In a strategic attempt to better position themselves in their respective marketplaces and to deliver more integrated and cost-efficient health care, some institutions bought and managed physician group practices. This experiment was often financially unsuccessful and in many instances engendered ill will and distrust between the hospital and the medical staff. Physicians increasingly felt used as mere employees instead of respected professionals with a clear and distinct voice and desire to participate in the future design of the health care system.

Physicians became increasingly disenchanted with their practice environment. They faced financial strains, legal threats, and often contentious relationships with hospitals, third party payers, and patients. Although physician reimbursements declined, practice expenses continued to rise. Managed care necessitated further bureaucratic expenses. For example, doctors had to obtain preapproval for patient diagnostic testing, admissions, and procedures. As their reimbursement rates declined, surgeons found it increasingly difficult or impossible to provide free care services and to perform previously uncompensated hospital services (eg, emergency room calls).

Substantial strains in the physician-patient relationship also developed. Physicians faced a climate of growing consumerism in which patients shopped for various health plans, often terminating relationships with their physicians for economic savings. In 1997 57.7% of all American adults were “somewhat” or “strongly” willing to limit their choice of hospitals and physicians to save on out-of-pocket costs. By 2003 this percentage had risen to 60.9%,28 with 70.3% of those between ages 18 and 34 reporting this mindset.28 Increasingly more educated about various
health care options, patients came to the physicians demanding particular drugs, testing, or treatments.2

In light of this changing environment, it is not surprising physician job satisfaction has declined in the past few decades.19 In a 1972 study, Mechanic found that 95% of American physicians were satisfied with their jobs.16,18 In 1993, Skolnik et al7 reported a 65% satisfaction rate. By 2001, 39% of primary care physicians and 41% of specialists were very satisfied with their jobs.15 In 2000, a survey of physicians found 54% felt the practice of medicine was “less satisfying” over the last 5 years; in 2004, this number increased to 76%. The greatest sources of professional frustration (in declining order of frequency) included malpractice worries, managed care, and Medicare/Medicaid regulation.19 In a 2002 survey of 2608 physicians, 87% reported the overall morale of physicians has declined in the previous 5 years, 58% reported their enthusiasm for practicing medicine had declined in that same period, and 45% stated they would not recommend the practice of medicine as a profession to a young person.

Factors cited as the main reasons for their negative response (listed in order of decreasing frequency) included paperwork and/or administrative hassle, loss of autonomy, excessive professional demands, less respect for the medical profession, and inadequate financial rewards.12

The data on the career satisfaction of orthopaedic surgeons specifically is relatively recent and conflicting. When Sargent et al compared orthopaedic attendings to the norm for American health-care workers, they found orthopaedists had low levels of burnout, scoring in the lower third for emotional exhaustion, the middle third for depersonalization, and the upper third for personal achievement.24 When comparing job satisfaction across medical subspecialties, Leigh et al16 found orthopaedic surgery was above the mean for both “very satisfied” and “dissatisfied.” However, using family medicine responses as the control, orthopaedic surgeons were overall more likely dissatisfied with their jobs.16 A 2002 survey found 83% of orthopaedic surgeons would choose orthopaedic surgery as their specialty if they were beginning again. However, 32% of orthopaedic surgery respondents indicated they would not choose medicine as a lifetime career if they were beginning again.1

To gain more administrative and economic control, many physicians are becoming more involved in the business of health care. More physicians are investing in various health care related business ventures such as imaging facilities and ambulatory surgery centers (ASCs).21 Hospital administrators and some of their physician staff, however, argue physician-owned ASCs divert profits away from community hospitals, leaving insufficient funds to run costly trauma centers, burn units, and emergency departments.29

The hospital-physician relationship dynamic has thus in many instances devolved from implied collaboration to direct competition. Given a shared mission of providing the highest quality health care, for the benefit of their patients, hospitals and physicians must find ways to work together towards this common goal. The establishment of new covenants based on collaborative strategic development can transform the current embattled health care environment to the benefit of patients, physicians, and hospitals.

Physician Challenges to Establishing Partnerships

In many institutions and health systems, a lack of physician cohesion precludes them from serving as effective partners in developing appropriate institutional strategies and prioritizing resources. In a survey study of 236 senior physician executives, Bard et al reported that only 21.1% of physicians “agreed” or “strongly agreed” that physicians are able to speak with one voice on important matters, and only 41.7% believed that physicians practice within a structure that allows effective decision-making and follow through.3 If one believes in the philosophy that strong partners make the best partners, the lack of physician cohesion is detrimental to the establishment of positive hospital-physician relationships.

Bujack argued the dynamics of physician training and practice have imbued them with characteristics antithetical to cohesion.4 Stature within physician society is determined by individual performance rather than teamwork. Physicians fiercely covet individual autonomy. Ironically, the greatest impetus for physician cohesion is a threat to their individual autonomy. In these cases, the medical staff can mobilize into a powerful force to influence critical decisions. The physician population is a diverse community (eg, primary care physicians versus specialists, academicians versus community practitioners), making consensus on most issues difficult.

There is also an instinctual resistance to leadership within the physician population. When gathered they often conduct meetings in the style of a town hall (rather than a representational democracy) in which each member has an equal voice. For these reasons, a medical staff is generally most effective as a negative force to fight a threat to the group rather than a proactive force for change.4

As their relationships with hospitals have changed from collaborative to competitive (and often from implicit relationship to legal contracts), physicians find themselves in the unfamiliar position of negotiators. In negotiation simulation tests, physicians tend to default to the “lose-lose” alternative, whereas business school students tend to find the hidden “win-win” solution in which the pie is not just divided but is actually “made bigger.”25 Arriving at the latter solution requires understanding different parties
have different priorities. Again, perhaps the highly competitive nature of medical education biases physicians toward competitive rather than collaborative strategies. If parties take the time to communicate honestly, scenarios in which both parties achieve their goals can be structured. Strong negotiation skills must be taught to physicians, especially those in leadership positions, to assist them in this work. Trust instead of competition, relationships instead of autonomy, hard work, time commitment, imagination, and creativity are hallmarks of an effective negotiator and partner.

Foundations of a New Relationship

The traditional hospital-physician relationship was most often simply symbiotic and implicit, perhaps explaining its vulnerability when faced with the challenges of the new health care environment. We propose more durable, synergistic physician-hospital relationships can be established through dedicated communication on both sides. The cornerstone of this new relationship is the explicit identification of common goals and priorities and the understanding of individual perspectives. Only after such open, thoughtful conversations can successful negotiated planning occur.

In general, hospital administrators and physicians rarely meet other than in instances where they are negotiating a contract or there is a request from one party to the other. These encounters often revolve around resources (eg, space, money, and personnel) and power issues that lead to a relationship of competition and distrust. Interaction beyond these types of power plays is important in moving forward from the current reactive to a future proactive relationship.

For example, physicians and hospital administrators can meet to explore shared decision-making models around quality and cost management. Frequently broadly described as “gain-sharing,” there are many variations on this collaborative approach. Some examples of hospital-physician partnering models are: compensating physicians for consulting services and medical directorships; reinvesting savings in clinical programs or departments; implementing a quality incentive program; participating in joint payer contracts with physicians; and entering equity or joint-venture arrangements with physicians. Although both sides will inevitably need to compromise, the establishment of common goals and objectives and individual priorities from the outset can help mitigate many of the associated tensions. It is only through multiple positive and mutually beneficial interactions that heightened trust and increased open communication will result. The proper organizational structure and environment must be purposefully engineered to foster this cycle of trust and collaboration.

Reaching Out: The Role of Hospital Administration

To provide a balanced look at the dynamics of a stronger, more explicitly synergistic hospital-physician relationship, the role and perspective of the hospital administrator must be examined. Successful hospital administrators in the current health care environment must develop strong multidisciplinary skills and a broad understanding of all aspects of the health care environment. By virtue of their education and training, administrators should be collaborative team players who also understand the necessity of hierarchy in the management of increasingly complex organizations in the health care field.

Bujack proposes a shift in leadership mentality through a nautical metaphor. He describes current health care organizations as having been focused on building an ark that moves toward perceived common goals. Administrators and physicians alike are expected to board and cooperate in sailing forward. However, the diversity of physicians makes it difficult to go in a single direction. Instead, administrators should invest in building a flotilla of different boats so individuals can board the boat of their liking with others who share their values and objectives. In contrast, an ark can only sail to one location with only one set of amenities at one speed. Bujack suggests the focus should not be on the ark, but rather on providing for water transportation.

Anderson proposed the lofty ideal of the servant leader who subscribes to MacGregor Burn’s model of transforming leadership. The most common type of leadership is “transactional,” in which some type of tradeoff is expected. This can lead to a Machiavellian environment with manipulation of others and a lose-lose negotiation scenario. Transforming leadership is the ideal in which the leader and followers desire to be raised to a higher level of motivation and morality. Interactions are seen as opportunities for expansion and growth. These leaders double as mentors and/or teachers and perpetual students. The emphasis on being both a leader and student underscores the importance of open dialogue and earnest listening in establishing new covenants.

Establishing meaningful relationships is paramount. This must include informal opportunities to get to know all physicians on the medical staff, and formal involvement of physicians in all activities throughout the hospital’s domain. This allows physicians to play a leadership role in the overall management of the institution and helps administrators to learn directly the major concerns, issues, and priorities of their medical staff.

It is also important to embark on activities of growth and creativity that will allow both parties to succeed. Both parties should think about opportunities for joint ventures that will create substantial value for the institution and its
physicians. Working on an established foundation of communication and trust, an open dialogue delineating the nature and degree of physician participation in these projects will lead to true collaboration.

The Physician Executive

Increasingly, physician leaders are emerging as executives in the health care industry. Moving into the administrative realm is natural for physicians. Traditionally, the locus of patient care decision making has been the physician-patient interaction. That locus is drifting further away to realms outside the natural purview of physicians: boardrooms, courtrooms, and political arenas. Physicians must become more involved in these arenas to continue to direct patient care. We believe the movement of physicians into the administrative realm is a positive phenomenon because it bridges the unnatural disconnect between the suppliers of patient care resources (the hospital) and those ordering and utilizing patient care resources (physicians). Physician-executives may choose to be leaders of their departments (eg, chairmen) or may move to the hospital administrative realm. Either way, they bring the knowledge of what resources are necessary to provide the highest quality of patient care. It is imperative, however, that physicians wishing to navigate into this realm acquire the necessary professional training to be successful in this discipline.

The role of the physician-executive is not new. In the past, physicians have been very involved in the financial and administrative responsibilities associated with patient care. This is particularly true for private practitioners providing patient care outside of the hospital setting. Historically, hospitals were, for the most part, largely owned or operated by physicians, and physicians clearly have had longstanding power via their provision of patient care and their influence over hospital leadership. However, as health care administration has become more complex and physicians have become more specialized in their respective fields, non-physician hospital executives increasingly began to occupy high-level hospital administrative positions. By 1985, only about 230 of 6872 hospitals had physician administrators or chief operating officers (CEOs). In 2003, still only about 200 physicians were serving as hospital CEOs, meaning just 4 percent of the 5,000 acute-care hospitals in the United States were run by doctors.

Acknowledging the intricacies of the current health care system, physicians now seeking a greater voice in hospital leadership are achieving advanced degrees in administration and management. However, there are only certain MBA programs approved by the Accrediting Commission on Education for Health Services Administration; these programs specifically ensure training in quality measurement, cost-benefit analysis, health economics, epidemiology, medical ethics, population health measurement, and management of physicians. More physicians now seek Masters in Public Health (MPH) and Masters of Health Administration (MHA) degrees that often provide a more focused and equally competitive level of training specific to the needs of future health care administrators.

Physician-executives face a unique challenge. Hospital administrators and their physician colleagues often view their qualifications with a certain degree of suspicion. The former question their financial and administrative skills, whereas the latter question their loyalty to their colleagues and patients. Physician-executives confront many of the same challenges as lay executives. They must develop trusting relationships and open communication with the physicians they represent. They must also show exquisite negotiation skills and work collaboratively with their lay counterparts in administration and management to effect an integrated health care delivery system. They must also decide whether, and to what degree, they should continue clinical practice. Some insist that without their clinical practice, physician executives lose their major advantages: the understanding of the evolving medical care process, the physician-patient relationship, the hidden subtleties of medical ethics, and the difficulty of balancing quality and cost at an individual patient level.

Physician executives must draw out their colleagues by establishing or enhancing forums where the medical staff can meet and generate ideas, make decisions, and improve trust. Realizing perhaps the most precious commodity for physicians is their time, these forums must have real value and substance, run efficiently, and produce results that will motivate physician attendance. Working with their hospital administrative colleagues, can be a force in creating the physician cohesion necessary for practical, productive partnerships with the hospital.

Case Study in Collaborative Planning: Developing the MGH Orthopaedic Ambulatory Surgical Center

Ambulatory Surgical Centers (ASCs) have grown in popularity throughout the last decade in the United States. This development can be an example of the most direct form of competition between physicians and hospitals when ASCs are developed separately from the hospital. There are many possible economic and governance models associated with the centers, including models in which physicians and non-health–care financial partners have equity in those centers.

Physicians have two major incentives for establishing an ASC. Surgeons want to achieve maximum efficiency and deliver the highest quality of patient care through operational oversight of such a center. The second major incentive for surgeons is economic. Enhanced clinical and surgical productivity generates greater professional in-
come as patient volume increases. Certain ASC governance and financial models generate an additional income stream based on equity or other types of direct financial incentives. For example, physicians may share in the facility fees, separate from their professional fees, traditionally channeled to hospitals.

The financial incentives of ASCs raise the concern that surgeons may increase their operative load, perhaps operating on people with at best marginal surgical indications. Woods et al tracked the practice patterns of 10 orthopaedic surgeons in a single group practice 7 years before and 8 years after the opening of an orthopaedic surgery specialty hospital in which those surgeons held a financial interest. They found the number of surgical procedures performed per year, the average rate of change in the number of surgical procedures per year, the total patient volume, and the percentage of patients undergoing surgery did not substantially change after the specialty hospital opened.

Although some argue the direct physician equity model allows physicians greatest autonomy and opportunity for profit, there are considerable financial, administrative, and legal disadvantages to this model. For example, physicians must obtain a certificate of need in many states requiring evidence the community would benefit from a new facility. This can be an expensive, lengthy, and politically difficult process. However, in Massachusetts a certificate of need is not necessary if the ASC is established under the hospital’s license. In addition, an ASC established under a hospital’s license, if it falls within a predefined radius of the main hospital, is considered an “on-campus” facility, qualifying it for a higher level of Medicare technical reimbursement.

Establishing an ASC without physician equity minimizes potential tax issues. There is considerable scrutiny by the Internal Revenue Service (IRS) when non-profit, tax-exempt hospitals enter into arrangements that could compromise this status. The IRS wants to ensure tax-exempt dollars are not funding a venture that will also benefit private individuals (eg, physicians). Furthermore, when physicians own ASC equity, they cannot use a non-profit hospital’s tax-exempt status to purchase equipment.

In formulating any ASC model, legal counsel is critical as local, state, and federal regulations are complicated and vitally important to understand, as ignorance is not a defense in court. For example, generally speaking, the Stark law forbids a physician from making a referral for services paid by Medicare or Medicaid to any entity with which either the referring physician or his/her immediate family member has a financial relationship. Anti-kickback laws prohibit being rewarded for bringing business to anyone. The Office of the Inspector General (OIG) created “safe harbors” for surgeon-owned ASCs, single-specialty and multi-specialty ASCs, and hospital/physician-owned ASCs. To qualify for this safe harbor the ASC must be an extension of the physician-investor’s office practice. Hospital investors cannot be in a position to make or influence referrals. There are 13 specific requirements an ASC must meet to qualify for the OIG safe harbor.

We offer the development of the Massachusetts General Hospital (MGH) ASC as a case study in successful hospital-physician coordinated planning, as the two sides were able to collaborate to develop a model acceptable to both parties. The perspective of this particular model is specifically from an academic non-profit institutional environment. Members of the Orthopaedic Service at the MGH approached the hospital leadership with the concept of a single-specialty ASC. An investigation of the various financing and governance options determined licensing a facility under hospital ownership provided the most straightforward development approach (eg, no certificate of need required) and best opportunity for enhanced reimbursement. Still, in accordance with the physician priorities mentioned above, paramount goals remained physician control of the ASC operations and the opportunity for physicians to reap direct economic rewards from the center’s success.

The MGH president delegated the MGH Department of Orthopaedic Surgery the authority to develop and run the ASC. The chief (HER) of the Department of Orthopaedics in turn selected a Medical Executive Committee (MEC) including surgeons, an anesthesia representative, a nursing representative, and an administrator representing both the hospital and the physician organization to design and execute all aspects of the center. A medical director, assisted by a nurse manager, was selected to oversee the operations according to the framework established by the MEC. Anesthesiologists, nurses, and support staff will report directly to the medical director but maintain ties to their respective professional departments for institutional appointments, credentialing, and ongoing professional development. The orthopaedic surgeons will continue to report directly to their department chief; however, from a daily operational perspective, they will be expected to work under the oversight and guidance of the medical director.

At the MGH ASC, surgeons and anesthesiologists receive professional billing payments, whereas the hospital bills for the technical components of patient care. The Department of Orthopaedic Surgery will collect the surgical professional revenues. The anesthesia professional revenue will be held by the ASC for those anesthesiologists hired separately by the center for their work specifically in the ASC. The technical revenues will be captured in a single ASC cost center that will also track all expenses. The ASC Medical Executive Committee (MEC) members will receive a base management program fee to com-

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To create appropriate financial incentives for all personnel working at the center, MGH has established a performance management model. All surgeons, anesthesiologists, nurses, and support staff working at the center will have the opportunity to earn additional bonus dollars associated with reaching annually established performance goals. Prior to the opening of the ASC and then prior to the beginning of each fiscal year from FY 2008 on, the MEC, with the agreement of the hospital and the Orthopaedic Surgery Department, will establish performance incentive program goals, quarterly measures to determine whether the goals have been met, and the performance incentive fees for achievement of each goal. This performance incentive program will also be reflected in agreements with the private orthopaedic surgeons operating at the ASC. Earned performance incentive program fees will be distributed to the ASC non-physician staff quarterly and to the ASC surgeons and anesthesiologists every six months.

During the period from the opening of the ASC through FY 2007, ASC-wide goals include: paid clinical non-physician hours of no more than 12.5 hours/case, start time within 10 minutes of scheduled time in 95% of cases, 95% rate of patient responses of “good” or “excellent” on locally generated patient satisfaction surveys, and average operating turnover time of no more than 15 minutes. The individual orthopaedic surgeon performance incentive goals are: complication rate below 1% of patients and infection rate below 1% of patients. Orthopaedic surgeons who perform at least fifty operations a year at the ASC will be paid a set annual incentive fee for meeting each of these two goals. Anesthesiologists will be eligible for a performance incentive program fee at an annual rate of up to 20% of base salary based on the achievement of the four ASC-wide performance incentive program goals selected, technical proficiency, ASC surgeon satisfaction scores, and the number of ASC surgeries performed compared to budget. The Medical Director will be eligible for a performance incentive program fee at an annual rate of up to 20% of base salary based on the achievement of the four ASC-wide performance incentive program goals selected, ASC leadership, technical proficiency, communications, ASC surgeon satisfaction scores, and the number of ASC surgeries performed compared to budget. Nurses, technicians, and administrative personnel incentive fees will be based on the achievement of the four ASC-wide performance goals selected and the number of ASC surgeries performed compared to budget.

Because both of these fund categories (management fees and performance incentives) are built into the expense base of the model, they will be paid annually, regardless of whether or not the center is generating a profit, provided the management objectives and the performance standards are met. Seven percent of the projected net revenue of the ASC is built into the operating budget to fund these initiatives. It is expected the initial contract period for this arrangement will be three years to allow the center an appropriate opportunity to ramp up to its full operating capacity.

By identifying the priorities and motivations of each party, a unique collaborative hospital-physician model has been established in the development of a freestanding orthopaedic ASC. The cornerstone of the MGH model is alignment of incentives for teamwork and collaboration throughout the ranks of the ASC. Surgeons, anesthesiologists, nurses, and support staff all can profit by working together to achieve predetermined performance goals that can ultimately lead to a more efficient and higher quality of patient care. Again, it must be emphasized the MGH ASC is a case study in successful collaborative planning. The success of its actual execution has yet to be determined.

DISCUSSION

We describe and examine the recently embattled relationship between physicians and hospitals in the United States and propose strategies for enhancing this collaboration as both parties work towards the ultimate goal of quality patient care. Historically, there has existed a largely implicit, symbiotic relationship between hospitals and physicians shored up by substantial health care reimbursement. Financial strains in the 1980’s and 1990’s considerably compromised this tenuous relationship. The hospital-physician relationship devolved into a contentious atmosphere in which hospitals and physicians struggled to remain economically practical. The two parties found themselves in direct competition as new physician-owned health-care entities were developed. We propose that new, explicit, formal relationships built on communication and trust can lead to mutually beneficial collaborations. The MGH hospital-physician model for an orthopaedic ASC represents one hospital’s attempt at formally identifying common hospital and physician goals and embarking on a potentially mutually beneficial venture.

A major weakness in the literature is the lack of data on the success—based on economic, job satisfaction, and patient quality outcome measures—of hospital-physician relationships. For example, while we outline the process in
which hospital and physician executives at MGH were able to agree on an ASC model, our ASC has not yet opened. Therefore, the ultimate success of the collaboration, as judged by its ability to create a cost-effective environment of quality and efficient delivery of outpatient orthopaedic surgical care, has yet to be determined.

Some interesting investigations can be pursued to further shed light on the current status of the hospital-physician relationship. Prospective studies examining the career satisfaction of physicians, quality of patient care, and economic efficiency of patient care before and after concerted hospital-physician collaborations would provide confirmation or refutation of the success of various collaborative models. Furthermore, the decline in physician job satisfaction is troubling in part because of its implications for the future recruitment of high caliber physicians. With only 36% of physicians in 2004 reporting they would encourage their children or other young people to choose medicine as a career today, who will serve as mentors for interested students?19 A study of college students examining their choice of career path could elucidate whether the most academically gifted students are choosing medicine as a career and why or why not. A study of medical students may identify attractive and unattractive aspects of orthopaedic surgery.

While the financial strains of the 1980s and 1990s compromised implicit, tenuous hospital-physician relationships, there are opportunities in the future to purposefully rebuild this relationship in a form stronger than ever before. The process of reformulating this relationship into more formal, thoughtfully crafted collaborations can only succeed if both parties commit to ongoing, open dialogues in which each party honestly presents their priorities and objectives. Commonalities can then be identified and can serve as the foundation of well-defined joint ventures. At first, this relationship can be fortified by the success of small collaborative successes. Once this trust has been established, physicians and hospitals can embark on more substantial projects, such as an ASC. While the development of the MGH ASC serves as an example of how physician and hospital administrators can collaborate effectively to plan a major joint endeavor, the success of the MGH ASC, as measured by quality of patient care and economic viability of the ASC, has yet to be determined.

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