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POSITION PAPER

Ethical and Professionalism Implications of Physician Employment and Health Care Business Practices: A Policy Paper From the American College of Physicians

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The environment in which physicians practice and patients receive care continues to change. Increasing employment of physicians, changing practice models, new regulatory requirements, and market dynamics all affect medical practice; some changes may also place greater emphasis on the business of medicine. Fundamental ethical principles and professional values about the patient–physician relationship, the primacy of patient welfare over self-interest, and the role of medicine as a moral community and learned profession need to be applied to the changing environment, and physicians must consider the effect the practice environment has on their ethical and professional responsibilities. Recognizing that all health care delivery arrangements come with advantages, disadvantages, and salient questions for ethics and professionalism, this American College of Physicians policy paper examines the ethical implications of issues that are particularly relevant today, including incentives in the shift to value-based care, physician contract clauses that affect care, private equity ownership, clinical priority setting, and physician leadership. Physicians should take the lead in helping to ensure that relationships and practices are structured to explicitly recognize and support the commitments of the physician and the profession of medicine to patients and patient care.

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Medicine, a moral community (1) and learned profession, is characterized by a specialized body of knowledge its members must share and teach, a code of ethics and duty of service elevating patient care above self-interest, and a duty and privilege of self-regulation (2). Its commitment entails individual and collective obligations to uphold ethical duties that may conflict with other goals and practices, including those of employers of physicians, physician-employers, health systems, or institutions.

Today, changing practice dynamics place greater focus on the business aspects of medicine. Although employment or consolidation within larger organizations may not be problematic per se, physicians, regardless of practice setting, should challenge business concerns that are placed above the best interests of patients.

The Changing Practice Environment

Most states prohibit the "corporate practice of medicine," although exceptions exist for certain organizational structures and for physician employees or independent contractors (3). Based in state medical practice acts, this doctrine also reflects concerns about the commercialization of medical practice (4), interference with physician clinical judgment and professional self-regulation, and the differing obligations of corporations to shareholders versus physicians to patients. However, questions have been raised about organized medicine's motives in this area and attempts to restrain competition (5, 6). Definitions and enforcement vary by state, but the underlying principle is that individuals or entities without medical licenses should not direct or practice medicine. For example, Indiana's statute allows employment or contractual relationships "if the entity does not direct or control independent medical acts, decisions, or judgments of the licensed physician" (7).

For physicians in changing practice environments, the legal doctrine and practice reality may not align. In 2018, employed physicians outnumbered those owning their own practices (8). Changing market dynamics (including mergers and acquisitions), concerns about the undervaluing of primary care (9), value-based payment models, and regulatory issues (on reporting, compliance, and electronic health record [EHR] requirements) have accelerated. The coronavirus disease 2019 (COVID-19) pandemic is disrupting health care delivery and revenue necessary to sustain medical practices.

Ethics, Professionalism, and the Business of Medicine

Health care delivery arrangements come with advantages, disadvantages, and salient issues for ethics and

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professionalism. Regardless of employment status, fee-for-service incentives may result in more (and potentially unnecessary) tests and treatments; other incentive arrangements might encourage undertreatment (2). Retainer fees or direct primary care practice can raise access, equity, and cost issues (10). Larger organizations may facilitate efficient, innovative, high-quality, and well-coordinated care (11) or access to specialty care, and the accountability created by organizational structures can support physicians' other ethics and professionalism obligations (including medical education and peer review). However, physicians employed in large organizations may experience challenges to the exercise of clinical judgment, professional integrity, or the ability to put patients first (as when outpatient scheduling frequency unreasonably reduces visit time).

Employment of physicians likewise has advantages, such as financial stability, practice management assistance, and opportunities for collaboration and continuing education, but there is also the potential for dual loyalty when physicians try to be accountable to both their patients and their employers (12). Dual loyalty is not new; for example, mandatory reporting of communicable diseases may place societal interests in preventing disease at odds with patient privacy interests. However, the ethics of everyday business models and practices in medicine has been less explored (13).

Trust is the foundation of the patient–physician relationship (2). Trust, honesty, fairness, and respect among health care stakeholders support the delivery of high-value, patient-centered care. Trust depends on expertise, competence, honesty, transparency, and intentions or goodwill (14). Institutions, systems, payers, purchasers, clinicians, and patients should recognize and support "the intimacy and importance of patient–clinician relationships" and the ethical duties of physicians, including the primary obligation to act in the patient's best interests (beneficence) (15).

Business ethics does not necessarily conflict with the ethos of medicine (16, 17). Today, physician leadership of health care organizations may be vital for delivering high-quality care and building trust (18), including in health care institutions. Truly trustworthy institutions may be more successful (in patient care and financially) in the long term (19, 20).

Blanket statements about business practices and contractual provisions are unhelpful; most have both potential positives and potential negatives. Nevertheless, it is important to raise awareness of business practices relevant to ethics and professionalism in medical practice and promote the physician's ability to advocate for arrangements that align with medicine's core values. In this paper, the American College of Physicians (ACP) highlights 6 contemporary issues and offers ethical guidance for physicians. Although the observed trends toward physician employment and organizational consolidation merit reflection, certain issues may also resonate with independent practices and in other practice settings.

METHODS

This paper was developed on behalf of the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP's conflict-of-interest policy and procedures (www.acponline.org/about-acp/who-we-are/acp-conflict-of-interest-policy-and-procedures), and appointment to and procedures of the EPHRC are governed by the ACP's bylaws (www.acponline.org/about-acp/who-we-are/acp-bylaws). After an environmental assessment to determine the scope of issues and literature reviews, the EPHRC evaluated and discussed several drafts of the paper; the paper was reviewed by members of the ACP Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and other committees and experts; and the paper was revised to incorporate comments from these groups and individuals. The ACP Board of Regents reviewed and approved the paper on 15 September 2020.

BUSINESS PRACTICES, EMPLOYMENT, AND ETHICS: RECOMMENDATIONS

Incentives in the Shift to Value-Based Care

Health care financing is shifting from volume-based fee-for-service to value-based health care to try to achieve better patient outcomes and lower costs while reducing inequities in care. Primary care necessarily plays a central role in achieving these goals (9). This requires investment in primary care and the clinical relationships that patients value.

When aligned with medical ethics and professionalism to promote the best interests of all patients and to support evidence-based care, value-based care incentives can support high-quality care delivery (21). However, previously voiced concerns about pay-for-performance seem applicable now (22, 23) and may be validated by mounting evidence (24). These concerns include inappropriately influencing patient or physician choice, failing to account for complex medical illnesses (particularly for older adults), failure to demonstrate appropriate respect for autonomy, and creation of barriers to access for disadvantaged patient groups. A fundamental concern is whether the use of extrinsic incentives—financial or nonfinancial—actually undermines the intrinsic motivation of physicians (a phenomenon known as "motivational crowding"). Paying physicians incentives could reduce intrinsic reasons or motivations of professionalism, clinical integrity, and the sense of medicine as a calling (25–27).

Referral-based incentives can encourage efficient, coordinated care but may also restrict patients' choice of physician and affect how care is delivered. Ethics requires that incentives for referrals be transparent to patients and physicians; be based on appropriate, patient-centered metrics, such as continuity, convenience, time, and costs (particularly to the patient); and not inappropriately influence decision making (28). Incentives must not disadvantage classes or categories of patients, including underinsured and uninsured patients (2).

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The potential for conflicting incentives must be recognized. When performance incentives are based on volume (for example, number of patients seen or procedures performed), it can be challenging for physicians, who are increasingly taught to focus on value, to "do the right thing." It is inconsistent to judge physicians solely on relative value unit (RVU) performance when, increasingly, the societal goal is instead to deliver high-value care.

An obligation exists to monitor for adverse effects and unintended consequences of external motivators. Professionalism can be co-opted. Physicians' commitments to excellent patient care and their efforts to engage in such activities as charting, responding to patient portal messages, or authorizing electronic refills at all hours of the day can inadvertently hide system inefficiencies, harm clinician well-being, and lead to clinician deprofessionalization. Regardless of system incentives for fee-for-service or capitation arrangements, "physicians must not allow such considerations to affect their clinical judgment or patient counseling on treatment options, including referrals" (2). ACP ethics position papers further discuss these issues (15, 22).

ACP Recommendation 1: Ethics and professionalism must be emphasized and explicitly addressed in the implementation of business practices and employment relationships, including in the face of external motivators for clinicians, such as financial incentives.

Contract Clauses Affecting Care

In-Network Referrals

Contracts may require physician referral within the institution or system, resulting in narrow or closed referral networks. A recent Supreme Court ruling, when applied to health care, could allow large health insurers or systems to create contract-based barriers to referring out of network (29). In principle, such provisions may aid patient care responsibilities (for example, by avoiding unnecessary duplicative testing done because records cannot be accessed "out of network") and consultation (for example, by improving care coordination). In practice, whether because of strict payer restrictions or financial constraints, such as higher out-of-pocket costs, they may also unduly limit physician recommendations (as the unfortunate term to describe them, "leakage control," may imply), patients' choice of physician, or equitable access to the most skilled physician for a particular condition (28).

"Outside" Activities

Contract provisions prohibiting the practice of medicine outside one's employment may limit physicians' nonclinical "outside" activities. These provisions could restrict or appear to prevent physicians from fulfilling their societal commitment to teach, to engage in unbiased research, and "to advocate for . . . the public" (2).

Restrictive Covenants

Restrictive covenants, or "noncompete clauses," are governed by state law. They attempt to balance the interests of employers (who may have invested resources in helping a physician develop a patient panel and requisite skills) and the public (through regulation and stabilization of a competitive marketplace by, for example, preventing "bidding wars" over physicians) with the interests of the physician who leaves the practice later. They may restrict physicians from practicing for a specific period within a particular geographic area after departure. Although higher compensation or other benefits may accompany restrictive covenants (30), restrictions may disrupt patient–physician relationships or access to care or interfere with the responsibility to notify patients or forward medical records if a physician leaves a practice (2).

The maintenance of strong patient–physician relationships is paramount. Employment contracts should not restrict physicians' actions to promote patients' best interests. ACP supports the American Medical Association recommendation that physicians should not sign contracts with restrictive covenants that "(a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician" (31). What constitutes an unreasonable restriction requires case-by-case analysis; a 20-mile restriction may be considerable in an urban area but not a rural one, and large, geographically widespread health systems may pose unique challenges related to restrictions. Such clauses may be less likely to adversely affect patients when a practice is sold or when a physician retires (when issues of competition and patient choice are less relevant) (32).

Contracts should not prohibit outside activities that do not interfere with the physician's duties as an employee and should include due process (12). Physicians should scrutinize contracts that include unreasonable "hold harmless" clauses or lack remedy provisions if employers fail to meet their contractual obligations (12, 33). The ACP contracts guide (34) advises physicians to negotiate so as to limit a covenant's geographic and time restrictions and address specific remedies for violations in advance. Because restrictive covenants are a matter of state law and vary widely, consulting legal counsel on these and other contractual provisions is advised.

In the past, physicians were arguably in a stronger position to negotiate contract terms. Yet even today, physicians should feel empowered to negotiate and, if necessary, refuse to accept terms that do not align with ethics and professionalism.

ACP Recommendation 2: Contract provisions affecting practice should align with the ethical commitments of physicians and be subject to negotiation that recognizes that alignment.

Contract Clauses About Confidentiality

Contractual limitations on physician disclosures or speech ("gag clauses") are, in general, ethically problematic. They can undermine trust in the patient–physician

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relationship, violate informed consent, and obstruct the physician's ethical duty of beneficence. Ethical analysis of clauses was extensive in the 1990s during the managed care era (35, 36). Recently, different types of clauses have arisen.

Clauses about EHRs can prevent disclosure of problems with EHRs or "hold harmless" (of liability) EHR companies (37, 38). Vendors say these clauses are narrowly focused and protect confidentiality and intellectual property. However, physicians and others worry that overly broad clauses stifle discussions about problems that affect patients or slow workflow (39, 40) and discourage error reporting (41). Clauses vary among technology vendors and may be difficult to oversee. Federal regulations now restrict some types of clauses (42).

Blanket confidentiality clauses or nondisclosure agreements could prevent physicians from discussing other safety, quality, or problematic practices for fear of legal action (43). Such clauses may make it difficult for safety and quality concerns to become known. They can compromise professional integrity and physician ethical obligations with regard to disclosure to both individual patients and the community (2). In addition, they permit few avenues for remediation, other than whistleblowing.

These clauses may seem removed from patient care, but their implications must be fully considered. The principles of transparency and honesty also require this. And, as ACP has reiterated during the COVID-19 pandemic, physicians should not be at risk of being fired for speaking out on patient welfare and patient and health professional safety (44).

ACP Recommendation 3: Confidentiality clauses should not interfere with patient well-being, respectful professional relations, or the individual and collective responsibility of physicians to promote patient best interests, community health, and quality improvement.

Contract Clauses About Termination

Some contracts allow for termination without cause, meaning an employer could terminate a physician's employment without having to provide justification. Physician employees may be "at will" employees, their employment subject to termination without cause unless other contract provisions govern termination. There may be advantages to these arrangements if the contract allows the employee to terminate the employment relationship or provides flexibility for parting ways on mutually accepted terms. Termination without cause may also avoid litigation costs.

However, abrupt terminations can interfere with the continuity of the patient–physician relationship, and the possibility of termination without cause may prevent physicians from addressing safety and quality issues or lead to their being labeled "disruptive" (43). Although truly disruptive behavior can negatively affect patients, physicians, other health care professionals, and the culture of health care (45–48), advocating for patient well-being is not only appropriate but also an ethical obligation (2). Physicians should also advocate for practice environments that foster physician well-being and safety, as has been done during the COVID-19 pandemic with advocacy for personal protective equipment and patient care resources, provided such efforts do not include joint actions that harm patient access to care or result in anticompetitive behavior (2).

The ACP contracts guide (34) recommends that any provisions related to termination without cause be reciprocal (meaning the physician has an equal right to terminate the employment relationship without cause) and time-limited (for example, during only the first year of employment). Employers may recognize that the potential adverse effects on their reputation for terminating without cause may outweigh the benefits.

ACP Recommendation 4: Physicians should consider carefully whether to sign an employment contract that permits termination without cause. Provisions related to termination should be reciprocal and time-limited.

Private Equity Ownership

Private equity firms are acquiring physician practices as part of a trend toward private equity investment in health care (49). Physician practices acquired by private equity increased from 59 in 2013 to 136 in 2016 (50). However, data are limited and lag behind the trend. Because of financial strain on practices during the COVID-19 pandemic, private equity interest may increase in its aftermath.

Typically, private equity firms purchase a large stake in a physician practice, invest resources to expand market share, increase revenue (for example, by adding services), decrease costs, and then sell the practice within a few years to generate returns for the firm's investors (51). The practice may be sold to another private equity firm, a large health care conglomerate, the public via an initial public offering, or an insurance company. This desire to sell the practice soon after acquisition can create the incentive to sell off parts of the practice or undertake drastic short-term cost-cutting measures, including staff layoffs, to make a potential sale more attractive. Insurance companies may further narrow their networks or restrict patient access to only their employed physicians (52). Because of their current value, relatively limited supply, and perceived future earning potential, dermatology, radiology, and ophthalmology practices particularly interest private equity firms (53–56).

The additional investment private equity provides can provide resources necessary to maintain practice solvency and promote practice innovation. However, firm ownership can limit physician control over the practice, and the need to generate returns in a short time frame can compete with other interests, such as long-term investments in safety and quality (57). In one high-profile case, Hahnemann University Hospital in Philadelphia, Pennsylvania, was purchased by a for-profit corporation and closed abruptly a year later; its closure within 4 weeks of announcement left patients without access to care and medical trainees and staff without positions (58).

The private equity firm might also limit practice populations, such as Medicaid or Medicare patients, due to

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lower rates of reimbursement or higher complexity (59). This can conflict with physicians' obligations to promote justice and fairness in health care and the ethical commitment to serve all patients. Private equity–owned practices have been accused of intentionally engaging in aggressive or surprise out-of-network billing practices that adversely affect patient financial well-being and foster distrust (60, 61).

Physicians who sell to a private equity firm must assess doing so with attention to potential effects on ethics and professionalism. At present, there is insufficient evidence comparing the clinical performance and ethical implications of private equity ownership versus other practice arrangements (partly because of nondisclosure agreements in some private equity agreements). Caution is needed.

ACP Recommendation 5: The net value of private equity investment in physician practices for patients, physicians, and medicine is unclear. Systematic studies of this trend on patients, medicine, and society are needed.

Clinical Priority Setting and Time

Clinical priorities at the practice level can be influenced by different parties, including government (for example, via regulations regarding quality measures), payers (for example, via value-based payments), health systems, and institutions. Together, these can influence which clinical conditions receive attention and how care is delivered. Ideally, these interests will align with those of individual patients and overall population health, but that is not always the case. Employed physicians may have less control over how employer organizations respond, which can create challenges for respect of patient autonomy, justice, physician professional integrity, and the primary obligation of beneficence.

Increased financial pressure on organizations to meet certain quality metrics or spending benchmarks at the aggregate level may be cost-effective and good for the overall health of a population, but there can be unintended consequences (23). Organizations may exclude or limit certain patients, including underinsured or uninsured patients, who are perceived to be more clinically challenging or to result in lower reimbursement. Denying care on the basis of the ability to pay can compromise physicians' commitments to ensuring all people receive care and honoring medicine's social contract with society (2).

Even high-quality metrics that support population health have varying benefit to individual patients. Patients and physicians may feel undue pressure to start use of new medications to meet a metric when doing so provides minimal benefit, especially for patients with complex comorbidities. Physicians may be prompted by EHRs to use certain diagnostic codes that are not entirely accurate but maximize reimbursement. Billing for services that are not provided is unethical (2). The very need to address such metrics and coding issues can shift physician focus to them.

These and other shifts in focus take time, which is a precious and limited resource that is valued highly by patients and physicians yet undervalued by existing health care payment structures (62, 63). Shrinking time for direct patient–physician interaction during visits has ethical implications (64). Effective communication, counseling, physical examination, and expression of compassion take time. Concerningly, women physicians may experience greater time pressures in practice and may be disadvantaged by existing reimbursement systems (65). Less time pressure exists where there is better alignment in values between clinicians and leaders, greater perceived clinician control over the work environment, and a stronger emphasis on quality over productivity (66). This may also have the positive effect of encouraging physicians who may otherwise retire to continue to share their expertise by practicing part-time. Although efficiency can be a legitimate goal, time is also an important, patient-centered metric of health care quality.

Health care payers and organizations increasingly engage in direct patient outreach about medications, health care maintenance, and other health issues. Even if motivated by financial gain, outreach can help improve care quality for individual patients. Nevertheless, these activities involve ethical questions of justice or resource allocation and potentially affect patient–physician relationships (67). Focusing on blood pressure control, for example, may mean that depression or substance use disorder is not addressed. When organizations reach out directly to patients without physician awareness, they may inappropriately capitalize on trust in the patient–physician relationship or disrupt that trust.

Employed physicians should ensure that patient and physician voices are heard in organizational priority setting; physician health care leaders should consider maintaining direct participation in patient care, which can be personally fulfilling and provide insights into frontline care (68). Integrated leadership models that include practicing physicians can foster organizational values that support patient-centered care (69). Some data suggest that organizations led by physicians may also be more successful at achieving quality and appropriate cost goals (70). Physicians should advocate for appropriate health care resources, including time and the value of a trusting patient–physician relationship. The physician should not allow specific quality, cost, or population-based goals "to diminish commitment to and advocacy for individual patients" (2), and medicine must maintain its collective voice on behalf of patients (1, 2).

ACP Recommendation 6: Organizations and employers should recognize and appropriately value time for patient–physician encounters and engage patients and physicians in priority setting across all aspects of health care.

CONCLUSION

Business practices can challenge the ethics and professionalism of individual physicians and the collective responsibility of the medical profession to patients. The social mission of institutions can be challenged as well.

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Physicians, whether in training, newly graduated, or with decades of experience, must be aware of the effect business practices, employment terms, and contracts can have on ethics and professionalism. National organizations, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, and medical schools and residency programs should develop strategies for and educational materials on these issues. Because details matter, physicians must be prepared to ask questions about arrangements and feel empowered to advocate for practices that promote patient health and the patient–physician relationship. If a practice or policy harms or has the potential to harm patient care, the physician should speak out and "resist and even refuse to carry it out" (1).

It is also important for physicians to inform patients when these arrangements affect practice. Doing so preserves trust in the patient–physician relationship and helps make patients and society more aware of forces shaping the practice of medicine. Physicians should be actively involved as a major force.

The practice of medicine must be defined by the ethics of medicine. Efficiency and productivity are important but secondary to serving the needs of patients. Intrinsic motivations of service, professionalism, and clinical integrity must guide physicians and be respected by institutions and health systems. Trust in systems, individual clinicians, and the patient–physician relationship demands no less.

The challenges to care and medical practice during and after the COVID-19 pandemic underscore the need to reemphasize the ethical foundation of medicine. The commitment to ethics in the response of clinicians to COVID-19 has helped sustain the profession and society in the emergency. Some see in COVID-19 an important "lesson that the system can be reset" to better serve both patients and clinicians (27). Looking anew at the environment in which care is delivered, physicians should lead in ensuring that business relationships explicitly recognize and support the fundamental and timeless commitments of physicians and medicine to patients.

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