Aligning Physician and Hospital Incentives

Editorial Comment

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Published online: 22 February 2013
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Nothing can be said to be certain, except death and taxes [5]. As in the age of Benjamin Franklin, this is true for us today. Perhaps nowhere is change more immediate today than in health care. The aspects of health care that are evolving include insurance reforms that extend access, new models of care delivery, increasing need for physician and healthcare organization alignment, consumerism and public reporting of metrics and outcomes, and payment reforms for hospitals and physicians [1, 6]. While there are many drivers of this change, the primary issue continues to be the rising cost of health care in the United States [6]. Left unchecked, the rising costs are unsustainable. Young physicians starting their careers today are looking at the potential for increased patient volumes requiring treatment in the face of declining professional reimbursement. Physicians are increasingly being asked to engage with their healthcare organizations to improve efficiency and quality of care delivery [4, 8]. It is likely such alignment between physician and healthcare organizations will increasingly become a necessity to maintain viable support for clinical practice.

Each of the guest editors has unique experiences that led to the development of this symposium entitled “Aligning Physician and Hospital Incentives.” In 2007, one of us

(SAO) had the opportunity to become chief medical officer of Duke University Hospital. During the 3-year tenure in this position, effectively 50% time was dedicated to administration and 50% to clinical practice and research as an orthopaedic surgeon. A primary lesson learned during this experience is that clinicians and hospital administrators see the world of health care from very different perspectives. In 2008, with the establishment of the Medical Economic Outcome Committee process at Vanderbilt University, the other of us (WTO) had similar impressions of the difference in perspective between physicians and administrators. These differences are particularly striking in the perception of how value is created in the process of the delivery of health care. The healthcare administrator views his or her world from an operations management perspective that requires approaching health care as a business. Most physicians are not trained in healthcare administration or even basic business skills in medical school. We owe a debt of gratitude to the many hospital administrators and physician leaders who have helped guide our development in healthcare administration. As we reflected on these differences, it became important to us to find a venue to share what we had learned with the community of orthopaedic surgeons and other clinicians.

Physician leadership is critical to the success of healthcare systems. Physicians with the inclination are important because of the unique training and skill sets to understand patient care, as well as the “institutional” perspective. While physicians can learn to be full-time administrators and lead organizations, without considerable training, administrators cannot become part of a team to provide primary care for patients. This symposium was designed to give a variety of perspectives on how physicians can lead and contribute in several ways. Contributions discuss physician input into leadership of advocacy, governance, and alignment in academic and community practices.

All ICMJE Conflict of Interest Forms for authors and *Clinical Orthopaedics and Related Research* editors and board members are on file with the publication and can be viewed on request.

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Fig. 1 Dr. Steven A. Olson is shown.

Fig. 2 Dr. William T. Obrebsky is shown.

Leadership is also reviewed in service line efficiency, purchasing, and product selection. Examples of how physicians have participated in these areas are demonstrated in a community practice, academic medical center, and integrated network models (ie, Geisinger and Kaiser).

Involvement of physicians as leaders of healthcare efforts to improve quality and safety is not new. One of the early leaders in this area was Ernest A. Codman [2] (see Classic in

this symposium, <http://dx.doi.org/10.1007/s11999-012-2751-3>). Codman is known among orthopaedic surgeons for his seminal work in the shoulder. This complex physician developed the “end results” process, a process of tracking patient outcomes after hospitalization for care [7]. In his early career, he was ostracized for his views concerning the need for physicians and hospitals to monitor their outcomes. However, he persevered, becoming one of the founders of the American College of Surgeons. He developed the first recommendations for hospital standards, including the need to maintain medical records, and he began the first sarcoma registry. In an introductory comment in his 1918 text *A Study In Hospital Efficiency*, he wrote: “It is Idle to Consider the Standardization of Hospitals without considering the Standard of the Product of each Hospital, the part which the Professional Staff plays in raising the Standard of the Product, and the Compensation which the Hospital grants the Staff in return for their services” [3].

Codman’s recommendations in the early 20th century have come full circle. In the 21st century, these ideas are being driven by regulatory agencies and payers. The need for surgeons and physicians of all disciplines to engage in these discussions is critical. Changes in health care are coming. It is important that as physicians we begin to take on leadership roles in determining the future of healthcare delivery. One of the key steps is to be able to develop sound alignment strategies with healthcare organizations. We hope the reader finds value in the contributions of this symposium.

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