Updated July 12, 2021

The Reclamation of Emergency Medicine: "Take EM Back" White Paper

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Vision

Emergency physicians will be re-empowered to advocate for their patients and communities without fear of job loss, disciplinary action, or other professional retribution.

Background

Emergency medicine (EM) is unique in many ways, not least in that it is *the* safety net for a broken healthcare system. For this reason, the ethical crises plaguing our specialty warrant immediate action not simply because they pose an existential threat to the profession, but also because they threaten to destroy that very safety net. Patients, in their most vulnerable moments, suffer physical, psychological, and fiscal harm as their best interests are superseded by those of profiteering corporations. An emphasis on understaffing and corporate metrics, in combination with a sense of powerlessness to address the ethical transgressions rampant in corporate healthcare, leads to moral injury (formerly known as "burnout") as emergency physicians are effectively forced to violate their Hippocratic Oaths as a condition of employment.

The American Antitrust Institute recently concluded that *"the private equity (PE) business model is fundamentally incompatible with a stable, competitive healthcare system that serves patients and promotes the health and wellbeing of the population."* Nonetheless, emergency physician staffing groups are increasingly being voluntarily sold for exorbitant personal profit, or hostilely ousted by PE-backed contract management groups (CMGs). As of 2021, an estimated 50% of emergency physician jobs are through large, PE-owned CMGs. The standard five- to seven-year life cycle of a PE-leveraged buyout places enormous pressures on companies to expand rapidly, aggressively increase revenue, and cut operating costs. In the field of emergency medicine, "cutting operating costs" usually means decreasing staffing or replacing emergency physicians with lower-cost labor, often at the expense of patient safety. Why do so many emergency physicians continue working for these CMGs despite such ethical qualms? Simply put, they don't see any viable alternatives. As of 2021, the average

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physician ultimately pays $365,000 – $440,000 for their educational loans plus interest, a daunting amount for any newly graduated physician. As more residency programs flood the job market each year, desperate emergency physicians see little choice but to work for predatory CMGs.

As conflicted, debt-ridden, morally injured emergency physicians continue doing their best to care for patients, their names and licenses are further exploited by private equity-owned corporations to invoice patients through aggressive use of out-of-network "surprise bills" not covered by insurance. These same corporations have shamelessly stooped to suing even the poorest patients for payment of these nefarious "balance bills," resulting in garnished wages and patient harassment by unscrupulous debt collectors.

Many emergency physicians aren't even aware that this is happening because, at present, there is no requirement for transparency with regard to what is billed and collected in their names. Because emergency medicine is largely hospital-based, an emergency physician's ability to see and treat patients is largely dependent on the arrangement of physician services determined by hospital administrations. When hospitals contract with CMGs, many of those CMGs force physicians to surrender a percentage of their professional fees in excess of fair market value for administrative services (e.g., scheduling, malpractice insurance, billing, and coding). This "fee-splitting" is actually illegal in many states and at the federal level, and it amounts to an unscrupulous "tax" on the emergency physicians, as it benefits only the corporations and their investors.

Such illegal practices go unchecked because the CMG model also frequently and explicitly eliminates physician rights to due process. When a hospital administration contracts with a CMG, the contracted physicians are often required to agree to a co-termination of their rights to due process as members of the medical staff. Such policies make retaliation by means of "termination without cause" a formidable risk when confronting CMGs, hospital administrators, fellow physicians, and other staff members such as nurses. This doesn't merely inhibit their ability to protect themselves personally from corporate crimes such as the aforementioned illegal fee-splitting. More concerningly, it fetters their ability to advocate for patients and act in their best interests.

By this mechanism, for example, emergency physicians have been rendered powerless to protect their patients from inappropriately utilized, lesser-trained practitioners. Coercive arrangements whereby emergency physicians are essentially forced to engage in "notional supervision" agreements with non-physician practitioners (NPPs) as a condition of employment are pervasive in emergency medicine. NPPs are often hired by CMGs in lieu of physicians in order to decrease overhead, directly increasing returns for their investors. These NPPs are, in many cases, working outside their scope of practice. In agreeing to "supervise" them in name only (i.e., via retrospective chart review or from an off-site location), not only are physicians made complicit in this corporate farce and actively endangering patients, they are also being forced into positions where they may be credibly accused of aiding and abetting the illegal practice of medicine. The blame for this lies not primarily with the physicians, but with the CMGs who actively disincentivize proper supervision by

intentionally, chronically understaffing physicians to increase profits, and fail to compensate physicians for the extra time that would be required for safe supervision of NPPs. The very cost savings associated with these notional supervisory arrangements is therefore predicated on *not* paying the supervising physicians appropriately.

Even in the face of such egregious contractual self-slaughter, physicians keep silent because the threat of "termination without cause" is very real. During the height of the COVID-19 pandemic, multiple emergency physicians were terminated without cause by private equity-owned CMGs including TeamHealth (owned by Blackstone) and Envision (owned by KKR) shortly after publicly speaking out against clinical injustices. Countless other emergency physicians are *actively* being threatened and silenced by this very mechanism.

Burnout, now alternatively reframed as moral injury, occurs when clinicians are repeatedly expected to make choices about patient care that transgress their longstanding, deeply held commitment to healing. It is a proximate cause of poor morale, anxiety, and depression, which are well-known to negatively impact patient care. Research has demonstrated that depressed residents exhibit a six-fold rate of medication errors and that "physician burnout" is "independently associated with major medical errors." Moral injury also contributes to a physician suicide rate nearly double that of the general population. All of society loses when disaffected physicians leave the profession entirely while still in their prime, and physicians are indeed leaving clinical medicine in droves. At the time of writing, a Facebook group for physicians seeking alternative employment touted a walloping 79,000 members.

In 2004, the Federal Trade Commission (FTC) stated, *"Professional associations can, of course, respond to market conditions or behavior of market participants that it believes are detrimental to its members or the public."*[1] Despite this explicit sanction, our professional organizations have failed to take meaningful action against the market participants who exhibit such egregious behaviors. The American College of Emergency Physicians (ACEP) is the largest specialty organization in emergency medicine with sufficient standing to address this issue boldly, yet it has not. Notably, physician executives of lay- and private equity-owned CMGs have infiltrated generations of ACEP leadership, resulting in unacceptable conflicts of interest that undermine the best interests of both its emergency physician members and society at large.

The American Academy of Emergency Medicine (AAEM) was founded in 1993 by Dr. James Keaney, with Dr. Robert McNamara as its second president. It was established in response to Dr. Keaney's book, *The Rape of Emergency Medicine,* which exposed the complicity of leadership within ACEP and the abuses suffered by emergency physicians at the hands of CMGs. AAEM's values are sound, and with no CMG executives among its leaders, it is the only EM organization to reject all forms of CMG or PE support. Unfortunately, AAEM's structure

[1] Letter to Alvin Dunn, Esq. from Jeffrey Brennan of the FTC 8/30/2004.

as a professional trade organization is not conducive to political action at the speed and scale that this crisis demands. Their efforts, while commendable, have ultimately proven insufficient to combat the corporate takeover of emergency medicine and the subsequent imperiling of emergency physicians and their patients.

The Accreditation Council for Graduate Medical Education (ACGME) sets the educational standards essential in preparing new physicians for their careers and is the other organization well-poised to enact meaningful reform. The ACGME's stated mission is *"to improve healthcare and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education."* The establishment of corporate-funded residencies in any field is fundamentally incompatible with these objectives, as the overarching goal in private equity-backed endeavors is to maximize returns for their investors. The Healthcare Corporation of America (HCA), a for-profit hospital chain, recently boasted that it is now the leading provider of graduate medical education with over 250 ACGME-approved programs nationwide. This includes HCA's joint venture with Envision, a private equity-owned emergency medicine CMG, to proliferate emergency medicine residencies nationwide, including 10 in Florida alone.

While much of the medical profession suffers from a residency shortage, the recent explosion of new corporate-funded EM residencies further threatens the integrity and the very existence of the specialty. Emergency medicine saw an astonishing 80% increase in programs between 2012 and 2021. This redistribution of patient acuity and academic resources threatens the quality of the established programs. Additionally, a 19% oversupply of EM physicians is expected by 2030. As CMGs have a vested interest in shareholder profit rather than in public health or patient care, the funding of these programs is not a charitable or even primarily educational venture, but an unabashed mechanism by which to drive down the market value of EM physicians. The savings from decreased physician salaries are unlikely to be passed on to patients or society, but will almost certainly pad corporate profits. With decreasing salaries, physicians struggle even more to repay educational debt. As emergency physicians increasingly become mass-produced and disposable, emergency medicine will cease to exist as an esteemed specialty, and society's safety net will be further compromised.

In 2019, AAEM wrote an open letter to the ACGME concerning the rapid growth in EM training programs leading to a "*decrease in the quality of emergency medicine residency training, by diluting the pool of talent for emergency medicine resident candidates as well as core faculty."* The letter further stated, *"We are concerned that many programs recently approved do not offer the environment expected to train high-quality emergency physicians."* Training is being compromised by the indoctrination of young resident physicians into prioritizing corporate metrics and revenue generation over academic and clinical development.

Of note, one "solution" to this issue suggested by ACEP was to require an additional year of EM residency training to delay the pipeline of emergency physicians by a year. Apart from being temporary and ineffective, this absurd proposal would also burden our residents with another year of loan forbearance on a resident's

salary with no benefit to their careers or to public health. Nonetheless, the notion is still of interest not for its merit, but for its motive. In July 2017, Envision taught at the ACEP Directors Academy, *"...the use of residents in the ED is only a net gain when you are using senior-level residents (final year)."* While an additional "final year" of residency is clearly without educational necessity, it would generate profits for investors by providing additional low-cost labor. Such a suggestion from ACEP highlights the necessity of scrutinizing our professional organizations for any untoward conflicts of interest.

As private equity has permeated medicine, we have watched our specialty be reduced to nothing more than profits and losses. We are on the verge of losing control of our formerly esteemed profession. Our professional associations are compromised or handicapped, our physicians are hamstrung, and our patients are in danger. We *must* reclaim medicine for the benefit of our patients and society by restoring autonomy for practicing EM physicians, excising corporate interests that are incompatible with the practice of medicine, ending moral injury, and returning to a focus on public good and patient advocacy.

Emergency medicine is in crisis, and the time for action is upon us.

Mission

Our mission is to reclaim the professional integrity of the field of emergency medicine by purging our specialty of private equity and the corporate interests that undermine our physician-patient relationships and threaten our professional longevity. We will reclaim our professional autonomy by every means necessary, including deliberate proliferation of transparent, equitable, democratic staffing groups and full restoration of due process for all emergency physicians, regardless of employment status. Wall Street has no business at the bedside.

Positions and Objectives

1. **Private equity ownership of emergency medicine groups is incompatible with the ethical practice of medicine**. Concrete steps toward eliminating Wall Street's influence at the bedside are needed, beginning with an unequivocal rejection of private equity, corporate, and lay ownership by all EM physicians and specialty societies.

    - EM specialty societies, state medical societies, and other oversight agencies should adopt meaningful, clear-cut positions opposing private equity ownership of EM groups.
    - Enforcing, strengthening, and litigating existing state prohibitions on the corporate practice of medicine should become a priority, and a strong federal statute prohibiting the corporate practice of medicine should be enacted and enforced.

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- State medical boards should discipline physicians who aid and abet the corporate practice of medicine by acting as “paper owners” with the intent of allowing these companies to skirt the prohibitions on business interference in the physician-patient relationship.

2. **The proliferation of corporate- and private equity-funded EM residency programs is a danger to public health and antithetical to a mission of training EM physicians to act primarily in their patients’ best interests.** Rather than squandering limited resources to credential new training programs while the speciality is rapidly becoming oversaturated, the ACGME must rededicate itself to ensuring the integrity and quality of existing training programs. There is no evidence that additional training beyond three years contributes to public health.

    - The ACGME should place an immediate moratorium on approving new EM residency programs and redirect its efforts to improving and maintaining standards at existing programs.
    - The ACGME should not mandate an additional year of training for EM residencies for the primary purposes of slowing the production of new emergency physicians or providing fiscally conflicted CMGs an additional year per resident of low-cost labor to increase profits.
    - The ACGME should launch an urgent, transparent investigation into the effects of corporate- and private equity-funded residency programs on the quality of emergency physicians and the safety of the public.
    - The ACGME should examine the **fundamental incompatibility** of private equity and ethical medical education and promptly refuse to accredit any corporately funded residency programs.

3. **Opaque billing practices are anticompetitive and obscure physician and patient insight into the organizations that benefit from often outrageous billing practices.** Transparency for EM physicians as to what is billed and collected in their name is a fundamental necessity. Emergency physicians must be empowered to protect both the public from predatory billing practices and themselves from implication in illegal fee-splitting schemes.

    - Specialty societies must ensure that every EM physician is routinely provided with unfettered electronic access to the details of what is billed and collected for their patient care services. Emergency physicians should not have to ask for this information.
    - ACEP should fully and meaningfully adopt Resolution 29 (requiring billing and collections transparency) put forth by Dr. Robert McNamara including requiring compliance for all entities doing business with ACEP.
    - The unethical and illegal conduct of fellow members of the emergency medicine profession should be exposed, consistent with the original by-laws of ACEP.

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- ACEP should restore section 7 of their original by-laws which stated, *"In the practice of medicine, a physician should limit the source of their professional income to medical services actually rendered…"*
- Specialty societies should initiate legal actions, including class action lawsuits, to hold corporate groups financially liable for illegal fee-splitting and return those proceeds to the earning physicians.

4. **Notional supervision of non-physician practitioners is unsafe and increasingly ubiquitous.** Supervision should be voluntary, meaningful, and appropriately compensated. Emergency physicians who agree to supervise NPPs as a condition of employment should be afforded the time and resources to do so safely.

    - Emergency physicians should not be asked or required to teach NPPs procedures that are unapproved by their state boards or not permitted as a condition of state nursing or medical acts.
    - Under no circumstances should emergency physicians be forced to assume liability for other clinicians without being afforded the opportunity to supervise them safely and legally.
    - Proper supervision is laborious and time-consuming. The time required to safely supervise NPPs should be fairly compensated. It is not appropriate to require physicians to donate their time and expertise for corporate profit in lieu of their own.
    - Liability for any adverse outcomes related to notional supervisory arrangements, including unsafe interpretation of scope of practice, should lie with the employer coercing both physicians and NPPs into these exploitative and dangerous arrangements.

5. **"Termination-without-cause" employment practices in CMG contracts serve to deter physicians from their primary duty of advocating for their patients**. Reestablishing due process for EM physicians as it relates to their clinical practice is necessary to protect the physician-patient relationship.

    - Specialty societies should ensure that every EM physician has the right to due process as it relates to their clinical practice. In particular, ACEP should fully and meaningfully adopt Resolution 44 (restoring physician rights to due process) put forth by Dr. Robert McNamara including requiring compliance for all entities doing business with ACEP.
    - Legislation that protects due process should be strengthened and adopted, including HB6910, the "Emergency Room Hero and Patient Safety Act," which *"requires hospitals that employ, or contract with, physicians who furnish emergency medical services to provide specified due process protections before taking certain actions with respect to their employment. Specifically, hospitals may not terminate or restrict the professional activity or staff privileges of these*

physicians without a fair hearing and appellate review process through appropriate medical staff mechanisms. Third-party contracts shall not deny these processes."

6. **Any replacement to the current EM model must be uncompromisingly transparent.** The ideal practice model for patients of EM physicians involves a clear, reasonable path to equal partnership with a truly democratic voting structure and full transparency. The interests of corporations, bankers, and private equity firms do not warrant consideration.
    - Transparency of finances should be a fundamental right for all physicians regardless of employment status.
    - Physician groups should reject billing practices that are unfairly punitive to patients including undue or aggressive "balance billing" for out-of-network groups.
    - With respect to discussion of healthcare reform efforts on the national stage, EM specialty societies must ensure that voices representing patients and the integrity of the profession are put forth rather than those serving the interests of corporations, bankers, or investors.

7. **The ethics of medicine, including its financing, should be required learning in medical education.** The ethics of business models in emergency medicine should be a core component of the curriculum required by the ACGME for all emergency medicine residency programs to ensure that emergency physicians can be effective patient advocates. This should include a standardized curriculum about the ethics and legality of:
    - Threats to professional licensure
    - Professional fee-splitting
    - Billing fraud
    - Corporate practice of medicine
    - Ownership of physician services
    - The fee-for-service insurance-based system in the United States

Conclusion

The epidemic of complacency within our specialty must end. Our loyalties as emergency physicians must be to our patients and our communities, not to corporate overlords. The return of structurally ethical business models is the only viable path to a future in which patients will continue to receive high-quality, evidence-based emergency care. It's the only way to keep the safety net intact. If we, the physicians, don't stand up for our patients and for ethical medicine, who will?

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Ready to get involved? More information and resources can be found at www.takemedicineback.org.

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