RETHINKING ETHICS

Employed Physicians, ACOs, High Costs Prompt Review

New business structures, new partnerships, changing reimbursement norms are among changes in health care that are keeping ethicists engaged with a host of new questions and challenges. The reflections below are based on presentations from the podium (John Paul Slosar, Ph.D., and John Gallagher, Ph.D.) and a provocative reflection from the floor (Monsignor Steve Worsley, MD) at CHA's Theology and Ethics Colloquium in March, 2013.

Challenges, Opportunities in Physician Employment

BY JOHN PAUL SLOSAR, Ph.D.

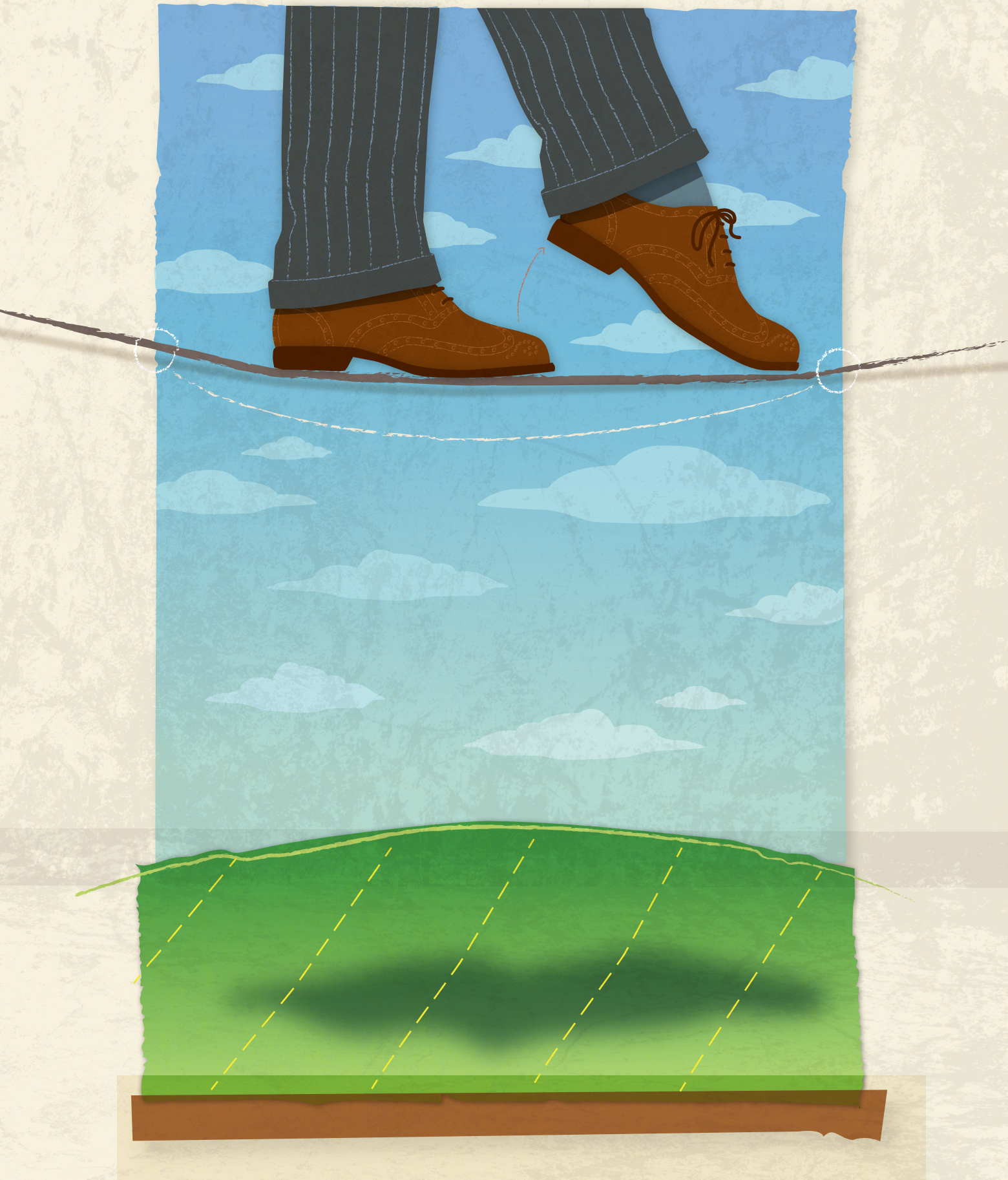
A significant recent trend in health care toward physician employment by hospitals and health systems poses some pressing challenges and opportunities.

As we begin to think more about this topic, it is important to have clarity around the concept of physician employment itself, particularly as it relates to the authority to practice medicine. This authority does not come from a physician's employment status but from a state's licensure process. To put it more succinctly, physicians are physicians first and employees second. Likewise, most, if not all, states have some type of legal regulation prohibiting hospitals from engaging in the practice of medicine and from controlling the practice of medicine by any physician, including those employed by the hospital, whether or not that hospital is in a state that has a formal anti-corporate practice of medicine statute. In this way, physicians have a greater sphere of professional and moral agency than other types of employees might normally enjoy in their relationship with their employer. Physicians simply are not limited in their professional capacity to acting as an agent of their employer. How we understand what physicians can do as their own moral and professional agents has implications for what we as Catholic health care can, should or must do with and for our employed physicians.

While employment establishes greater opportunity for influence, this influence is not achieved through the direct exercise of control. The influence gained through employment is primarily achieved in two other ways. First, as hospitals and health systems, we have influence through the control of what we, as Catholic organizations, will or will not actively participate in, permit or provide the means for within our facilities. Second, our influence is also established through the alignment that comes from compensation structures and other nonfinancial benefits, such as alleviating physicians from the burden of managing the business of medical practice and allowing them more time to care for patients, which is why they went into medicine in the first place.

These considerations give rise to conceptual questions regarding just how much control and how much influence is garnered through an employment relationship. Does it even make sense to speak in terms of control, or are physicians such a special type of professional that we must limit our conceptual understanding of the opportunities and challenges in terms of influence alone?

The fact that we inherently must partner with physicians in order to live out our healing mis-



sion raises some classic questions of cooperation in intrinsically evil, i.e., objectively immoral, acts. Given that employment does not necessarily establish control over the practice of medicine by physicians, and physicians therefore retain some professional and moral agency independent of the employing institution, these issues will persist in the new landscape of health care. These are not new issues, and for the purpose of this brief reflection, I will not consider the cooperation questions related to employing physicians who might prescribe contraceptives in the course of a well-woman visit or physicians who might want to retain the ability to perform tubal ligations or vasectomies independently of and outside the scope of their practice with a Catholic health care institution.

While these questions alone could constitute the substance and breadth of an entire book, it is most important to note that whether our approach to structuring physician employment agreements and the support services we provide to their practice of medicine will remain essentially the same in this respect or will need to be somehow different in the new health care landscape largely depends on how one understands the independence of physician agency in light of the balance between control and influence that results from a physician employment relationship.

Of course, challenges are not the only consequence of physician employment. In fact, I would suggest that the challenges are not even the primary consequence. To the contrary, the alignment and influence that come along with physician employment bring many more opportunities to advance the Catholic identity of the healing ministry than they do challenges. Ultimately, I would argue that these opportunities to have a positive moral influence on the practice of physicians strengthen the ability of the Catholic health ministry to be a prophetic voice and pay public witness to Catholic values within and for the good of society, which itself constitutes a proportionate good that justifies most (if not all) of the instances of mediate material cooperation that may result from employing physicians.

In particular, physician employment provides unique opportunities to have positive influence in three key areas of moral concern to the healing ministry. First, there is evidence, at least anecdotal, of an increasing trend in some markets of physicians who are unwilling to take Medicaid or Medical Assistance patients. Physician employment offers the opportunity to give the incentive to these physicians, through their compensation structures, to care for more patients who are poor and vulnerable. This will also be an even more significant advantage once reimbursement moves to a pay-for-performance model in which many physicians may have concerns about caring for the underinsured who often present with greater acuity, multiple comorbidities and increased complexity.

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Second, by providing a combination of more practice management services, quality and efficiency protocols, data analytics, network development and care-design models, we will be able to significantly influence the type and way that employed physicians actually provide care to patients. Specifically, we will be able to offer physicians the environment and capabilities to provide holistic, person-centered care of the highest quality and safety. Of course, it takes more than just incentives and infrastructure to provide such care; it also takes the desire and will to do so.

This brings me to the third key area of opportunity for influence: physician formation in the context of Catholic culture and values. In addition to helping physicians see the value in holistic person-centered care, physician formation programs can offer opportunities to provide more adequate education around Catholic values, spirituality and anthropology as well as to restore the physician's

connection to her original sense of vocation and to a robust understanding of the philosophy of medicine, all of which ultimately improve patient care. In the end, employment offers a meaningful context within which to care for the physicians who care for our patients.

Regarding an important implication of physician employment — the question of values compatibility — whether and how we screen for values compatibility in our processes of hiring physicians, whether we give these considerations serious weight in the selection process or simply leave the selection of physicians solely to the whim of market forces and referral patterns, becomes of increasing importance in the new landscape of health care. As accountable care organizations, "narrow networks" of physicians and integrated delivery systems become the norm, we will find ourselves doing even more with and for our employed physician partners. We must be persistent in attending to what it means for physicians to be values-compatible and the importance of selecting for values compatibility, even as the concept of values-compatible physicians itself evolves in response to the new health care landscape.

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Ethical Considerations in the Shift to Population Health

BY JOHN A. GALLAGHER, Ph.D.

The Affordable Care Act (ACA) requires substantive changes to the institutional structures as well as to the economics that shape the Catholic health care ministry. These are not simply a matter of tinkering with aspects of the ministry's delivery system or accommodating new financial incentives. They are profound changes that will call for fundamental rethinking of how that ministry and mission of Catholic health care are carried forward.

Hallmarks of changes under health reform include the following:

- Accountable care organizations (ACOs)
- Population health management
- Pay for performance (also called value-based payments)
- The patient-centered medical home

Such substantive changes in the health care delivery system go to the core of the ministry and mission of Catholic health care, shifting past focus on the healing of sick individuals to the new model centered on the health and wellness of individuals and populations. Of these, ACOs and the shift to population health are the most likely to affect and require that fundamental rethinking of ministry and mission. As Catholic health care leaders know, the goal of ACOs is to replace the current fragmented delivery system, in which various components compete with one another, with an integrated delivery network characterized by cooperation and collaboration. Reducing duplication of services is expected to enhance quality of care and reduce costs. An ACO is composed of all points of service necessary to provide health services to a population: physician practices (both primary care and specialists), outpatient ambulatory services, acute care facilities, rehab centers, skilled nursing facilities and home health. Further, in the near future, some ACOs will become insurers as well as providers of health services, thus assuming the financial risk and benefits for managing the health of a covered population.

Many Catholic health care organizations already are well into the process of employing or partnering with an array of physicians, as well as forming or considering partnerships with other organizations in order to create a comprehensive ACO. A key question is whether the ministry and mission models that correspond to these changes in health care delivery are as developed and sophisticated as the business and clinical plans.

Population health management is a second key area calling for more ethical analysis, as well as more education of colleagues in ministry and the patients we serve. Under health reform, the route to quality improvement is not patient-centered care, but rather the management of the health and well-being of a covered population. The focus of

medical practice is expanded to include social determinants of health and well-being.

METRICS OF THE ACO

The core metric to drive the new model of health care under the ACA is expressed as Value = Quality divided by Cost (V=Q/C). However, from the perspective of Catholic health care, it might be helpful also to look at what that equation leaves out: ministry (the relationship of Catholic health care to the institutional church) and mission (an organization's stated mission and core values). If a primary goal of Catholic health care is that its ministry and mission are to be integrated and embedded in its operations, then these factors need to be taken into account in the planning of a new delivery system. Community benefit and charity care, pastoral care and spirituality in the work place, ethical reflection and health care ethics consultation will each need to be profoundly rethought in light of the new context.

If justice needs to supplant autonomy in the new delivery system, it will prove to be a wrenching experience for many Americans — but it will be a less challenging transition from the perspective of Catholic health care ethics.

It is easy enough to assume that pastoral care, for example, will need to be provided in home health organizations and perhaps in the office practices of oncologists, cardiologists and pulmonologists. But important new questions are now on the table. For example, what is the role of pastoral care in the wellness model of health care delivery? How will programs to instill spirituality in the work place be expanded to associates across an ACO? Is there to be a distinct mission leader for each component of the ACO? What about the uninsured? Community benefit will perhaps remain substantively unchanged, but will the ACO be willing to provide charity care for uninsured members of the community? If some points of service within the ACO are not owned and managed by a Catholic organization, is charity care negotiated as part of the partnership?

In each of these areas, practice is likely to reflect continuities with the recent past, but new approaches to integrating mission and ministry going forward will require thinking outside the box — determining what ministry and mission mean in a new clinical, business and financial setting. In Catholic health care, ministry is used in this context to refer to the link between Catholic health care and the institutional church and pertains to the notion of Catholic identity. Questions that arise under the organizational structure of an ACO include the following:

- If a Catholic health care organization owns, governs and manages the entire ACO, must each part of it have Catholic identity?
- Are all employed physicians required to practice in accord with the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs)?
- If the ACO is a partnership between a Catholic organization and one or more non-Catholic organizations, must the entire ACO abide by the ERDs?
- Must physician practices that contract with the ACO conform to the ERDs?
- What is the role of the ERDs in an ACO in which the Catholic organization is a minority, perhaps a very small player?
- Will all these partnerships need to be evaluated in terms of the principle of moral cooperation?

ETHICS AND POPULATION HEALTH

Perhaps the most daunting ethical challenge that ACOs pose to the mission of Catholic health care occurs in the shift from patient-centered care to a focus on population health. The challenge, or at least so it seems to me, is whether the principle of justice will need to replace the principle of autonomy as the centerpiece of American and Catholic health care ethics.[1] In many ways, autonomy has served as the most important single moral principle of American health care ethics. Grounded in the American liberal tradition and marvelously expounded by Beauchamp and Childress in their *Principles of Biomedical Ethics*,[2] the principle of autonomy has resulted in government and institutional review boards' oversight of medical trials and the requirement of informed consent prior to any medical procedures that pose a risk to the patient.

The principle is based on the right of individuals to have control over their own affairs. The same principle protected physicians and other providers from being compelled to perform procedures that violated their consciences. The principle was a perfect fit for a health care delivery

system centered on patient-centered care.

But ACOs are based on population health management. The focus is on the wellness of a covered population. Care is extended to well persons and to the control of the social determinants of illness and disease. The model is closer to a public health model rather than to a model geared to the treatment of victims of trauma and disease.

As the health care system is asked to expand its scope of treatment so broadly, issues of allocation and rationing will need to be addressed. This is precisely the issue that raised the most opposition to the Affordable Care Act. If the model is, indeed, focused on the wellness of covered populations or communities, then the principle of justice will be the more appropriate moral measure to resolve moral conflicts.

If justice needs to supplant autonomy in the new delivery system, it will prove to be a wrenching experience for many Americans — but it will be a less challenging transition from the perspective of Catholic health care ethics, where autonomy is not in the moral repertoire. In its place is the principle of human dignity, the inherent self-worth of every individual created by God and redeemed by Jesus Christ. What is due to the human dignity of every individual has always been assessed within a social context and from within the framework of the common good.

The health care resources of an ACO are part of the common good of every community. It should not be a stretch for the Catholic health care community to think of the principle of justice as the moral instrument through which the health care services within the community are allocated to the population.

In this regard, perhaps the Catholic health care community can serve as a model for other ACOs being constructed across the nation. But this can only come about if we work our way carefully through the equation; that is, if mission and ministry are fully integrated into new clinical and business models being developed in support of ACOs.

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NOTES

1. On this point see Ron Hamel, "Catholic Identity, Ethics Need Focus in New Era," *Health Progress* 96, no. 2 (May-June 2013): 85-87.

2. Tom L. Beauchamp and James E. Childress, *Principles of Biomedical Ethics*, 7th edition (New York: Oxford University Press, 2012).

Balancing Needs as a Function of Justice

BY MONSIGNOR STEVE WORSLEY, MD

As medical students in the 1970s, we stood just behind the resident physicians, peering curiously over their shoulders at the light box in the radiology reading room. Suddenly, in a voice as sharp as a scalpel, Dr. Herman Grossman challenged us: "What is *this* study good for?" An awkward silence descended upon us as we groped for answers, praying that one of the interns would answer before the professor shifted his attention to the back row.

Finally he cried, "Four hundred dollars! That's all it's good for. Nothing else! Just a #@% waste of money!" Exhaling a sigh of relief, grateful that students lacked the authority to order tests, useless or otherwise, I recognized Dr. Grossman, a pediatric radiologist, as unique among the faculty at the Duke University medical school. He not only knew what tests cost, he actually cared!

To be sure, the days of ordering studies "for interest" and assuming they will be paid on a fee-for-service basis have largely passed. Today we are entangled in an incomplete paradigm shift that regularly delivers confusing and conflicting messages to beleaguered providers. Having adopted ever more complex technologies to avoid being left behind, hospitals face powerful incentives to promote the use of expensive tests and treatment modalities that generate higher margins. And in the midst of a nearly universal cry for some kind of health care reform, nonprofit health systems lobby aggressively for greater resources to meet the many challenges they face.

Before we join the chorus lamenting that an emphasis on value is taking center stage and shoving aside quality and compassion as the central themes of our ministry, we would do well to look back to the establishment of many of our ministries. In the 19th and early 20th centuries, when heath care was inaccessible to a large segment of the population, delivering value was, of neces-

sity, inseparably linked to the provision of justice. Otherwise Catholic hospitals and others committed to serving the poor could never have afforded to make admission decisions independent of a patient's ability to pay the dollar-a-day cost of hospitalization.

While today, stewardship remains among the stated core values for many Catholic health systems, over the past half-century, third-party payment and increased government involvement have driven resource consumption beyond the wildest dreams of our founders. Given the huge portion of our nation's gross domestic product currently consumed by health care, our founders might wonder whether the foundational connection between value and justice has been lost.

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In a provocative article entitled "Rationing Health Care: Why We Shouldn't Always Get What We Need," ethicist Gopal Sreenivasan argues that while health care is a good, it is not the only essential good competing for finite resources. He writes, "... when access to every medically necessary good and service leads to overspending on health care, a country is forced to underspend on schools, roads, and other critical services. This is incompatible with justice ...

"Countries are therefore morally obligated to observe a strict limit on health care spending. In effect, they must fix a ceiling on their annual health care budgets before knowing the total cost of the medically necessary care required by their population over the year."[1]

Whether due to a growing concern for justice or simply a diminished willingness of the public to forgo other goods and services, it seems unlikely that the recent trajectory of increased health costs will be sustained much longer.

Traditionally, physicians are expected to focus on the needs of one patient at a time, without having to balance one patient's needs against those of others.[2] But entrusting macro allocation decisions entirely to legislatures and government agencies is a strategy fraught with peril. Notwithstanding conflicting incentives, health systems can and should play a critical role in the national conversation about costs by developing successful models for providing more efficient and cost-effective care.

This will inevitably require a willingness to engage in an honest and more public discussion of diminishing returns, when balancing the potential value of adding exotic new treatment modalities as well as the cost of providing experimental and/or extended intensive care for the dying when the family isn't ready to "give up hope." Ultimately to be successful, new models will require a careful realignment of incentives for consumers, payers and providers.

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And since we can be sure that every patient will die eventually, embracing models that support and assist patients and families in preparing for that eventuality is an important part of health care. Finding ways to do this in a timely, consistent and appropriate manner will serve patients, families, providers and the larger community well.

Catholic health systems can elevate their commitment to providing value to the same level as their concern for quality and compassion without apology. Our sponsors' historic and passionate embrace of Catholic social teaching and their advocacy for social justice strategically positions Catholic health systems to serve as leaders in the ongoing struggle to see that essential goods and services (not just health care) are available to our weakest and most vulnerable neighbors. The Catholic ethical tradition offers valuable tools to help with the complex process of balancing individual and communal good. These tools will be essential as our systems evaluate new business

models with providers who do not share all our Catholic values.

The potential benefits to the people we serve and to our nation are staggering if we can muster the courage and the wisdom of the women and men who founded our ministries. Like them, we are challenged to develop models that empower our colleagues to more efficiently serve patients in ways that fully align with our core values.

MONSIGNOR STEVE WORSLEY serves on the board of St. Joseph of the Pines, in Southern Pines, N.C., a member of Catholic Health East.

NOTES

1. Gopal Sreenivasan,"Rationing Health Care: Why We Shouldn't Always Get What We Need," *DukeMed Magazine*, (Winter, 2009). www.dukehealth.org/health_library/health_articles/rationing_health_care_why_we_shouldnt_always_get_what_we_need.
2. A notable exception is the practice of triage during pandemics and other disasters, when providers may be called upon to balance the needs of one patient against another.

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