

Virtual Mentor

American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 141-144.

JOURNAL DISCUSSION

The Physician-Employee/Hospital Partnership

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Belde DM. Physician employment in an era of health reform: using shared ideals to achieve social interests. *Health Prog.* 2012;93(2):62-71.

Changes over the last 30 years in how medical care is delivered and paid for in the U.S. have put financial and administrative pressures on solo and small-group-practice physicians. As a result, more and more are becoming employees of hospitals or health care organizations. While becoming an employee reduces the financial uncertainties of managing one's own practice and relieves administrative headaches, it introduces an equally troubling set of concerns that range from clinical autonomy to ethical decision making.

In "Physician Employment in an Era of Health Reform: Using Shared Ideals to Achieve Social Interests," David M. Belde, vice president for mission and ethics at Bon Secours Richmond Hospital System, presents a vision for how physicians can become hospital employees while retaining their clinical autonomy and professional integrity [1]. I call it his "vision" because Belde describes a true partnership between physicians and health care organizations based upon shared ideals but points to no existing exemplars.

Belde believes such a mutually beneficial partnership is possible if both parties put the "socially directed ideals of the profession and health care organizations" first and only then "get on to the business of making it work operationally" [2]. (Belde's writerly decision to avoid "operationalize" in this sentence tells me he is thinking as a humanist educator first and a hospital administrator second.)

Belde begins by explaining why physicians choose to become employees. The first and most obvious reason is financial security that employment brings [3]. Other "pushes" toward employee status include "administrative burdens associated with participation in private and government-sponsored insurance programs" [3]; financial burdens associated with capital investment in medical technology, clinic facility overhead, rising cost of medical malpractice insurance, and paying off medical education debt; and, finally, the changing priorities of physicians, many of whom now seek more work-life balance [3].

Provisions of the Patient Protection and Affordable Care Act (ACA) that emphasize illness prevention, managing chronic conditions more efficiently, reducing hospital admissions, and providing greater continuity of care compound the inducements for

physician employment that existed before its passage in 2010. Most of these care initiatives rely on close collaboration among numbers of specialties and greater attention to patients' lives inside and outside the doctor's office.

During the 1970s and '80s, "hospital systems employed physicians at a feverish pace," Belde says [4]. He thinks these arrangements failed chiefly because the hospital and health care organization employers tried to manage the practices of their physician workforce on the acute care model appropriate to hospitals. Such organizations' operational strategies, one can infer from this statement, did not transfer to care of patients and families with needs that range from extended management for chronic conditions to patient education, to well-man, -woman, and -child visits to care for mental health problems. Observers of the HMO and managed care era can certainly agree.

The radical reforms in delivery of and accountability for medical care represented in the ACA give physicians and health care organizations a chance to get it right, opines the optimistic Belde, and they can do so if and only if both groups allow the "social ideals foundational to the health professions" to "constrain the self-interests that often tend to dominate their public actions" [5]. Belde defines these foundational ideals as amelioration of pain and suffering in patients, individually and in the aggregate; disease prevention; and clinical research into the causes of and cures for pain and suffering [2].

But in the United States, delivery of health care is a business. Is it possible to strive toward these foundational social ideals and turn the profit needed to sustain the health care enterprise? Here are Belde's suggestions for doing so.

1. Understand health care as a *unique* business activity (emphasis added), one that is meant to serve humanity [2]. With this imperative Belde intends to expose as unethical any practice that ignores preservation of health or prevention of illness on the grounds that treating sickness is profitable and creates jobs for lots of people. The boost to the economic cycle that comes from providing care for sick people would be welcome in another industry, but it cannot serve as a rationale for neglecting conditions that foster illness just so the economy can benefit from treating that illness. (This reasoning re-emerges in principle #3.)
2. Treat health care as a social good. The point here is that "a social good is not, in the financial sense 'owned' by any one individual" [6], but, like education, owned collectively by those it serves. Belde interprets society's collective ownership of health care services on behalf of all its members to mean that business and corporate interests should not have the final say in health care reform [6].
3. Direct health care towards amelioration of social inequities because those inequities, by and large, are the social determinates of health status [6].

The final section of “Physician Employment in an Era of Health Reform” outlines strategies for incorporating these organizational principles into physician-health care organization relationships. Belde believes that creation of the relationship he describes—“envisions” is still the better word—is in the enlightened self-interest of all, and can be achieved if all parties recognize that long-term professional rewards redound from this socially sensitive orientation. He also urges employer organizations to endorse “critical loyalty,” a felicitous term that allows for disagreement and constructive criticism within a relationship to which both parties remain committed [7].

All in all, Belde’s optimism stems from his view that the ACA aligns economic incentives with good medical practices in a way that the U.S. health care system has not seen before [8]. The attentive reader’s question has to be whether Belde’s optimism is naive or experienced. The idea of enlightened self-interest is not a new economic theory, but one of those enduring concepts that, as has often been said about democracy, is the best alternative after all others have failed. We are about at that “all-others-have-failed” place with health care in the United States. We tried the open-market, fee-for-service model until the cost of it became unsustainable and many people were overtreated along the way. We experimented with “managed” (not entirely open-market) care models. These left professionals frustrated, their clinical judgment second-guessed and their autonomy abrogated.

Now comes a model that says, in effect, to physicians and health care organizations “work it out among yourselves.” It preserves professional judgment while holding those professionals accountable for the outcomes and rewarding them when the outcomes prove best for patients and economically sustainable.

Yes, Belde is an optimist, but he did not propose a single-payer system. *That* would have been naive in 2012. Rather he exhorted health care organizations to remember the origins of their enterprise, acknowledge the ideals they share with the profession of medicine, and begin to build their business operations on those mutual foundations.

References

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