

# From my perspective

**A**s we begin a new year and reflect on the holiday season that has just passed, we must prepare for the challenges ahead. This month marks the fifth anniversary of the release of the Institute of Medicine's report, *To Err Is Human: Building a Safer Health Care System*. This landmark study galvanized all medical and health care professionals to undertake an effort to critically examine our current health care delivery system and seek out opportunities for improvement. Clearly, the College has taken its role in this process very seriously, and the delivery of safe, cost-effective surgical care is foremost in our minds and on our agenda and always will be.

Concomitantly, we are facing a myriad of changes with respect to the design of our health care system. As I said in last month's column about residency training, many of these transformations are really cultural in nature, pitting the traditional ways of practicing medicine against the innovative. All of us can think of examples of how these shifts have affected our beliefs about health care and the delivery of medical services. The cultural changes include the team approach to providing services, adoption of standards of care and best practices, a focus on an aging population with chronic diseases, and outcomes assessment. The list could go on, but suffice it to say that medicine will never retreat to the practices of the past; rather, it will continue to be driven by new demands for cost and quality controls and the development of a true health care *system*, as opposed to the "nonsystem" that currently is in place.

## **An "immature" model**

As I travel around the country and observe how physicians and hospital administrations interact, I am often surprised at how poorly some of them coordinate services and that they don't really strive to achieve mutual objectives. This situation is in stark contrast to how physicians and hospital ad-



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ministrators acted toward each other in the past. Indeed, in some hospitals outright conflict and hostility surface over such issues as emergency room coverage and requirements for hospital privileges. Likewise, both hospital administrators and health care professionals are often at odds with insurance companies and other payors, largely because of reimbursement levels.

A system containing this much discord could be described as "immature." This overemphasis on self-interests is inherent to a system based on fee for service and results in a patchwork of care for our patients.

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### ***A “mature” model alignment***

In contrast, some providers operate in a manner that allows physicians, other health care professionals, hospital administrators, and payors to work in alignment—with all stakeholders acting in the spirit of cooperation and collaboration. Unquestionably, the physicians in these plans have had to relinquish some of their autonomy, at least as measured by the standards of the past. However, in return, they have gained the opportunity to work in environments in which they, their hospital officials, and the plan administrators all have the same overall mission of delivering quality care at affordable prices.

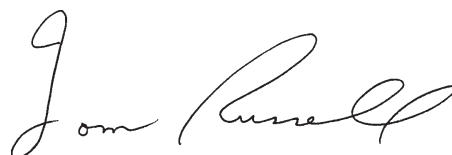
Such groups look at the broader picture of how care can be provided to ensure long-term positive medical and fiscal results, rather than worrying about the immediate incentives sought by the providers of fee-for-service care. They are often self-governed with respect to disciplinary actions and physician education. They analyze efforts to prevent problems and errors, the management of chronic disease, and spending, and they impose appropriate controls as necessary. What emerges is a more mature model that manages not only the quality of care, but also its cost.

### ***Physician interest increasing***

It is estimated that more than 300 medical groups in this country now include in excess of 100 physicians each. Perhaps the oldest and best-known large group model is Kaiser Permanente. Although it may have had problems attracting the best physicians and specialists in the past, Kaiser Permanente now finds itself in the enviable position of having to turn away health care professionals seeking positions because they are already filled. The way in which Kaiser Permanente and other groups that follow its model currently manage benefits, pay, incentives, and time off clearly appeals to the new generation of physicians, who are often con-

cerned about quality of life issues. Furthermore, these systems are clearly in a better position to respond to the evolving needs and demands of the marketplace and purchasers of care.

Only time will tell if these integrated models will be applicable to the country as a whole. But two points are indisputable: The debate over health care reform will continue, and the models that are most likely to survive the imminent turbulence will be those that are best able to adjust to the increasing demands for quality, cost-effective care.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).