

CASE AND COMMENTARY

How Should Commerce and Calling Be Balanced?

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Abstract

Physicians and all health professionals need to find an appropriate balance between the interests of individual patients and their organization's bottom line. Corporatization in health care has complicated such efforts. More and more health professionals function as employees of health care organizations, some of which value leaders' and shareholders' interests over those of patients. When faced with such conflicts, physicians bear a responsibility to put patients first and to advocate for their profession.

Case

Dr D has just completed residency training and has decided to join a large practice near her family. When she was recruited, the practice was negotiating its acquisition by a private equity firm.¹ Shortly after beginning in the practice, Dr D learns from a colleague that the firm's existing network of urgent care centers around the state is staffed by physician assistants (PAs)² whose work physicians in the practice are expected to supervise.³

Dr D expresses concern about being "stretched too thin" when this supervisory role is added to her already full clinical schedule. She is also concerned about whether remote supervision would ensure sufficient understanding of what's going on with patients for her (or any other physician) to adequately supervise and assess whether and when PA colleagues' responses to patients are clinically appropriate. She is particularly worried about whether remote supervision is sufficient when PAs care for patients with multiple comorbidities in the firm's most remote locations. She wonders whether working for this practice is turning out to be far more distressing than she'd thought when she signed her contract. Frustrated, Dr D thinks, *Working for a company that tries to economize personnel at the expense of patients' quality of care is just what I was trying to avoid by coming to work here.*

Commentary

At the core of this case is an ontological question that each physician needs to revisit again and again: Is medicine primarily a business activity that happens to involve the care of patients, or is it a calling to care for patients that cannot afford to ignore sound business practices? Is it more accurate to say that physicians are health care “providers” and patients “consumers” of health care? Is their relationship fundamentally an economic one, or should patients be seen as vulnerable human beings whom physicians are called upon to serve for reasons that are professional, humane, and perhaps even sacred?

Professional Issues

Many questions can be raised about Dr D, her employer, and the difficult situation in which she finds herself. How deeply did Dr D inquire into the nature of her employer’s business model, [utilization of PAs](#), and evolving ownership, and how accurately did representatives of her employer describe the nature of her employment? As a practical matter, one of the most important steps prospective employees and employers can take to promote a fruitful and enduring relationship is to ensure that both parties to an employment contract understand one another’s expectations and cultures. This seems not to have been the case here.

Of course, an even deeper issue is in play—the fact that Dr D is not only joining a practice but also becoming an employee. For much of US medical history, physicians enjoyed an ownership interest in their practices, which ensured that they bore some degree of control over how their practices were structured and operated day to day.⁴ When a medical practice, a hospital, or a health system is acquired by a private equity firm or a publicly traded company, the loyalties of the people making business decisions and the loyalties of those to whom they answer are likely to be focused on rates of return on investment (ROI).⁵ For the time being, providing health care offers a relatively high ROI (which explains why such firms have invested so heavily in it), but that could change. When it does, who will remain on hand to serve the welfare of patients and communities?

Another issue at play here is Dr D’s responsibility to supervise other health professionals—in this case, PAs at remote sites. From the point of view of a profit-focused health care firm, the employment of physicians may be an inconvenient necessity required to satisfy accreditors, regulators, and payers. Such a firm might prefer, wherever possible, to shift patient care responsibilities to lower-cost health professionals, such as PAs, in order to boost ROI. On the other hand, physicians might not wish to locate or commute to remote sites, making it difficult to provide services to patients in

need. In theory, [telehealth](#) offers one solution to this challenge. When push comes to shove, however, a physician's judgment that patients are being placed at risk through poor supervision should prove determinative.

Protecting Patients

There are numerous ways that patient interests can be [protected](#). One way would be through adequate staffing. An effective triage system might also address the problem by ensuring that complex patients with multiple comorbidities are seen by appropriately qualified health professionals. Still another means of addressing the problem would be to ensure that physicians are available in remote facilities. This option might require offering higher compensation or other benefits to make such postings sufficiently attractive, but in a practice that puts patient interests first, doing so should be understood as a necessary cost of doing business.

Of course, the PAs in this case also bear professional responsibilities. They should clearly understand their own scope of practice and their legal and ethical obligations to ensure that they enjoy adequate physician consultation and [supervision](#). Dr D would be well advised to talk with them about the nature of their daily work and perhaps to visit them at their practice locations. What kinds of patients are they seeing, and what is the scope of decisions they make in caring for them? Would they like to see more physician engagement? It is quite possible that many PAs feel uneasy about exceeding their scope of practice and would like to see the organization develop a better system of collaboration between PAs and physicians.

Dr D also needs to speak with colleagues in medicine in and outside her firm. How do they regard their workload—both the patients they see firsthand and those whose care is provided by PAs under their supervision? Do they believe Dr D's concerns are largely unfounded and, if so, why? If they share her concerns, can they cite specific cases when patients suffered as a result of remote supervision? Do any of them have suggestions for how the situation could be rectified? Are there examples in the organization of PA-physician teams that appear to be functioning well together, and could their approaches offer lessons for the rest of the organization? By learning more about what her colleagues think, feel, and do, Dr D can approach the situation with deeper understanding.

Forcing Dr D to stretch herself too thin is not in anyone's best interest. An employer that enforces unrealistically high expectations for physician productivity is merely sowing the seeds of physician burnout, with accompanying higher rates of error and patient dissatisfaction.⁶ Patients will

also suffer. Ultimately, even the employer will suffer, as physician recruitment and turnover deteriorate. Good physicians will not seek employment in poor-quality practices, and eroding physician quality will not work to any organization's advantage. An employer seeking to make a quick buck might judge such sacrifices tolerable, but no one with a long-term commitment to patients, health professionals, and the community could conscience such a practice.

Organizational Response

How the practice and its owners respond to the concerns of Dr D and others would offer deep insight into what kind of an organization it is. It might care very little for patients and health professionals, regarding them as mere commodities. Or it might be doing the best it can under difficult economic circumstances. Does the organization take the expression of Dr D's concerns seriously as a learning opportunity, attempting to adjust its practice model accordingly, or does it dismiss them out of hand? Does anyone in the organization engage with her in a personally responsible way, or is she met with handwaving and vague expressions of regret about "the system?" Does anyone seem to care about her capacity to practice medicine in a way she is proud of, or is she met with attempts to silence, isolate, and intimidate her?

Calling Over Commerce

We might think Dr D's concerns are novel and perhaps even unprecedented—the product of new health information technology, health care payment systems, and the corporatization of medicine. In fact, however, the underlying issues are as venerable as medicine itself. One of the finest voices of medicine's conscience, Sir William Osler, well captured the timeless nature of such concerns when he wrote, "Our fellow creatures cannot be dealt with as man deals with corn and coal; 'the human heart by which we live' must control our professional relations."⁷ In other words, patients, families, communities, and the profession must never be treated as mere means of making money.

Osler warned physicians never to allow business considerations to trump the higher calling of compassion and hope.

You are in this profession as a calling, not as a business; as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow-men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed. You must work in the missionary spirit, with a breadth of charity that raises you far above the petty jealousies of life.⁸

As *professionals*, as opposed to *workers*, physicians should profess something—a dedication to purposes beyond money and self-enrichment. This loyalty implies, at least in some cases, a refusal to participate in—and even a mission to oppose—organizational policies and pressures that violate higher professional responsibilities. There are things a physician must never do, no matter how much an employer promises by way of reward or threatens in punishment. An employment contract is just that—a contract. But medicine is a covenant, a calling to a higher order that supersedes the business objectives of any particular health care organization.

Dr D's choices are multiple. First, she could simply resign, rejecting an approach to patient care that she would not conscience for her own loved ones. Second, she could remain in the organization as an advocate for patients, making the case as effectively as she can for an alternative approach that would better serve patients and health professionals and ultimately redound to the benefit of the organization. Third, whether she resigns or remains, she could make it her business to increase awareness of what she sees as unconscionable threats to patient safety and quality care. Assuming the role of whistleblower might get her fired, but it might also save lives.

Suppose a group of rich people buys a professional sports team and, brandishing financial penalties, termination, and even lawsuits, requires the team's players to start breaking the rules in order to win games. Would the players be obliged to accede to their bosses' demands and start cheating? I think not, and this conclusion remains equally valid regardless of whether employees can appeal to an arbitrator. The players should abide by what they know to be right. More broadly speaking, it is never wrong to do what is right, no matter how dire the consequences. Like athletes who refuse to cheat, physicians who refuse to allow ROI to trump the welfare of patients are always on the side of the angels.

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Editor's Note

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