



Ethical Perspectives On Health Care Reform

PHYSICIAN EMPLOYMENT IN AN ERA OF HEALTH REFORM

Using Shared Ideals to Achieve Social Interests

By DAVID M. BELDE, Ph.D.

The reform of our health care delivery system is well underway. In reality, it has been part of a broader and ongoing evolutionary process aimed at improving the way health care services are delivered and financed in this country. A significant step in this evolution came two years ago, when President Barack Obama signed into law the controversial Patient Protection and Affordable Care Act. For some, this law represents government intrusion and overreach,¹ while for others, it did not go far enough, falling short of achieving adequate, cost-effective care for all.² Regardless of where one sits on this critical continuum, the Affordable Care Act is already altering the practice of medicine in this country.³

One of the more dramatic changes to that practice is likely to be in the relationships between hospitals and physicians. Traditionally, many American physicians have been skeptical of government-driven health care reforms, especially those that could be viewed as a threat to business and their professional autonomy.⁴ Private practice physicians, those who have made an intentional choice to remain independent and who operate on a small- to medium-scale business model, tend to view government reforms with even more suspicion than their peers who have chosen employment with a health care organization.

Health care systems, for their part, tend to view government reforms insularly, tending to focus on how reform impacts the bottom line. Even so, health systems rely significantly on government-sponsored health insurance, Medicare in particular, as an important payer source. This presents an interesting question for health systems and community-based private practice physicians: Will the reforms that lie ahead provide a stimulus for partnership between physicians and health care organizations as a means to secure survival? For

now, the answer to this question appears to be yes.

Despite the common ideals between physicians and health care organizations, successful collaboration between the two parties has, on balance, been a struggle.⁵ Given the current financial circumstances in which access to capital and reimbursement rates from third party payers — government payers included — appear likely to decrease, physicians and health care organizations are seeking to form tighter relationships, including the direct employment of physicians within health care organizations as well as the formation of various alignment strategies between health systems and community physicians.

The current trend in physician employment offers an occasion to alter the emphasis on, and primacy of, profit in the current health care system. Profit, in and of itself, is not necessarily an ethical problem. If, however, physicians and health systems change or direct their behavior toward a certain set of strategies — strategies that in themselves do very little to alter the health outcomes of society — solely because of profit, then ethical issues will arise.

By virtue of the fact that health care delivery is undeniably linked to individual and social well-being, this legislative reform affects everyone. Ethically, this means, among other things, that the Affordable Care Act sparks interest precisely because it impacts interests. That, in turn, affects commitments, decisions, goals, life — plans, priorities and values. A significant challenge to fundamentally altering the way health care is delivered is how to adequately balance the multitude of interests bound up with health care delivery so that social interests can be attained. While it is natural to cling tightly to self-interest when real or perceived threats enter one's worldview and alter one's accepted notions around "business as usual," I argue that if physicians and health care organizations commit to lifting up their shared ideals, society as a whole can benefit.

Undoubtedly, some of these new partnerships between physicians and health care organizations will be merely transactional and pragmatic — products of necessity because of changed circumstances. Some, however, will be deeply relational and principled, rooted in shared ethical ideals. When approached in a relational and principled way with a desire to draw upon the common ideals of physicians and health care organizations as a platform for social good, physician employment strategies may prove more beneficial than burdensome in the long run.⁶ Instead of choosing to view the reforms of the Affordable Care Act as a challenge in the sense of a threat, health care organizations and physicians could instead choose to see them as a challenge in the sense of an opportunity. From the inception of Medicare in 1965 to the development of managed care in the 1970s and the creation of diagnosis-related groups in the 1980s, the health care apparatus in the United States has had many opportunities to fail. For many reasons, it has not.

What cannot be put aside any longer is the opportunity that current health care reforms and conditions leading to these reforms offer to create new processes, relationships and structures for moderating the self-interests of physicians and health care organizations. Given impending payment reforms brought on by the Affordable Care Act, these groups have no choice but to work together.

In the three sections that follow, I explore the important opportunity that physician employ-

ment affords as health care reform continues to evolve:

- The primary reasons behind the current physician-employment trend

- Three mutual interests that can serve as shared ethical ideals that physicians and health care organizations can use as an ethical foundation for mutuality. In identifying and using these reciprocal interests as organizing principles for collaboration, there is reason to be hopeful that physicians and health care organizations can rise above the historical and seemingly inherent tension that has subverted their relationship in the past⁷

- Some practical strategies that can help create a more sustainable and productive approach to physician employment than we have witnessed in the past⁸

PHYSICIAN EMPLOYMENT

As recently as the late 1980s and into 1990s, many health systems employed physicians at a feverish pace.⁹ At the risk of over-simplifying, these acquisitions failed for at least three reasons. First, health systems did not reap the benefit of their investments. With their acquisitions, health care organizations expected to see a downstream economic benefit. That simply did not occur. Second, nervous about losing market share, many health systems intentionally overpaid for their investments.¹⁰ Rather than continue to lose money, they chose to divest. Third, from an operational and management standpoint, the private practice are-

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na is very different from the acute care setting. Resorting to the same attitudes, operational strategies and tactics that worked in the acute care side did not transfer to the physician practice side. In the end, health systems did not have the cultural, operational and managerial agility to manage these newly acquired entities.

In the relatively short time since, however, the environment has changed for physicians and health care organizations in ways that enhance the benefits of direct physician employment. When the payment reforms related to health reform are added to the mix, the result is an ever greater opportunity for mutually beneficial relations between physicians and health care organizations.¹¹

Today, many physicians are attracted to the financial security that employment with health care organizations is expected to bring. Other factors that make partnerships more appealing to physicians include: relief from the administrative burdens associated with participation in private and government-sponsored insurance programs; the lack of available capital needed to open new practices or to invest in new technologies consistent with evolving methods of care; relief from the costs associated with operating a clinic, including back-office costs, malpractice insurance and electronic medical records; the growing burden of debts associated with medical education; and new generational priorities, such as a desire for predictable working hours, that are pushing new medical school graduates to pursue the option of employment.¹²

That some physicians seek such employment to obviate problematic circumstances ought not to be viewed as defeat or failure on their part. It

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is a pragmatic response to external threats that could undermine the values and patterns of a proud and socially significant profession.

Although the Affordable Care Act seeks to overcome access challenges to vulnerable persons through increased access to health care, its requirements may be too costly for individual practices to implement. To offer some perspective, nearly 75 percent of office-based physicians,

which represents nearly 95 percent of all medical practices in the United States, work in groups of five or fewer clinicians.¹³ Successfully managing the necessary changes in medical practice ushered in by the Affordable Care Act will require more attention to services that many medical practices do not offer and cannot afford to provide. These services, many of them critical to positive and cost-effective health outcomes, include coordinating care across the continuum, managing preventive care, managing chronic illness more effectively, collaborating with hospitals to reduce admissions, engaging more in advance-care-planning conversations with patient and families, altering practice-based care delivery processes and escalating the use of electronic medical records.¹⁴ All of these very important improvements to current medical practice are economically incentivized by the Affordable Care Act. And, large integrated health systems, as opposed to small and independent practices, may be best positioned from structural and financial points of view to provide these services.

For their part, health care organizations are experiencing lean economic times as well. They are economically stressed by declining reimbursement rates; payment schemes connected to better performance as opposed to volume of services performed; capital restrictions that impede investment in new technology and upkeep of current physical structures; and workforce challenges that will require likely cutbacks in labor. These pressures, in the context of a desire for service line growth and increased market share, have converged to make physician employment an attractive business strategy, one that is viewed as a means of securing admissions, referrals and expanding revenue streams.¹⁵

Health care organizations should not be naïve about the challenges associated with employing physicians. The investment connected to physician employment is substantial. Hospitals typically lose between \$150,000 and \$250,000 per year over the first three years of a single physician's employment contract.¹⁶ Under the multitude of reimbursement schemes that accompany the Affordable Care Act, health care organizations with multi-specialty physician networks and standardized care processes may be in a better position to thrive clinically and financially in the long term.¹⁷

Past experience notwithstanding, many cur-

rent health policy experts argue that it is one thing for health care organizations to adopt physician employment strategies; it is another to make them work. In order to develop satisfying partnerships with physicians, health care organizations need to be able to see beyond the dollar signs and seek to create a sustainable vision and culture by respecting the interests and ideals that individual physicians and the profession as a whole bring to the table. Reaching out to physicians from a place of mutual interest — clinical, financial and scientific — can create a foundation for moving forward to

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gether. Actions so motivated will not only help ensure that the overall health of society can improve but will also honor the goals and deepest ideals of the health care professions.

This work centers largely on building trust and changing perceptions about those gathered at the table to configure a health system that benefits all those with a significant stake in it. And, it takes time and energy to build the culture necessary to move a new group composed of strange bed-fellows forward in a systematic and coordinated fashion. As Nathan Kaufman, a national leader in physician relations, argues: "If you don't focus on creating a vision and self-managed culture, the next thing you know, you will have 100 physicians in 60 different locations practicing in their own style with no standardization, some refusing to see Medicare patients because they are not as profitable. What you have essentially done is shifted where the physicians get their W-2s."¹⁸ Kaufman's point: employment is one thing — lasting partnership is another.

MUTUAL INTERESTS THROUGH SHARED IDEALS

According to Jean Bethke Elshtain, a leading political philosopher and professor of divinity at

the University of Chicago, the great challenge the founders of this country faced many years ago "was to create a political body that brought people together and created a 'we' but still enabled people to separate themselves and recognize and respect one another's individualities."¹⁹ She goes on to lament what she calls the "politics of difference," the strategy she believes is used today to promote individual and communal identities. In such a strategy, like persons align with like persons to form a group with insular interests and like identities. The result, she argues, is a "public world with many 'I's' who form a 'we' only with people exactly like themselves."²⁰ As opposed to "negotiating the complexity of public and private identities, they disdain all distinctions between citizenship and any other identity and seek full public recognition" as a member of a particular group with particular interests.²¹ They gain acceptance, legitimacy and preferential status through the power of this association, not necessarily through their core ideals or a prudential and enlightened self-interest that respects multiple perspectives and the interdependent social reality in which we exist.

In perhaps its most extreme form, this tendency plays out in our political processes with well-oiled interest groups and lobbies fighting tentatively for their separate and individual interests. It also plays out with our professions — and the professions that make up health care in our society are far from immune.²² The political strategy to promote self-interest is common among them.²³ I would argue, however, that though the political strategies that promote self-interest are all too common in health care, the social ideals foundational to the health professions can adequately constrain the self-interests that often tend to dominate their public actions. To do this, however, voice must be given to both the particular ideals of those within the profession and the universal ideals the professions seek to create. There is no better time than now to take on the challenge of cultivating an enlightened form of self-interest as we contemplate once again the widespread employment of physicians in today's health care market.

Even where health care organizations might decide to refrain from direct employment relationships and instead pursue different collab-

orative relationships directed toward enhancing quality, decreasing costs and enriching the patient experience of care, the approach for which I am advocating holds: Begin with the socially directed ideals of the medical profession and health care organizations, then get on to the business of making it work operationally.²⁴ For voice to be given to mutual ideals, an intentional recognition of the fundamental purposes of health care must be more fully appreciated. To name a few, the principled mutual interests and interdependencies that transcend fixation on self-interest include: patient well-being, community health, health promotion, disease prevention, clinical research and ameliorating pain and suffering. It is important that we not lose sight of the important goals of patient care and the social role and underlying purpose that physicians and health care organizations share. Then, the administrative and procedural decisions that follow must flow from these core convictions.

What are these foundational commitments? In the preamble to the *Code of Ethics* of the American College of Healthcare Executives, we read: “The fundamental objectives of the health care management profession are to maintain or enhance the overall quality of life, dignity and well-being of every individual needing health care service and to create a more equitable, accessible, effective and efficient health care system.”²⁵ Similarly, the Physician’s Charter promulgated by the American College of Physicians, the leading professional organization for internists, states: “To maintain the fidelity of medicine’s social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society.”²⁶

Even a cursory glance at the stated core commitments of other health care organizations reveals the desire to advocate first for the interests of others, *both* the individual patients sitting across from them *and* the health and well-being of society at large. For the reforms of the Affordable Care Act to work and the attempt to align with physicians as a means of meeting the aims and intentions of the act, then these core commitments must enjoy more primacy than they currently do.

Taken together, each statement above from

the respective health care professional groups reflects the notion that health care delivery is, firstly, a humanitarian service directed toward the good of individuals and society. In today’s challenging context, these ideals expressed in these statements could be dismissed as naive idealism. On the contrary, they form the shared ideals upon which physician employment can proceed. They can help restrain unbridled self-interest while at the same time promote a health care delivery system ordered toward enhancing the interests and needs of society, thus moving toward the creation of a shared “we” to which Bethke Elshtain refers. For either group to overlook or push these ideals aside would be a mistake. Idealism is precisely what is in order during this vexing time.

Following from these statements, I argue there are at least three mutual interests that physicians and health care organizations hold in common.

Health care should be understood as a unique business activity. The organizing ethical purpose of health care is centered on the traditional notion that it is meant to be a service to humanity precisely because such service promotes human flourishing. Such goals as saving and prolonging life, preventing illness, promoting wellness

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and researching the cause of and treatments for disease combine well with the generally accepted belief that persons have inherent value. This combination of medicine’s traditional goals and Western ethical values give health care inherent moral ends and a proud moral tradition.²⁷

Commercial interests can have a corruptive influence on health care delivery. For instance, the notion that health care providers and health care systems continue to benefit from illnesses that are otherwise preventable presents an ethical challenge to the health care industry. Sickness increases the volume of health care services and

interventions. Volume produces financial well-being for clinicians and health care organizations. The more people who catch the flu or need cardiac surgery in a community, the more health care organizations will benefit financially in that community. Sickness provides business. Business generates wealth. Wealth provides growth. Growth means more jobs. More jobs generate more money for consumption. Consumption produces tax revenue. For some, it is precisely this kind of economic cycle that makes the world a better place, because it promotes the maximization of individual preference. In the health care context, however, this economic gain can come at a social cost. While health care organizations are businesses — and thus designed in part to make money — they must not lose sight of their ethical mandate to be servants of the social good.

Health care should be treated as a social good intended to benefit society. On August 10, 2010, the World Health Organization

(WHO) declared an end to the global H1N1 flu pandemic. The virus was first detected in the United States in April 2009. Just two months after that first U.S. case was detected, the WHO announced that a global flu pandemic was under way. By that time, 70 countries had confirmed cases of H1N1.²⁸ According to the U.S. Centers for Disease Control and Prevention (CDC), there were about 60 million cases and 12,270 deaths in the United States alone.²⁹

For the better part of 18 months, daily reports informed the country of the magnitude of the pandemic. Governmental agencies responsible for the public's health issued regular communications and held frequent press conferences to educate the public, including health care providers, on the development, characteristics and treatments of the disease. Ethicists, public health professionals and policy makers debated the thorny issues involved in determining the allocation of limited resources, such as the equitable use of mechanical ventilators and immunizations, which were often needed to treat persons with the disease and to prevent further illness.³⁰ In situations like this, we are reminded that life is precarious, medicine is imperfect and that health care delivery is a crucial social good.

A social good is not, in the financial sense, “owned” by any one individual. That is, a social good is not owned like a piece of property such as a car or bicycle. A social good is collectively owned — all persons within society have a stake in its well-being. Education is another social good. No single person, corporation or interest group “owns” the educational system. However, all of us own it in the sense that we depend on it — and therefore seek to attend to it responsibly — for the overall well-being of society. Whether health care is more important than other social goods is not the point. And, although it may well be financially

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Health care should be directed toward the amelioration of social inequities. We have long known that even if health care reform efforts succeed in offering all persons affordable access to a basic level of health care, there is still more to think about regarding individual and social health. Consider the following:

- A baby born to a mother who has completed fewer than 12 years of education is almost twice as likely to die before its first birthday as a baby born to a mother with 16 or more years of education³¹

- Adults with family incomes below the federal poverty level are more than twice as likely to have diabetes and nearly 1.5 times as likely to have coronary heart disease³²

- Even when important variables such as insurance status, age, income and the presence of other poor health conditions are accounted for, African-Americans and Hispanics are less likely to receive appropriate cardiac medication or undergo necessary cardiac surgery than whites³³

- African-American patients with congestive

heart failure or pneumonia receive inferior care as compared with whites³⁴

Such statistics are chilling. They refer to what are called the social determinants of health. This means that, regardless of whether one has access to health care, implicit attitudes and sensitivities within a culture can bias treatment decisions and impact health outcomes. Deeply ingrained in our social dynamics are complex realities that significantly affect the health status of individuals and communities, regardless of whether one has health insurance. Individual and community health is affected by one's culture, ethnicity, physical environment, personal behavior, economic and educational level and other social realities.

These three ideals are rooted in the foundational principles of health care professions and are therefore principles upon which an ethically sensitive physician employment strategy could be based. While these three may hold no particular value over other, similar ideals that physicians and health care organizations share, they are the kind of ideals that can help both physicians and health care organizations transcend their own self-interest and collaborate in order to confront important social concerns related to the health of the population.

Intentionally, these mutual interests are not administrative and procedural.³⁵ Instead, they represent socially construed and ethically oriented mutual interests designed to appeal to the ideals of health care organizations and the medical profession. They are consistent with, and embedded within, the reforms outlined within the Affordable Care Act, which is designed explicitly to remove the barriers that inhibit good medical practice while at the same time redress burdensome and perverse economic incentives that impede quality care for individuals and communities and create unnecessary waste.³⁶

PRACTICAL STRATEGIES

If the current trend toward physician employment can help realize the goals of increasing quality, lowering costs and enhancing the experience of medical care it will be due, in large part, to organizing such relationships around the mutual interests and shared ideals of physicians and health care systems. In so doing, the elusive "we" to which Bethke Elshtain refers can be attained. How can this be accomplished? While there are indeed many different ways, I suggest three practical strategies that can assist:

Promote enlightened self-interest. An en-

lightened form of self-interest is one in which a person, by virtue of acting to promote the interests of others or the group to which one belongs or may eventually join, can be the vehicle through which one promote one's self interest.³⁷ This means there is complementarity between the vision of the individual and that of the whole. The synergy is so tight that, in fact, acting to promote the good of the whole is acting to promote the good of the individual. It is naive, however, to suggest that individuals completely set aside their self-interests. They are a natural and necessary element of human life. The most one could — or perhaps even should — ask is that someone seek to promote one's goals by developing and securing the goals of the group. In this way, saying yes to the group can be, therefore, synonymous with saying yes to one's interests.

This is the kind of nuance that physician employment requires — neither physicians nor health systems should impose their respective self-interests on the other. That is a fight that neither can win. Instead, an enlightened application of self-interest would require that through employment each individual party, in seeking to promote the interests of the other, actually promotes its own interests. This can only happen if, over the course of the initial employment conversation and throughout one's employment relationship, the voice of each is duly respected.

■ **Endorse critical loyalty.** Critical loyalty is loyalty with a certain kind of edge. Not all the elements of any group will be endorsed by every individual within it. And, where this disagreement can turn into constructive and new approaches to doing the work of the group, it can serve a positive end. When any person chooses to be employed, and this is especially true for a profession that enjoys (and has earned) the degree of social privilege common within the medical community, there is an expectation that the voice of the employee will be sought and heard.

When an organization says yes to a physician or a physician group and when a physician or physician group says yes to an organization, it is not a one-time event. That yes is reciprocal and meant to be long-lasting, intending to bear fruit in sustainable ways over time. One way to make this yes mutual and maintainable is to give the incoming party the permission to be critically loyal. Critical loyalty should not simply be tolerated, it should be cultivated through building structure that creates intentional participation within the workings of the group, creating leadership pathways that empower physicians to develop the mission

and vision of the group, and giving physicians the skills to make day-to-day operational decisions that are consistent with the group's overall vision.

Focus on community and population health. For any health care organization seeking to employ physicians for the purpose of creating a multi-

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specialty network as one among other methods aimed at achieving a greater degree of financial security, there is an equally important social value to be attained, namely: community and population health. There is no greater challenge to our health care system, and therefore to our medical providers and health care leaders, than chronic illness. According to the CDC, chronic diseases, many of them preventable, are the leading cause of death and disability in this country. Empirically, the CDC reports the following:

- 7 out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer and stroke account for more than 50 percent of all deaths each year

- In 2005, 133 million Americans — almost 1 out of every 2 adults — had at least one chronic illness

- 1 in every 3 adults is obese and almost 1 in 5 youths between the ages of 6 and 19 is obese (BMI \geq 95th percentile of the CDC growth chart)

- About one-fourth of people with chronic conditions have one or more daily activity limitations

- Diabetes continues to be the leading cause of kidney failure, non-traumatic lower-extremity amputations and blindness among adults, aged 20-74³⁸

These data are not new, but they should be alarming, clinically and financially.³⁹ Even though our health system has not been structured to ameliorate chronic illness and individuals are not taking the degree of responsibility required to live more healthily, there is no question that such a challenge — or opportunity, depending on one's perspective — is precisely the kind that the medi-

cal community, if given proper incentives, can overcome.

This does require an admission that, in itself, represents an attitude change on the part of clinicians, health care organizations and the public at large. Specifically, it requires all to admit that the health of the population is the best benchmark of what constitutes a high quality health delivery system. Ultimately, if a health care organization cannot demonstrate that the community's health is better because of its presence within the community, then its ultimate value must be questioned. Health care organizations need physicians who are committed to redressing these trends, and physicians need health care organizations that will invest in alternative health care delivery models that will advocate for, and invest in, structures to enhance the community and population health.⁴⁰

CONCLUSION

No reasonable persons can deny the fact that our current health care system is seriously flawed and in need of wholesale repair. Yet, as is common with any major social change, especially one attached to governmental mandates, there are visceral reactions either for or against such change. Often, when I hear these reactions, I am reminded of the quip attributed to Daniel Patrick Moynihan, the late four-term U.S. senator from New York, noting that people are entitled to their own set of opinions but not to their own set of facts.

Despite strong objections from some quarters, some of them well-reasoned and ethically defensible, it is likely that many, if not all or most, aspects of the Affordable Care Act are here to stay. While it is a game-changer for contemporary medical practice,⁴¹ the Affordable Care Act stands a far better chance of succeeding when the shared ideals between physicians and health care organizations are used as an ethical foundation for the inevitable cooperation that the current clinical and economic conditions create.

I have argued that there is a way to make physician employment more successful than in the recent past. To achieve this success, an intentional choice must be made to organize such employment around the shared ideals that health care organizations and physicians hold in common. In so doing, all of society can benefit, which is precisely the outcome that a properly ordered and prudently designed health system should achieve.

That benefit will not come if we choose to operate solely from a place of unbridled self-interest. We will continue to tumble along the road of mediocrity in health care delivery unless interests and ideals can be balanced in ways that promote the social good.

As long as there is reason to believe that physicians and health care organizations can meaningfully collaborate, then there is sufficient reason to hope that health care delivery can enhance individual and social well-being. The hope I have is principally rooted in the fact that the Affordable Care Act is designed to align good medical practice with better economic incentives than we have had up until this point. The major clinical and ethical hurdles facing our current health care delivery system stem, at least in part, from the incentives within it to practice medicine in ways that are not fundamentally aligned with the ideals of the health care profession. These ideals are not owned exclusively by physicians or health care organizations. They are shared between them and are to be used for the benefit of society as whole.

The challenge, then, is to engage in the hard work of creating the “we” of health care. It remains to be seen whether we can embrace this challenge with the creativity and tenacity it will require.

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NOTES

1. <http://health.carereform.procon.org/view.resource.php?resourceID=003808#2010>. (Accessed August 1, 2011).
2. www.physiciansnews.com/2010/03/22/reaction-to-health-reform-bill/. (Accessed August 1, 2011).
3. Robert Kocher, Ezekiel J. Emmanuel and Nancy-Ann M. DeParle, “The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges,” *Annals of Internal Medicine* 153 (2010): 536-39.
4. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), esp., 235-89. See also David J. Rothman, “A Century of Failure,” *Journal of Health Politics, Policy, and Law* 18 (Summer 1993): 271-86.
5. William D. Petasnick, “Hospital-Physician Relationships: Imperative for Clinical Enterprise Collaboration,” *Frontiers of Health Services Management* 24 (Fall 2007): 3-10.
6. In the interest of disclosure, my own health system is embarking on the second approach as we move

through our physician employment strategy. I favor this approach because I am experiencing its success. For an overview of what health care organizations are doing in relation to physician employment, see Mark C. Shields, et al., “A Model For Integrating Independent Physicians Into Accountable Care Organizations,” *Health Affairs*, 30 (2011): 161-172. See also Susan Birk, “Physician Employment: How It Can Work This Time,” *Healthcare Executive* 25 (July/Aug 2010): 8-17.

7. Christina Roman, “Simple Steps to Better Physician Relations,” *Trustee* 64 (April 2011): 13-19.
8. William D. Petasnick, “Hospital-Physician Relationships,” 3-10.
9. Robert Kocher and Nikhil Sahni, “Hospitals’ Race to Employ Physicians — The Logic Behind a Money-Losing Proposition,” *The New England Journal of Medicine* 364 (May 12, 2011): 1790-92. See also, Clayton Harbeck, “Hospital Physician Alignment: The 1990s versus Now,” *Healthcare Financial Management* (April 2011): 48-52.
10. Harbeck, “Hospital Physician Alignment,” 48-50.
11. Roger Strode and Carsten Beith, “Something Old Is New Again: Structuring Physician Practice Acquisitions,” *Healthcare Financial Management* 63 (July 29, 2009): 78-92.
12. Peggy L. Naas, “Why Physicians Are Seeking Employment,” *Hospital and Health Networks* (September 10, 2010), online edition at: www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/09SEP2010/092010HHN_Weekly_Naas&domain=HHNMAG. (Site accessed on August 5, 2011).
13. Robert Kocher and Nikhil Sahni, “Physicians Versus Hospitals as Leaders of Accountable Care Organizations,” *The New England Journal of Medicine* 363 (30 December 2010), 2580.
14. Kocher et al., “The Affordable Care Act and the Future of Clinical Medicine,” 537.
15. Birk, “Physician Employment: How It Can Work This Time,” 10-16.
16. Kocher and Sahni, “Hospitals’ Race to Employ Physicians,” 1790ff.
17. Kocher and Sahni, “Hospitals’ Race to Employ Physicians,” 1791.
18. Nathan Kaufman, as quoted in Birk, “Physician Employment: How It Can Work This Time,” 12.
19. Jean Bethke Elshtain, “Democracy and the Politics of Difference,” in *Essential Communitarian Reader* ed. Amitai Etzioni (Lanham, MD: Rowman & Littlefield), 259.
20. Bethke Elshtain, “The Politics of Difference,” 259.
21. Bethke Elshtain, “The Politics of Difference,” 259.
22. Harold S. Cox, “The Ethical Foundations of Professionalism: A Sociologic History,” *Chest* 131 (2007): 1532-40.
23. As expected, and as is typical, virtually every major health care organization — whether it be composed of

clinicians, executives or a mixture of both — has its own robust advocacy agenda. While pragmatically necessary, these agendas tend to promote the “politics of difference” that Bethke Elshtain critiques. In my own experience, little, if any, time is given to critiquing the broad ethical ramifications of these advocacy agendas. In this critique, one question would necessarily be: What is the balance between the financial investments in “self-interested” versus “socially-interested” advocacy agendas? Some may call this a false distinction, arguing that self-interested advocacy promotes social interests. My bigger point, however, is not so much the empirical realities of the balance but the ethical discernment underlying the financial decisions all corporations must make.

24. For an analysis of other physician relationships, models and strategies see Shields et al., “A Model for Integrating Independent Physicians into Accountable Care Organizations,” 161-72.

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