Reining in the Behemoth: Corporate Medicine and the Individual Physician

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Last week I received sign-out from a colleague I have worked with over the past eight years. I do not know him well, but I have listened to his lectures, chatted with him at social events, and worked alongside him in the emergency department (ED). He is occasionally irreverent, but in the ED, we all have at least a trace of gallows humor. He is bright, funny, and I have always respected his commitment to patient care. As I received his patients, I told him I heard a rumor he was leaving our department. Rather than the usual one-liner and deflecting joke, his expression changed. With shoulders hunched over, he told me his soul had been crushed. His metrics were not good, he was too slow, and he had begun to doubt himself. He questioned whether he could practice clinical medicine. I looked at his list of patients, and reviewed his evaluations after he left. Perfect. No flaws. Thoughtful. What had happened to this buoyant, energetic physician?

This was not an isolated incident. One month ago, I received a note from a friend explaining why he had left emergency medicine. He wrote:

> *I remember one night, the entire Emergency Department felt like it was drowning. The overflow area – a parking lot of patients arriving by ambulance mixed with intoxicated or psychotic (or both) patients – was packed. Several fights had broken out. Nursing was desperate to get patients who could safely leave out the door, and asked me to evaluate a patient in the overflow area for discharge. The patient had been waiting so long to be seen that his buzz had faded. The patient – linear, goal-directed, sober, and non-suicidal – was discharged. A few days later, my former director (truly, a wonderful man) told me the family complained about my care. At my best, I would've called that family before letting him go – just to make sure he had a safe place to go. And I couldn't. I had too many patients to see.*
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> *If the system itself wasn't beating me down, sometimes it felt like others working within the system were. Although rare, the disrespect encountered by other physicians was incredibly demoralizing. If I called the PCP to arrange a follow-up – if I got a call back – I was annoying. If I didn't call the PCP to arrange follow-up – I was an irresponsible doctor…In the end, it was too much.*

The Exodus

The flight from medicine is not unique to my colleagues. One report estimated that over 100,000 physicians had left the work force in 2021.[1] At first glance, I thought this was an exaggeration, but a remarkable number of my colleagues left medicine or shifted practice environments between 2021–2022. During the past year the literature examining the "great resignation" in health care has exploded. A recent Google search about post-pandemic physician retirement returned greater than one million results. Most of the "reports" are based on poor methodology, and the amplified impact of social media undoubtedly creates a pile-on effect. However, some of the research is of high quality. Shanafelt et al have studied occupational burnout longitudinally. His group noted that emotional exhaustion and depersonalization scores were significantly higher in 2021 than in 2020, 2017, 2014, and 2011.[2] Over 62% of physicians had at least one manifestation of burnout in 2021 compared to 38% in 2020, and satisfaction with work-life integration declined.[2] There are numerous reasons behind a physician's emotional depletion and dissatisfaction noted in Shanafelt's study. Workload, the lack of effective treatments early on in the pandemic, short-staffed health systems, as well as the divisiveness and politicization of vaccination – issues out of physician control – have all lead to emotional exhaustion.[2,3,4]

Corporatization

Yet, there may be more to the story. Over the past 30 years, the practice of medicine has been transformed. American hospitals have evolved from local, community board-operated individual hospitals to large systems with central corporate governance. U.S. health-care costs have risen from $721 billion in 1990 to $4.2 trillion in 2021, and account for almost 20% of the GDP. The Centers for Medicare and Medicaid Services (CMS) projects national health-care expenditures will reach $6.2 trillion in 2028.[5]

Physician practices have evolved rapidly, as well. In 2012, 60% of practices in the U.S. were physician-owned, and less than 6% of physicians were direct hospital employees.[6] Times have changed. Within one decade hospital systems now dominate the industry. Almost 75% of physicians are employed by hospitals, health systems, and other corporate

entities which frequently span many communities and multiple states, and hospital systems control over 80% of U.S. inpatient hospital beds.[6,7,8] The early promise of the corporate health/physician bargain was alluring – physicians would be allowed to practice medicine without the administrative red tape and financial stressors of practice management.[9] Unfortunately, this promise went unrealized. Physicians spend almost two hours on administrative tasks and electronic health records for every hour of patient care.[10] Additionally, a new player has entered the health-care equation. Private equity groups have targeted health care and physician practices because, at $4 trillion, to paraphrase Willie Sutton, that is where the money is.[11] While data is murky, many of these groups generate profits through decreased labor costs (stagnant salaries and lean staff employment).[7]

The government has been complicit in this radical transformation. Medicare physician payments, often used as a benchmark for private insurers, have not kept pace with inflation and the consumer price index, effectively falling 26% between 2001–2023.[12] It is no coincidence that burnout and emotional exhaustion have accompanied the shifting focus of health care from individual practitioner to employed physician. Combined with the burden imposed by a prohibitively expensive and serpentine regulatory environment replete with unintended consequences, physicians have traded away personal autonomy – the cornerstone of physician well-being – for an increasingly fragile sense of financial security.[13]

Academic medicine faces both economic and political challenges, as well. While some enterprises are physician-led, as systems enlarge differences in perspectives and incentives between rank-and-file physicians and their leadership are often divergent.[6,8] The financial and personal peril associated with quarterly metrics, which are often beyond the control of an individual, are frequently substitutes for quality indicators in corporate academia. They contribute to year-end performance evaluations, which are tied to salary growth. However, metrics such as patient satisfaction, which use questionable survey instruments, may be inversely related to physician performance.[14] Other metrics are often system-driven and invalid measures of physician efficiency. Some metrics are collected for "informational" means, giving physicians a sense that "Big Brother" is omnipresent and continually calculating. Additionally, both academic and community practices often use relative value units (RVUs) for remuneration, despite documented flaws, and in some centers, salaries are at risk.[15]

Unionization

The evolution of U.S. medicine into a corporate behemoth has not been fully appreciated by our profession. CVS' purchase of Oak Street Health for $10 billion (it is, of course, ironic that physicians cannot own pharmacies in RI) and Amazon's purchase of One Medical are some examples of a rapidly changing landscape. In a recent editorial in *JAMA*, Richman and Schulman ask what happens to the medical profession and medical practice when physicians are no longer independent. They suggest that physician employment by corporate hospital systems pose a challenge to professionalism and the medical community, both of which act as a counterweight to market incentives. They suggest that corporatization could diminish physician's long-standing devotion to patient welfare.[6]

While there is no simple answer, the authors present a compelling argument that collective bargaining through unionization might be an antidote to the increasingly toxic milieu facing physicians.[6,8] Physician unions have only had a small penetrance in U.S. health care and only about 6% of practicing physicians are union members.[8] In contrast, over 50% of physicians in the UK belong to unions. However, the trend in the U.S. is rising. Residents at Stanford, the University of Southern California, and the University of Vermont have had successful organizing drives. A recent commentary in the *Wall Street Journal* reported that residents at Mass General Brigham are attempting to unionize in an effort to reclaim their professional autonomy and identity, and the National Labor Relations Board has received petitions to initiate the unionization process in several physician groups.[8,9]

I have mixed emotions about such a prescription – it certainly is not what I imagined during my training. However, change is the one constant in our profession. Younger physicians do not know any way other than corporate medicine, and perhaps it is an acceptable future for recent graduates. Mid-career and older physicians sense the imbalance, but many have adapted or are resigned to the change. On a personal level, I feel powerless trying to support my friends and colleagues who have succumbed to the hardened path carved by corporate health care. I sympathize with my fellow physicians who, to paraphrase Arlo Guthrie (I am a Boomer, after all), feel as if they have been "injected, inspected, neglected and dejected."[16] The differential diagnosis for their malaise is relatively narrow, but it does appear that physicians have an additional management option at their disposal. ❖

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