

The Changing of the Guard

Implications for Hospitals

Developing and maintaining positive working relationships with physicians is an increasingly important challenge for healthcare marketers. Understanding the trends and issues affecting physicians, and the hospital-physician relationship, can guide marketers in meeting that challenge successfully.

For the past 30 years, the American healthcare system has been powered by baby boom physicians. Now, burnout, deteriorating practice economics, and disillusionment with the logistical challenges of practice are leading to earlier retirements among these physicians, many of whom are assuming new roles inside and outside the health system that are more satisfying and less stressful.

As these busy physicians retire, their patients are cascading down onto a new generation of physicians, with fundamentally different goals, work styles, and values. This new generation has already tilted toward medical specialties which mesh better with family and other priorities, and evinces a desire to practice medicine 40 hours a week or much less. They are also much less ideological than their elders about medical practice and its prerogatives, and less likely to remain in the same community for their entire careers.

After observing the wreckage that 24/7 medical practice caused among their elders—divorces, intra-professional conflict, disability due to stress, suicides—it's hard to argue with younger physicians' desire for a more balanced life. Yet, this generational transition—a changing of the guard in medicine—is wreaking havoc with hospital-physician relationships and may herald a crisis of access, particularly for primary care physicians and rural specialists, as



baby boomers begin to enroll in Medicare starting in 2011.

Here are some of the likely outcomes:

1 Surge in Physician Employment

Unlike multi-specialty physician groups, many of which are thinly capitalized, hospitals have enjoyed five years of record profits, and have the financial resources to absorb the economic losses associated with starting up and sustaining medical practices. They also have the capital resources and IT infrastructure to facilitate the digital conversion of medical practice. In rural areas, the hospital will likely become, by default, the employer of last resort for a majority of the community's physicians.

Many hospital executives remember the large economic losses, political disputes, and poor relationships engendered by hospitals' last foray into physician employment in the 1990s, so this time around they are approaching the strategy differently. There will be far fewer practice buyouts, and compensation packages will be less generous and focused better on clinical productivity.

Further, hospitals are unlikely to pursue physician employment to increase profits or obtain health plan contracts (two strategies that had limited success in the 1990s). Extending the hospital's imperial dominion into the physician sphere is not what this new wave of "integration" will be about. Rather hospital involvement in physician practice operations will



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be, in most places, an exercise in damage control and loss avoidance. Transparency, wide consultation in the broader physician community, and guidance from statesmen in that community are all essential to navigating the potential landmines in this delicate process.

The fact that there are no investor-owned practice management firms bidding up the prices for physician practices, as was the case in the 1990s, and relatively few competitive bidding situations between hospitals, should contribute to economic sanity. Hospital bargaining leverage is also strengthened by the Deficit Reduction Act of 2005's reductions in freestanding imaging payment and recent Centers for Medicare & Medicaid Services reductions in ambulatory surgery payment for freestanding facilities.

2 Shrinkage of Hospital Dependent Practice

The separation between hospital dependent and hospital independent practitioners will become more pronounced as hospitals increasingly employ hospitalists and intensivists. Many younger physicians with practices that are largely or completely ambulatory are turning away from the hospital and searching for new ways of interacting with colleagues, including the Internet (as evidenced by the explosive growth of Sermo, the physicians-only online community).

This tilt away from hospital-centered practice accounts for the declining rate of growth in hospital admissions over the past four years and the surprisingly rapid acceptance of hospitalists and intensivists in many communities. Practicing physicians in many areas have asked, even pleaded with hospitals to staff up to manage

their hospitalized patients. The shift to intensivists, while much slower, is driven by the same factors: demand from physicians, markedly improved quality of care, and reduced malpractice risk. Still, for hospitals, economic gains have proven elusive.

An important political consequence of this movement is that, as the hospital's medical staff represents a shrinking percentage of the total physician community, the hospital's real power—its power to convene the community's physicians—will diminish. Creating online clinical communities through clinical IT; converting billing and collection to digital, real-time processes; and collaborating to improve clinical quality under pay-for-performance plans present new opportunities for hospitals to add value for physicians who do not directly admit patients.

3 Conflict over Call Coverage

Conflicts with private physicians over the hospital's obligation to provide physician coverage after hours and on weekends will intensify. Today's physicians are less willing to trade their personal time to cover hospital call in exchange for admitting privileges. Hospitals have responded either by paying stipends to independent practitioners for call coverage or contracting with single specialty groups large enough to rotate call internally.

But hospital spending on stipends has soared, and continued rapid growth in these expenses appears unsustainable. So, most stipend arrangements are likely to be replaced by economically accountable contract relationships or, in larger hospitals at least, employment of general surgeons, cardiologists, and others to cover evening and weekend service demands created by emergency surgery and cardiac intervention.

4 Widening Physician Shortages

Without major changes in how primary care physicians are paid, particularly by Medicare, growing shortages of primary care physicians are inevitable. Current surveys suggest that close to 30 percent of Medicare beneficiaries experience difficulty in finding new physicians, and the percentage will increase as baby boom physicians retire in the next decade. Reforming and substantially increasing physician payment for primary care services, through the "medical home" or other models, is essential to avoiding a catastrophic shortage of physicians over the next two decades.

Regardless of what Washington policymakers do about reforming payment, primary care practitioners must also develop a new operational model, which hospitals can help "midwife." Information technology must play a major role in this transition, with more non-clinical or minimally-clinical interactions with patients being handled through automated voice response technology, e-mail exchanges, or with the support of nursing personnel (who will also be in scarce supply). Finally, movement to end-to-end electronic adjudication and payment of medical claims will be vital to reducing practice overhead, a process that Medicare program managers could markedly accelerate with the right policy choices.

But policymakers' perceptions of physician need are not in touch with the realities in many communities. So, hospitals will play a major role in filling widening gaps in physician coverage and in advocating aggressively in Washington and with private health plans for physician payment reform. With a larger stake in the physician enterprise, advocacy will make greater economic as well as political sense. The changing of the guard in medicine will broaden the hospital's role in the larger medical community, even as it is exposed to new economic and political challenges. ○

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