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Hospital-physician partnerships are an important part of our healthcare delivery system and can be a key aspect to delivering efficient, high quality healthcare. During the first five years of my practice, I have been privileged to work on and help facilitate various types of hospital-physician partnerships, ranging from joint ventures, to employment relationships, to professional services agreements, to hospital-practice affiliations. I have found structuring these types of relationships to be one of the most enjoyable aspects of what I do, because the parties involved generally desire to collaborate and work together to achieve mutual goals, such as improving the quality of care or bringing down the cost of such care. In the end, after all of the agreements have been negotiated and all issues resolved, the final product is usually an arrangement where the hospital and physician have aligned incentives, which, most importantly, benefits not only the patient, but also the hospital and physician.

For those newer to the practice of health law, it may seem that collaboration between hospitals and physicians is a new trend. There are an increasing number of physicians and hospitals adopting various models of collaboration, ranging from strongly integrated models such as hospitals directly employing physicians, to less integrated models such as equity ownership of ventures (i.e., ambulatory surgery centers). Within the spectrum of integration are professional services arrangements, gain sharing arrangements, and practice affiliations, among others.

While these collaborative approaches have become more popular in recent years, hospitals and physicians have always worked together in some fashion, although the driving factors behind such alliances have differed. For example, in the 1990s, many hospitals bought physician practices in anticipation of the managed care movement. In such instances, the hospital's dual desires to control the physicians and to ensure a strong primary care referral source network were key drivers behind the acquisitions.

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Ultimately, these collaborations (if they could be called that, since the hospital often went in and took over without much physician input on a going forward basis), were not successful. Most hospitals lost large amounts of money because they did not know how to efficiently manage multiple practices and had significant payment obligations to physicians under employment agreements. Thus, many hospitals sought to unwind these arrangements only a few years after the initial transactions. Fast forward ten years, and again we are seeing a large number of practice acquisitions by hospitals and other types of collaborations between hospitals and physicians. Unlike the acquisitions of the 1990s which, as noted, were largely driven by the managed care movement, hospital-physician partnerships today are driven by a number of different factors.

Physicians often desire to partner with a hospital because, among other reasons, the hospital can provide financial security in an uncertain economy. Whether the physician is employed by the hospital, has a service agreement with the hospital or is a joint venture partner with the hospital in an ancillary venture, the hospital, with its size, patient base, and established payor contracts, can serve as a solid foundation on which a physician can establish or grow his or her practice. Additionally, an increasing number of physicians desire work/life balance and a hospital can often offer the desired flexibility that these physicians want in an employment situation. Further, many physicians also want more control over things such as operating room times, nurse coverage and staffing, and supply purchasing. This type of control can sometimes be attained by partnering with, rather than competing with, the hospital.

Hospitals also have incentives to partner with physicians. Partnering with physicians can limit competition with the hospital, build loyalty to the hospital, and assist with recruitment and retention of physicians. More specifically, when structured and properly operated, collaborating with physicians can help a hospital build goodwill among the physicians in the community by showing that the hospital values physician input (assuming the hospital does actually address physicians' vocalized needs). This goodwill can help the hospital bring new physicians into the community, as well as keep current physicians satisfied.

Despite both parties' best intentions to collaborate, there are obstacles to such partnerships that must be overcome. Most importantly, the relationship must be structured in accordance with health care regulations. This may mean, for example, that a physician is not able to be paid as must as he thinks he should because all payments must be fair market value in accordance with various regulations. In addition, these partnerships often require a great deal of negotiation and compromise. Both parties usually harbor biases and fears of the other side. The physicians are typically concerned that the hospital will be too bureaucratic and slow moving to

allow the physicians to achieve the control that they want. In other words, there may be too many layers of bureaucracy to work through in order to gain approval for specific purchasing requests or staffing and scheduling preferences such that any control that the physicians thought they had was actually just perceived and not actual control.

The hospital, in contrast, may be concerned that the physicians will want too much control over governance and that the hospital may be unwilling or unable to cede as much control as the physicians desire. The end result of addressing both parties' concerns is a sort of détente, or delicate balancing act, where each party must concede a bit in order to achieve the greater goal of a successful partnership. Additionally, the parties generally share the concern that the arrangement will not meet the expectations of both parties, or will not be successful which could lead to infighting and disputes. This is why any documentation of the partnership or collaboration must include specific provisions addressing dispute resolution.

Despite the obstacles, hospital-physician partnerships are beneficial for several reasons. First, these partnerships have the ability to take a sometimes tenuous relationship between hospitals and physicians and turn it into a strong, collaborative relationship. The hospital and physicians will have to work through numerous issues (which will vary depending on the type of collaboration but may include issues such as non-competes, salary, and governance and control), in the process of moving from point A to point B. Negotiating these issues requires that each party's concerns and fears be discussed and resolved. Ultimately, the parties often better understand one another after working through all of the issues. The improved understanding between the parties can positively impact health care delivery by, for example, improving continuity of care by decreasing turnover in the physician community.

Second, partnerships can allow both the hospital and the physicians to achieve their independent and mutual goals. The physicians may hope to obtain a better work-life balance or to have a greater voice in the operation and governance of the hospital or ancillary venture. By becoming employed by the hospital instead of operating independently, a physician may be able to achieve the work-life balance he or she desires. This physician may also have the opportunity to assume leadership positions within the hospital and have a greater voice in governance. For the hospital, a goal may be to improve physician loyalty. By acknowledging the opinions and desires of physicians, a practice critical to building a successful partnership, the hospital builds loyalty among physicians and makes them feel like an important part of the hospital's processes.

Third, collaboration can improve efficiencies and drive down cost. For example, if a group of physicians desires to open and operate an ambulatory surgery center, and the hospital in town also desires to operate an

ambulatory surgery center, the physicians and hospital could instead partner to open a single ambulatory surgery center. Although the ownership (and the profits) would be shared, such a partnership would benefit each party. Specifically, the physicians would not have to shoulder the entire financial obligation of developing a surgery center (which can be expensive) and they also would have access to the management, staffing and billing expertise of the hospital. The hospital would not have to compete with another surgery center in town and could ensure that that the physicians remain committed and vested in the hospital and community. The community would benefit because resources would be efficiently utilized to create one strong surgery center instead of two smaller surgery centers which could cannibalize one another. Similarly, if the hospital and physicians partnered in a gain-sharing arrangement, the aligned incentives of the two groups would result in cost savings for the hospital and ultimately the patient.

As a lawyer who structures these types of arrangements and who often represents the arrangement rather than one of the parties, I have the unique perspective of seeing both sides of the partnership. I have listened to physicians and hospitals outline the merits of their positions, some of which directly conflict with one another. I have had to propose compromise positions and have helped the parties align their interests where they may not have thought possible. While not all hospital-physician partnerships are successful, successful hospital-physician partnerships show what can be possible when groups who may have inherent biases and differences compromise and work together to achieve a greater goal.