Not since Catholic Healthcare West (now rebranded as Dignity Health) announced its plan to buy the MSO (management services organization) portion of EPMG (now reorganized as a part of EMP) in 1998 has controversy swirled like that surrounding publicly-traded Tenet Health’s plan to put multiple EM, anesthesiology, and hospitalist exclusive service contracts out to bid at its 11 California hospital facilities. Tenet reportedly sent out RFPs (requests for proposals) sometime in June to EmCare, TeamHealth and ApolloMD, all publicly held entities. Emergency medicine, anesthesia and hospitalist contracts were all placed on the auction block, with essentially no input from the medical staff at the Tenet facilities. Tenet’s managers hoped to eliminate stipends to hospitalist and anesthesiology services by using ED profits to subsidize these specialties. Tenet’s plan sparked the formation of The Coalition for Quality Hospital Care¹, which represents the hundreds of affected physicians and serves as a focal point for information relevant to Tenet’s activities in the contracting matter.

Several months earlier, a Hospital Corporation of America (HCA) administrator at one of HCA’s southern California hospitals approached the longstanding local EM group at that facility and asked that the group, which had provided decades of excellent service, “talk to EmCare.” EmCare had become a subsidiary of Envision Healthcare, which went public in August 2013. HCA subsequently announced a “joint venture” with EmCare, and a significant number of independent EM groups lost their contracts to EmCare.

AAEM has been at the vanguard in voicing serious concerns about corporate practice of medicine (CPOM) violations and fee-splitting in both the Tenet matter in California and HCA-EmCare joint venture movement in multiple states, including Tennessee, Florida and Texas and California. When a group threatened by an EmCare takeover at an HCA site contacted AAEM for assistance, on June 11th, AAEM President Mark Reiter immediately wrote to the CEO at the HCA facility expressing support for the local group, noting their decades of excellent service. When the Tenet issue surfaced, on June 2, 2014, AAEM was the first organization to raise specific issues regarding potential CPOM violations and fee-splitting in a letter sent to multiple Tenet officers and medical staff leaders. The California Medical Association
followed AAEM and wrote Tenet decrying the total lack of input from the local medical staffs regarding the proposed sweeping contract change with a possible major negative impact on the medical staffs’ well-established network of trust-based relationships—the heart of the medical care system in any community. Cal-ACEP, though sharply divided years ago by the CHW-EPMG matter, now followed the CMA and wrote a letter to Tenet that mirrored the CMA’s concerns. ACEP’s leaders did not comment on the Tenet or EmCare matters, and specifically did not reach out to support the hundreds of physicians faced with the potential loss of their positions in communities many have been serving for decades.

Let’s investigate the “why” behind the behavior of Tenet, HCA, Envision, EmCare and TeamHealth, all of which are publically traded entities. If one looks at the “big picture,” beginning with the board of directors and executive team of each organization, I believe it is clear that a very small number of individuals are trying to gain total control of massive cash flow, generating enterprises where the controlling individuals are far removed from the locus of value generation, namely the bedside. Intellectual capital analysis of the balance sheet of any of these large organizations reveals that doctors, nurses and other allied health professionals are the assets whose licenses allow the creation of the overwhelming majority of the value and cash flows as they work with patients to find solutions to their health problems. If one tours the websites of HCA, Tenet, CHS, Envision Health and TeamHealth, paying close attention to bios of the board members and executive offices, and then peruses the SEC filings listing executive compensation, one can gain a sense what may motivate the managers to try to reduce the licensed professionals to fungible assets.

The Corporate Practice of Medicine, Conflicts of Interest and Fee-Splitting

The following excerpt from the Medical Board of California summarizes the bar against the corporate practice of medicine in California:

The Medical Practice Act, Business and Professions Code section 2052, provides:

“Any person who practices or attempts to practice, or who holds himself or herself out as practicing...[medicine] without having at the time of so doing a valid, unrevoked, or unsuspended certificate...is guilty of a public offense.”

Business and Professions Code section 2400, within the Medical Practice Act, provides in pertinent part:

“Corporations and other artificial entities shall have no professional rights, privileges, or powers.”

The policy expressed in Business and Professions Code section 2400 against the corporate practice of medicine is intended to prevent unlicensed persons from interfering with or influencing the physician’s professional judgment. The decisions described below are examples of some of the types of behaviors and subtle controls that the corporate practice doctrine is intended to prevent. From the Medical Board’s perspective, the following health care decisions should be made by a physician licensed in the State of California and would constitute the unlicensed practice of medicine if performed by an unlicensed person:

- Determining what diagnostic tests are appropriate for a particular condition.
- Determining the need for referrals to, or consultation with, another physician/specialist.
- Responsibility for the ultimate overall care of the patient, including treatment options available to the patient.
- Determining how many patients a physician must see in a given period of time or how many hours a physician must work.

To establish a frame of reference where adherence to the highest ethical principles is required to protect the members of a society, let’s consider how the law profession advises its members to comport themselves with respect to the attorney-client relationship, foundational in a justice-based society and analogous to the equally important doctor-patient relationship in the profession of medicine:

From the American Bar Association’s Model Rules of Professional Conduct section on Law Firms And Associations:

Rule 5.4 Professional Independence of a Lawyer:

(a) A lawyer or law firm shall not share legal fees with a nonlawyer...
(b) A lawyer shall not form a partnership with a nonlawyer if any of the activities of the partnership consist of the practice of law.
(c) A lawyer shall not permit a person who recommends, employs, or pays the lawyer to render legal services for another to direct or regulate the lawyer’s professional judgment in rendering such legal services.
(d) A lawyer shall not practice with or in the form of a professional corporation or association authorized to practice law for a profit, if:

(1) a nonlawyer owns any interest therein…;
(2) a nonlawyer is a corporate director or officer thereof or occupies the position of similar responsibility in any form of association other than a corporation; or
(3) a nonlawyer has the right to direct or control the professional judgment of a lawyer.
Thus, lawyers don’t sell their law practices to publically-traded entities, nor do they split their fees with non-lawyers. The interest conflicts inherent in such sell-outs and fee-splitting could destroy the trust at the heart of the attorney-client relationship and undermine justice at every level.

Contrast the foregoing rules of conduct adopted by the legal profession, which has not sold out to Wall Street, with what has happened in emergency medicine and other hospital based specialties. Through a long, perverse chain of principal-agent market manipulations\(^\text{12,13}\) enabled by cleverly crafted information asymmetries\(^\text{14}\), I believe some of our specialty’s greediest individuals have systematically built larger and larger contract management companies and then taken those companies public, reducing individual physicians to fungible commodities and severely undermining medical professionalism in the process.

The following letter, recently received by AAEM, underscores the potential safety risk to the general public if emergency physicians are not free to question a large, publically traded contract management company’s reduced staffing prices—clearly a major CPOM concern:

7-16-2014
Good Afternoon Dr. McNamara and Dr. Reiter,

I would like to express my appreciation of your article \(\text{[on the CPOM]}\). Although I am a practicing physician in Florida, not Texas, and realizing the potential variance in state law, I would like to seek assistance and feedback regarding the following most sensitive matter.

I was formerly employed by [widely recognized, publically traded large CMG], as a new grad having no idea regarding the pitfalls of corporate medicine. I was working during a significant surge, with over 75-100 patients to be seen at the beginning of my 7 p.m. shift, further complicated by the recent [large CMG] administrative decision to cancel calling the “back up help during surges” (to decrease the “increased compensation” budget expense which pays for the “surge back up,” I am sure).

The 1\textsuperscript{st} patients I evaluated were TWO sentinel events who were unfortunately left in the waiting area for 4 hours, violating JACHO stroke regulations as well as standard of care requirements, given that the 1\textsuperscript{st} was a large hemorrhagic CVA with documented right-sided weakness upon presentation (with a [large publically traded hospital chain] tracker [freeway billboard] advertising less than 30 minutes to be seen), and the 2\textsuperscript{nd} was a patient with DKA who was “sleeping” in the waiting area for 4 hours.

In hopes of addressing this administrative change [elimination of backup coverage during surges], I spoke to Mr. [name] (CEO of [the large chain hospital]), who assured me he would address the patient safety issues with [the large CMG] and make the appropriate changes at [the large chain hospital] to properly staff surges.

I then received a call from Dr. [name redacted], SW Regional VP of [the large publically traded CMG] terminating me without notice for “soliciting the [large chain hospital] account as well as the entire [large publically traded hospital chain’s] entire SW Division.” They affirm that they were informed by the CEO that I solicited the account. This retaliation for addressing patient safety issues has established a precedent of fear [emphasis added] among my colleagues against addressing ANY patient issue for fear of losing employment.

The outcome of these two patients, the influence of such staffing and retaliatory techniques on the doctor-patient relationship, obviously affirms the significant influence of corporate medicine on poor patient outcomes.

Regarding these events, does AAEM provide any protection, guidance or legislative authority? Especially given the Florida medical officers [in ACEP] are mostly composed of executive members of [the large CMG] and other contract management entities.

Your feedback and assistance in the matter is greatly appreciated. Thank you in advance for your time.

Sincerely,

Dr. [name redacted]

On September 23 AAEM sent a Message from the President: How You Can Help Us Stop Joint Ventures to AAEM’s membership. I hope the letter above from the wrongfully terminated emergency physician who had the courage to speak out on a major patient safety issue in the form of inadequate ED staffing will inspire others with similar experiences to come forth. I believe a “precedence of fear” about disclosing patient safety and other serious issues is widespread, but I hope others will reply candidly in response to AAEM President Mark Reiter’s request.

As the Coalition for Quality Hospital Care rapidly took shape in response to Tenet’s sweeping attempt to replace hundreds of dedicated physicians serving the 11 Tenet California hospitals, one emergency physician summarized the collective concern of the many physicians potentially affected:

“The proposal to replace local doctor groups with an outsourced staffing solution will negatively affect patient care. The present groups have provided high quality services to their communities, in some cases for decades. This personal accountability and local investment drives the personal, human care that is provided by these local groups. These groups are not being replaced for poor performance but in an attempt to maximize profits. Unfortunately, when doctors become employed by a large corporation, the incentive to increase corporate income will result in minimizing the local investment in the present high quality doctors and discouragement of the special kind of care presently practiced. This means less time
President’s Message

Christensen

to listen to a patient, less willingness to consider the patient’s point of view, lower qualified clinicians providing care. The argument made by these mega corporations is that they can deliver medical care for less. This is known as the economy of scale argument, taught in business school about factories that make “widgets.” We insist, however that hospitals are not factories, doctors are not assembly line workers, and patients are not widgets. We feel that the best care is determined by locally invested doctors who will support and defend the well-being of their patients, cooperating, communicating and collaborating with the health care team.”

This eloquent statement captures the spirit driving the advocacy efforts of AAEM, CalAAEM, CalACEP, the CMA and the Coalition for Quality Hospital Care on behalf the physicians and communities potentially adversely affected by the Tenet proposal. In response to the collective outpouring of support, Tenet did agree to negotiate with a number of the local groups, but I believe our work on this pervasive issue has only begun.

With best regards,

John B. Christensen, MD FAAEM
Cal/AAEM President
AAEM Board Member
Chairman, The AAEM Practice Fairness Council
Editor, The AAEM Practice Fairness Toolkit™

REFERENCES:
12. http://en.wikipedia.org/wiki/Principal%E2%80%93agent_problem [“The principal–agent problem or agency dilemma occurs when one person or entity (the “agent”) is able to make decisions that impact, or on behalf of, another person or entity: the “principal”. “]

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CAL/AAEM Contact
AAEM Liaison: Emily DeVillers, 555 East Wells St., Suite 1100, Milwaukee, WI 53202, www.calaaem.org, (800) 884-2236

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