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EDITOR'S PAGE

Integration Not Homogenization

I spent a couple of hours last week with my congressman, John Lewis, who is a true icon of the civil rights movement. He was recalling the 50+ year journey he has been on, and it was truly inspirational. However, I am not talking about that kind of integration here, but about the kind that is happening in medicine, especially in cardiology. The rugged individualism characteristic of doctors that was present when I began my medical career has morphed into collectivism. Most of my colleagues will object to that term, but in the desire for security, we have been coming together in larger and larger groups and larger and larger medical organizations. Perhaps a nobler motivation would be a search for quality and improved patient care, but that would be an admission that things have not been optimal. Perhaps we must admit that security has been the overriding stimulus for collectivism.

We physicians are not the only ones who are searching for security in numbers. Our hospitals are now entering into mergers in a "fast and furious" pace (no analogy implied). Partnerships, joint ventures, and outright acquisitions have become standard in order to form larger organizations that can become more effective and competitive. The stated goals are improved efficiencies of scale to enable the institution of quality improvement measures, such as electronic medical records and other systems of ensuring best practice principles. Unstated is the desire to be rewarded for these efforts with improved contracting positions. How this will all play out in terms of improved healthcare at reduced costs remains to be seen. Improved reimbursement is good for the providers but not necessarily for the payers, who are ultimately us. Regardless of the impact of integration on the imperative of more affordable healthcare, integration is a response to the rules that we are now playing by. How will we play the cards we have been dealt?

The private hospital I am associated with has now entered into a joint venture (joint operating company) with a major university system (where I spent my first 30 years of practice). Being able to observe this integration with experience on the academic as well as the community hospital side has enlightened me to some potentials for optimizing these kinds of integrations. Despite both organizations having strong tertiary programs in cardiovascular disease, the cultures of academic medicine and nonacademic medicine are different. The academic, by definition, has responsibilities for varying degrees of teaching, research, and patient care. The commitment to each component differs widely among faculty but all are part of the academic mission. The nonacademic physician, on the other hand, comes to work with the delivery of care being the overriding commitment. How does an integrated hospital system take advantage of these differences?

Of the 3 components of academic medicine, teaching is the one that will be least impacted by this kind of integration. At least in my institution there is no need for nonacademic practitioners to participate in medical student or house staff teaching beyond what some already do as volunteer faculty. In other institutions this may be needed. It is the other 2 legs of the academic stool that can benefit most from integration. The addition of many new patients to a system can enable recruitment for clinical investigation. In order to make this work, the "nonacademic" physicians must be viewed as more than suppliers of "clinical material" and having them actively engaged in trial design and execution will ensure relationships that can succeed. There is no question that participation in clinical investigation

Spencer B. King III, MD, MACC

Editor-in-Chief, *JACC: Cardiovascular Interventions*

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entails commitment of time and effort that frequently are not reimbursed. Therefore, the other rewards must be considered when recruiting the practitioner into the project. The academic faculty should have, in most cases, the leading role in clinical research, but there are exceptions. On the other hand, the "nonacademic practitioner" frequently has more experience in efficient delivery of care. Some of my colleagues whose success depends almost completely on effective and efficient care delivery have honed those skills to a fine edge. Integration with academic institutions provides the opportunity for those lessons to be applied by the faculty, as well as the nonfaculty physicians. Some observational research may be best led by physicians whose main commitment is care delivery.

Beyond the categories of patient care, teaching, and research, there are opportunities to develop multispecialty "heart team" approaches to improved care and investigation. As structural heart disease becomes a centerpiece of interventional cardiology, the collaboration of cardiologists, cardiac surgeons, vascular surgeons, anesthesiologists, and others is essential to building optimal programs. The nonacademic institutions usually do not have departmental structures and the integration of multiple disciplines may be easier to accomplish. This in turn should be stimulus for those multidisciplinary units to involve the faculty and nonfaculty participants with the sole objective of fostering the structural heart disease program. Similar approaches to heart team decision-making in revascularization and other areas should also be provided.

What are some of the pitfalls of integration of academic and nonacademic organizations? Physician incentive is beyond the intent of this brief discussion, but equitable reimbursement systems that reward group effort as well as individual contribution is essential. Whether on the faculty or nonfaculty side, the current fee-for-service system provides a convenient but perverse metric to reward the contributions of collective participants. Fee-for-service, for now, is the card that we have been dealt. That, by most accounts, will change, but regardless of the method of computing reimbursement, the principles of rewarding the effort of the team will be necessary to achieve optimal results. Organizational structure can be an impediment to effective integration. Deans and department chairs may not appreciate the potential contribution of physicians outside their chain of command. Nonfaculty physicians may not grasp the opportunity to enhance their practice through academic participation. Although an obvious oversimplification, physicians on faculty are programmed to collaborate on clinical investigations and other programmatic endeavors. Nonfaculty physicians are programmed to care for their patients and practices. Integrated medical organizations should not try to become homogenized, but to look to the respective strengths of all the components of a new organization.

Address correspondence to:
Spencer B. King, III, MD, MACC
Saint Joseph's Heart and Vascular Institute
5665 Peachtree Dunwoody Road NE
Atlanta, Georgia 30342
spencer.king@emoryhealthcare.org