

Driving the Nitroglycerin Truck

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Creating the integrated healthcare organization was 1992's most popular seminar topic. Attorneys and consultants, with transparencies (and billing sheets) flying, plied the field with the latest formula for success (remember "corporate reorganization"?). Yet these advisers often lacked not only a sense of irony but a sense of history.

As Rosemary Stevens and Paul Starr both told us, the relationship between the hospital and medical practice has been the focus of a century of conflict. The antibodies against a "takeover" of medical practice have been circulating in American medicine's system for at least four generations! Clever legal structures and slick presentations will not erase a history of suspicion and mistrust.

There is no doubt that conventional medical practice is in distress. Though average physician incomes apparently continued rising through 1991, the averages conceal regional bloodbaths, particularly in primary care. Specialists too are facing a double whammy-reduced fees and sharply higher taxes-which will push large numbers of them, already over-leveraged and cash poor, into substantial economic difficulty.

Physicians are increasingly pressuring healthcare managers (after hours and out of earshot of their colleagues) to bail them out-by increasing their subsidies, providing them paid administrative roles, or simply buying them out. A time of opportunity, perhaps, but it is a time of profound risk as well.

A marriage not made in heaven

Both sides of the bizarre sadomasochistic relationship between medical practice and management bring baggage to the "arranged marriage" of the integrated healthcare system.

Since neither spouse has had enough power to control the other, passive aggression has been the principal emotional theme.

Executives bring to the marriage long-simmering but rarely expressed resentments against the perceived capriciousness of physician input into management. As a consequence, there are a lot of Walter Mitty-like fantasies of power in the current generation of healthcare managers. Some managers misread the present distress of practicing physicians as foretelling the impending triumph of management. Finally, medical practice will be subsumed under management and "those S.O.B.'s will do what they are told!" Boy, are the Walter Mitty's going to be disappointed.

My University of Chicago experience taught me this lesson early: Physicians crave order but despise authority. Long deprived of the power to influence directly the management of their institutions, physicians have resorted to guile and guerrilla warfare to win their battles. While many physicians believe they are "expert" at management by dint of their medical training, most are incapable of submitting to the authority of others, physician or non-physician. They are "smarter" than their "bosses" on each successive issue.

When they are unhappy, they whine-deafeningly. They passively resist, often with a flair and elegance that dazzles even those who disapprove of what they are doing. They agree in public and privately subvert. They wait for temporary weakness in managers and savage them. They are easily swayed against common sense by "the last angry man" in their midst.

They are, in short, terrible employees. Ask any medical school dean or group practice CEO.

The private practice, fee-for-service framework that has both nourished and insulated medical practitioners for most of this century is dying in many communities. The fact that physicians are in distress does not mean they are emotionally prepared to surrender their autonomy or participate meaningfully in a redesigned healthcare system. In fact, frightened or angry people make awful partners in any new enterprise.

Few of the skills needed to function in an organized system are present in the contemporary generation of private practitioners. Like lifelong bachelors contemplating marriage in their fifties, these physicians often have little experience with sharing, compromise, and delegation of responsibility. And, frankly, many lack the civility needed to function inside a larger organization.

The current generation of healthcare executives and physician leaders are caught in a transition from atomized entrepreneurship to an organized, collegial physician culture. It is that cultural transition—not creating new corporate entities like foundations or InterStudy's MeSH plans (and herding physicians into them)—that is the heart of the management challenge in creating an integrated healthcare organization.

Collegiality is the key

Generations of physician leaders have sought to preserve clinical autonomy in the face of increasingly complex challenges from payers and hospitals. These fighters will not go quietly into the night. The key feature of the new integrated healthcare enterprise is not a balance of power, however, but the emergence of collegiality as the fundamental organizing principle. The essence of collegiality is tolerance and a sharing of common professional values. This trust and sharing of

values is, in turn, the central precondition of the ability to share and successfully manage the economic risk of health costs.

There are not many truly integrated healthcare organizations in America, and those that come to mind, like Kaiser or Mayo, are not only unambiguously physician-run but are anchored in a long tradition of collegiality. This collegiality-not who owns what, how physicians are compensated, or who works for whom-is literally what integrates them.

These organizations have functioned for three generations as a true "counter culture" within the broader context of traditional private practice. The best integrated organizations had the luxury of selecting from a larger universe the subset of physicians for whom collegiality was a higher priority than autonomy.

This was certainly the most striking impression I received several years ago as a patient at the Mayo Clinic. The facilities and administrative systems in the place were unexceptional, even a little shopworn. Yet the striking difference between Mayo and the teaching institutions with which Mayo allegedly competes was the effortlessness with which Mayo physicians collaborated with one another.

Each Mayo visit involves multiple physician evaluations under the guidance of an assigned primary physician (whose specialty depends on the primary complaint), Physicians returned their colleagues' calls within minutes and caucused in hallways on their way to and from lunch and committee meetings. The Mayo physicians revelled in collaboration, and they reached an informed consensus on what to do (supported by exceptionally rapid diagnostic test reporting).

Collegiality within an organized practice may be the only shelter physicians have from the corrosive suspicion and case-by-case second guessing of clinical decisions that have overwhelmed private practice. Collegial norms of conservative medical practice render hour-by-hour practice controls unnecessary. Formalizing these norms, creating clinical protocols to make them explicit, and explicitly linking them to clinical outcomes, is the ultimate goal of the outcomes movement in contemporary medicine. These protocols will form the backbone of any integrated system, a framework that "learns" (in Peter Senge's sense of the term) and adapts to new therapies as they become available.

Rising from the ashes

Building an integrated healthcare organization from the entrepreneurial residue of private practice may be the graveyard of a generation of lay healthcare executives. It is clear thus far that one cannot simply impose a collegial framework or economic risk on a medical community by administrative fiat. A failure to read the political tea leaves in this sensitive area has already cost one former AHA president his job (he landed on his feet, however). Timing,

accurately gauging the mood of a medical community, and creating a zone of tolerance for pluralistic relationships between the organization and its physicians are indispensable ingredients in making this transition.

The wreckage of Humana provides perhaps the best cautionary tale for integrated health system builders. It shows what comes of straddling the twin worlds of managed care and private practice.

In 1992, the year the company blew apart and divested not only its hospitals but much of its administrative staff, Humana was seven years down the same road many healthcare organizations are just now entering. Humana's leaders recognized by 1985 (the year of peak hospital operating profits) that future returns in hospital operations were not going to sustain the company's equity valuation, and they moved into managed care (placing their hospital operations in a kind of harvest posture).

Humana embarked on an integration strategy with a couple of handicaps: an authoritarian management style and poor relations with many of its medical staffs. Humana's physicians often founded new facilities in partnership with the company in rebellion against the larger medical centers in their communities, and these physicians, who remained "rebels" well into the Nineties, were poor candidates for any integration strategy. Nonetheless, with a singleness of purpose characteristic of Humana, the company invested many hundreds of millions of dollars (both in health plan operating losses and disrupted hospital cash flow) in building a managed care franchise.

The seeds of the company's dissolution lay in attempting to force physicians to change their behavior before they were prepared to do so. The "rebel" physicians in many Humana markets were doing well enough under the old rules to resist Humana's efforts to restrict physician activity or capitate their payment. Humana certainly did not have enough leverage to force them onto salary or into hospital-supported group practice. And their physicians had enough choices available to them to abandon Humana hospitals for their private patients, resulting in a hemorrhaging of admissions.

Weep not for Humana. Its 1.7 million health plan enrollees make it a formidable player in the managed care shootout of the Nineties. Humana has as much experience as any managed care player in addressing the care of the elderly, the biggest growth market for their product in the next 15 years. Shorn of its hospitals-along with the huge capital burden and political baggage they entailed-Humana could end the decade in a stronger position than where it began.

Not for the faint of heart

Embarking on the path of creating an integrated healthcare organization from a matrix of private practice is a little like driving a truck loaded with nitroglycerin along a bumpy road. Leaders without the political skills to sense the bumps in the road before

they hit them will never know what happened. They will be steak tartare. The following pieces of advice have been gleaned from observing many failures:

1. Begin with primary care, let the specialists "be free. "

Primary care physicians have thus far been those most affected by the changing payment climate. They are the practitioners most likely to have "hit the wall" in their existing practice arrangements, and therefore most able to make the tradeoff between reduced autonomy and practice stability.

The core architecture of any integrated healthcare organization is a cadre of committed primary care physicians. They are the indispensable actors in an effectively organized geographic distribution strategy, and in managed care networks. Eventually, the result of managed care growth will be the shifting of economic power in most medical communities to primary care physicians.

In many communities, the supply of new primary care physicians has dried up, and those that do exist are being snapped up by group practices and managed care plans that subsidize their incomes. The practical reality for most private practice-based health systems in these communities is that unless they can replace or expand their own primary care physician network, they are on the road to the tar pits already.

The first task on the journey to integration is creating a structure to support primary medical practice, hopefully one in which physicians are not merely employees but participants who share and exercise real power. A critical issue in creating this structure is determining whether the physicians involved can actually work together as colleagues.

Specialty physicians should be offered arm's-length assistance (practice consulting or group purchasing, for instance) in coping with practice pressures, but they should remain "free agents" until the exigencies of the managed care market (not your proselytizing) force them to accept economic risk. It would be foolish for the hospital or other healthcare organization to grandfather specialist incomes that could fall by 30 to 50 percent during the Nineties.

2. Encourage pluralism.

Nevertheless, specialists in the medical community must be brought to recognize that practice arrangements they would not tolerate for themselves must be created for the primary care physicians who send them business. Absent this tolerance, they will veto any organizational arrangements they perceive as altering the "balance of power" between the hospital and its physicians and block the emergence of an integrated enterprise.

The principal challenge of creating an integrated healthcare organization is political. Physicians of different specialties and ages will have different needs. Physician leaders

must be able to widen the medical community's comfort zone sufficiently to tolerate a variety of organizational arrangements.

A perception that some physicians will be given special treatment (or competitive advantage) over others erodes the trust necessary to achieve success. Trust, not structure, is the indispensable ingredient in an integrated organization. Collegiality will not flower in an armed camp, nor in a physician community where people are constantly wondering what kind of deal the other guy got.

3. Don't buy practices, merge them.

An important common denominator of the efforts underway in Sacramento and Albuquerque to create integrated physician-hospital organizations is that they are based upon voluntary mergers of practices into a larger group practice entity, not upon practice buy-outs.

A physician's interest in selling his or her practice may simply reflect a desire to harvest the maximum economic value from the franchise before it becomes worthless. By purchasing it, the hospital not only acquires another asset that is declining in its earning power but another disgruntled employee, whose economic risk has now been markedly reduced (along, perhaps, with his or her motivation). Having purchased the practice, you have shifted the physician's economic risk to you. Buying an asset that by the very fact of your purchasing it causes it to decline in value is not a good business strategy.

When other institutions offer to purchase a physician's practice, it is something of a nightmare. What you would like to do is call your competitor up and agree that neither of you will do it, but that, of course, would be an antitrust violation. The communities like Kansas City, which degenerated into a practice buy-out war several years ago, are surely not better off for having cashed out their physicians.

Offering a supportive group practice alternative to being a salaried hospital employee, one in which the physicians govern their own practice instead of working for lay management, may be a viable alternative. If "renting" physician loyalty through directorships didn't work as a long-term strategy, buying their loyalty probably won't either.

4. Be patient.

It took Kaiser and Mayo more than three generations to build their organizations. You are not going to create something of lasting influence in just a few years. In many communities, it may take the retirement of a generation of existing physician leaders to make a true integrated health care enterprise possible. In some communities in the South and East, the existing private practice framework could survive, albeit with stresses, for at least another ten to 15 years.

Sutter's Sacramento/Sierra Medical Group (the oldest of the new generation of groups founded by private practitioners) is eight years old, and it is a considerable distance from a completely integrated entity. Encompassing specialty services in the Sacramento/Sierra umbrella could take at least five to seven more years.

The hospital bows out

Perhaps the most important realization of all is that creating an integrated healthcare organization from the hospital side of the physician-hospital relationship means, eventually, ceding real power to a group of physicians. Achieving real power is the ultimate cure for the passive-aggressive bad habits many physicians currently display in labor organizations. The best antidote for the climate of suspicion and fear that exists in many medical communities is to cultivate physician leaders with management talent to assume ultimate leadership of the integrated enterprise.

Ironically, those lay managers who succeed in creating this new organization may have worked themselves out of a job and conveyed power, formal and informal, to a new generation of physician-managers who may be the heirs of our industry.

The architecture of health systems is not founded on physical assets like hospitals or health centers but on organizations of health services professionals. The core enterprise of most existing integrated healthcare systems-Mayo, Kaiser, Henry Ford-is a large multispecialty group practice.

One thing becomes clear from studying the small number of integrated healthcare organizations we have today: In them, the hospital is truly the ancillary service-a capital-hungry, troubled cost center. The hospital is certainly not the nucleus of an integrated healthcare organization; it is instead a high maintenance core asset, whose use must be rigorously limited in managed care arrangements. Those who seek to organize integrated healthcare systems are, unwittingly perhaps, the heralds of a post-hospital era of healthcare delivery.

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