Editorial: Physician-Hospital Partnership—What Really Counts?

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As a corporate enterprise, the US hospital has no business without the physicians whose admission orders populate its beds and whose prescriptions generate its services. Hospitals neither admit patients nor discharge them, and virtually everything that happens in the hospital is derived ultimately from a physician's order. The unique role of physicians is further recognized in the organized medical staff. The medical staff organization is meant to be self-policing, and also provides the nonphysician hospital board members with specialized technical expertise to help the board steward resources and assure the quality of care rendered within the facility.

So, hospitals cannot function without physicians, and the quality of the care provided to the patients whom the physicians admit to them provides the parties with a strong basis to act in common cause.[1] What then is the purpose of hospitals and physicians bonding more closely through legal, financial, corporate, or employment vehicles in relatively tighter or looser configurations with the hospital?

The range of integration and collaboration strategies described in this issue by Farber et al[2] would seem to speak to diverse strategies of the hospitals and physicians engaged in them. Two of the centers manifest a gamut of integration, from direct employment of physicians to medical directorships, management services contracts, and ancillary services' joint ventures. Unfortunately, the article does not speak to what the common purposes or what any purposes of such configurations might be.

In considering any potential form of hospital-physician partnering, it is important to remember that hospitals and physicians are engaged in distinctly different businesses. The core competence of hospitals is to bring together into well-organized delivery operations the highly complex combination of equipment, technical skills, and clinical expertise (particularly the expertise of highly trained nurses) to meet the needs of patients whose care requires the services that only hospitals, recognized by their distinct license, can provide. All the rest is incidental to that core competency.

Physicians are in a different business. It is true they are increasingly forming larger groups and are providing ancillary services also provided by hospitals. But most physicians still work in small constellations of less than three to five doctors. In any event, they are not really in the same business as the hospitals who serve their patients. The expertise of hospitals, therefore, to manage physician businesses is by no means guaranteed.

The contemporary moment for this discussion around oncology has emerged in part because the oncologists' business model has been significantly weakened by the application of new payment rules for oncology drugs. There is no question that this business challenge offers an opportunity for hospitals and oncologists to work together in new and creative ways—but, specifically, toward what end?

If the sole purpose of any hospital-physician engagement is economic alignment to increase revenues to the hospital, or to blunt a potential competitive challenge in which either might engage independently, or to lock in physician referrals, the strategy will inevitably fail to optimize results for one or both parties, and above all for the patients whom it is intended to serve. Without an overarching purpose beyond dollars, the many purely financial schemes and arrangements afoot today can only consume time and money in their design, but will ultimately be hollow and inadequate to any higher purpose for which hospitals and physicians both ought to stand.

I have seen a raft of hospital-physician bonding strategies come and go over the last 30 years. Many proved to be fads. The essential principle that ought to drive any hospital-physician collaboration is not just revenues to either party or promised security to the physicians as protection against the vicissitudes of a more competitive and difficult practice environment. Today, improved quality of care is a strategic and business imperative for both hospitals[3] and physicians—as demonstrated in our current era of pay for performance, quality branding, burgeoning report cards, physician pay for reporting, and fraud and abuse based on quality failures and reporting aberrancies.[4] Focusing heavily on how any specific collaboration will improve efficiency and quality of care will produce an arrangement that will likely be more sustainable over time.

A better provider payment model that would compensate both hospitals and physicians to deliver what science says and compassion would recommend that patients receive for their clinical needs would enhance these opportunities. Such a model is in development now[5] and will pilot cancer care as part of its first efforts. However, even without a change in payment, there are many ways physicians and hospitals can help each others' business case for quality, with the ultimate impact directed to improved care for patients. In essence, both can do well by doing the right thing.

There are a host of other collaborations one might consider in the quest for a solid, shared business case for quality for hospitals and oncologists. Consider the following:

- The hospital engages oncologists more actively in its own quality agenda, thereby improving those physicians' own scores[6];
- The hospital leases part-time to community oncologists nurse practitioners or physician's assistants for whom they can bill and generate revenues while helping the physicians provide more standardized care; and
- The hospital recruits a new oncologist to the community and leases him to a local oncology group that bills for him. He works part-time on quality for the hospital until he develops his patient base, at which time the oncologists employ him directly, full-time, and he contributes his new quality improvement skills to the practice.[7] All can be done completely within legal boundaries.

The models of hospital-physician economic collaboration described in the article may well merit consideration, but the real question is, How will this strategy directly benefit our patients and the care we provide them in a sustainable way? Financial (and legal) considerations are essential drivers in constructing these transactions, but improved quality performance should be the ultimate touchstone for all.

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