Editorial

The "Purge"

Lawrence R. Huntoon, M.D., Ph.D.

The percentage of hospital-employed physicians has increased dramatically over the past 16 years. In 2003, 40% of physicians working at hospitals were independent.[1] By 2012, 42% of physicians were employed by hospitals and another 38% had a contractual relationship with a hospital.[1] Fewer than one in five physicians were independent.[1]

In 2018, a different survey, conducted by Merritt Hawkins for The Physicians Foundation, reported that more than 36% of physicians received their compensation either directly (hospital-employed physicians) or indirectly (employed by hospital-owned medical group) from a hospital.[2] Fewer than one-third of physicians remained in independent practice, "the lowest percent recorded since the survey was first conducted in 2012."[2]

Hospitals have sought to maximize revenue and increase market power by employing physicians and changing "clinical practice behaviors"[1] and physician "referral patterns."[3]

Hospitals have also gained majority control over the most powerful medical staff committee in the hospital, the Medical Executive Committee (MEC), through employment and exclusive contracts with the heads of departments. The MEC has power over credentialing decisions and plays a prominent role in peer review in the hospital. Some MECs have also been given the authority to make changes to policies and bylaws in between regular meetings of the medical staff.

Many hospitals provide stipends of up to $7,500 per month to physicians for simply being loyal to the hospital.[3] "'Being loyal' means, among other things, admitting patients when the hospital administrator or marketing person calls and tells them there are too many empty beds."[3]

Hospitals have also developed great expertise in gaming the payment system. The Diagnosis Related Group (DRG) system of payment (fixed payment per diagnosis), initiated by Medicare, motivates hospitals to discharge patients as quickly as possible so as to maximize profits. Although there are regulations in place that attempt to prevent a hospital from profiting from sending a patient home too soon and then readmitting the patient, hospitals have learned to simply use a different diagnostic code for the same clinical problem for the readmission.[3]

Another creative technique used to maximize hospital profits is to implement a so-called co-management policy in the hospital whereby a patient's prognosis is determined by hospital-employed physicians, and patients are given Do Not Resuscitate (DNR) status and shipped off to the hospital-owned hospice care service without the knowledge, consent, or agreement of the independent attending physician. By discharging the patient quickly, the hospital benefits under the DRG payment system, and by transferring the patient to the hospital-owned hospice service, the hospital benefits financially by getting paid on a per-diem basis.

Hospice care is a very lucrative business.[4,5] As one investigation found, this financial success has often come at the expense of patients and the Medicare program:

> In dozens of lawsuits, federal prosecutors have accused hospice companies—including almost all of the largest players—of billing fraud, alleging they enrolled patients who didn't qualify and signed them up for extra-expensive levels of care….
>
> MedPAC, meanwhile, has warned for years that misaligned incentives in the industry are encouraging hospices to enroll healthier patients—and those that don't belong at all—in an effort to boost their billings.
>
> Almost all hospice revenues come from Medicare. In most instances, Medicare reimburses hospices on a flat per-day basis, about $160 [2015 data], with payouts adjusted based on location. A hospice's costs are the highest at the beginning of a patient's enrollment and again at the end. The days in the middle—when a care routine is established—are when hospices profit the most. As a result, hospices make more money from patients who live a long time than those who die quickly.[4]

The shift from independent physicians practicing in hospitals to hospital-employed physicians was escalated by new laws and payment policies. The Affordable Care Act (ACA) encouraged the formation of Accountable Care Organizations (ACOs). Hospitals often exerted strong control over ACOs by using management contracts, and government policy favored hospital-based ACOs over physician-based ACOs to the detriment of patients. As Larry Wedekind observed:

> Putting hospitals in control of an ACO through management contracts (http://innovations.cms.gov/Files/x/Pioneer-ACO-Model-Selectee-Descriptions-document.pdf) is as ridiculous as letting the fox guard the henhouse. CMS [Centers for Medicare and Medicaid Services] has exacerbated the problem by awarding Pioneer ACO status to Hospital-based Physician Organizations (HPO's) around the country instead of awarding Pioneer ACO status to true physician-based organizations that function as Integrated Delivery Systems (IDSs).[3]

Other laws that fueled the shift to hospital employment of physicians include the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 and the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. These laws foisted new economic and administrative burdens on independent physicians that made it difficult for small group and solo practices to survive.

Hospitals have also proven very adept at using accounting gimmicks to lead people to believe they are suffering financial loss by employing physicians instead of achieving significant financial gains. Some claim losses of $196,000 per employed physician; however, those losses do not take into account offsetting value-based bonuses or revenue gained from imaging, lab tests, and surgeries generated by employed physicians.[6]

The actual average revenue generated by hospital-employed physicians has been reported in an article published by *Becker's Hospital Review*.[7] Here are a few examples of average revenue

generated, by specialty, after subtracting the average salary for hospital-employed physicians: orthopedic surgery: $2,249,605; invasive cardiology: $1,923,136; neurosurgery: $1,892,810; general surgery: $1,830,973; internal medicine: $1,623,200; family practice: $1,295,518.[7]

One article reported that hospital-employed physicians tend to order unnecessary and duplicative procedures, cause a huge increase in unnecessary and preventable admissions, and engage in "churning of specialist referrals."[3] Another study found over-testing and over-treatment in hospital-based primary-care clinics.[8] The conclusion of a researcher and professor of healthcare policy at Harvard Medical School was: "Not seeing your regular primary care physician—what we call discontinuity of care—might be a weak spot where low-value care can creep in."[8]

In the context of the adversities inflicted upon independent physicians by new laws and government policies, which forced many independent physicians into hospital employment contracts, hospitals initiated an active effort to "purge" the last remnants of independent physicians from hospitals so as to achieve total control.

The methods used to carry out the "purge" include sham peer review, creating a hostile work environment for independent physicians, and financial attacks launched against independent physicians. These methods are not mutually exclusive and are frequently used together to achieve the desired outcome.

Sham Peer Review

Sham peer review remains a popular and useful tool to eliminate unwanted physicians from the hospital setting. Most hospitals, of course, never admit to using sham peer review to get rid of certain targeted physicians. However, in one case, much to the amazement of many, a hospital advisory board member went to the microphone in a packed auditorium at a town hall meeting and boldly declared that "sham peer reviews are a useful tool for hospitals to remove troublesome physicians," and it "has a lot of benefits."[9] She made this declaration during a question-and-answer period after I had explained to the audience that sham peer review was bad-faith peer review that has nothing to do with patient safety or quality care.

All of the hospital's surgeons had resigned because they were threatened with being labeled "disruptive" for voicing concerns about quality of care. One physician told the public that he "was tired of the hospital interfering in the treatment of his patients."[9] The surgeons knew that their privileges were at risk if the hospital administration labeled them as "disruptive."

The strong immunity provided by the Health Care Quality Improvement Act of 1986 (HCQIA) has invited abuse of the peer-review process.

Hospitals continue to develop bold new tactics to deprive targeted physicians of due process and fundamental fairness.

In the recent past, we have seen the emergence of the "Thought Police," whereby a hospital terminated an independent physician's privileges based on what officials believed the physician was thinking. In true Orwellian style, alleged thoughts, not approved by hospital authorities/leadership, were punished. Any attempts by the physician to explain what he was actually thinking were automatically rejected as the "Thought Police" believed they knew his thoughts better than the physician himself did.

Additional reasons given for a so-called peer review against the physician included his ordering a medication that was not listed on the hospital formulary, and ordering a medication that the hospital alleged was harmful to a patient, possibly hastening the patient's demise. A review of the patient's hospital records, however, revealed that the medication was never actually given, and that the charge was entirely false.

In yet another case, a hospital that had a Star Chamber provision in its bylaws,[10] which allowed it to repeatedly impose punishments/requirements on an independent physician with no opportunity for hearing or appeal to contest negative findings, was also found to have another section of medical staff bylaws that blatantly deprived the physician of due process and fundamental fairness.

Shockingly, the medical staff bylaws allowed the hospital board to vote on the "guilt" of the physician and denial of privileges prior to any fair hearing or appeal process. Since the hospital board is the final adjudicator for whether or not a physician's privileges are terminated or denied, this is like a jury being allowed to vote and provide a verdict prior to the start of a trial. The bylaws provided that the board's decision be held in abeyance until after hearing and appeals had been completed. After "going through the motions" of hearings and appeals under the bylaws, the hospital board could then make its decision final. This is reminiscent of Moscow show trials under former Soviet dictator Joseph Stalin and represents the very essence of a sham process.

The "disruptive physician" label continues to be used by hospitals to remove targeted physicians. It frequently arises when a hospital lacks objective evidence to prosecute a physician based on professional competence issues. The "disruptive physician" label provides the perfect accusation because it is highly subjective and requires no "evidence" beyond the mere claim of the accuser.

Following a Sentinel Event Alert about "behaviors that undermine a culture of safety," which the Joint Commission issued on Jul 9, 2008, the Joint Commission implemented a new Leadership standard (LD.03.01.01) on Jan 1, 2009, requiring hospitals to have a Code of Conduct policy and procedures to address disruptive and inappropriate behaviors as a condition of accreditation.[11]

Physician Code of Conduct policies in hospitals typically include both verbal and nonverbal behaviors that can be used to prosecute a physician under the "disruptive physician" label. Typical nonverbal behaviors include tone of voice, facial expression, body language, and body posturing. These examples of nonverbal types of communication in the workplace have been well-described.[12]

Implementation of the new Joint Commission standard dealing with "disruptive physicians" led to the emergence of "a new cottage industry of programs claiming competence in treating, curing and intervention for physicians who are engaging in disruptive behavior toward medical staff and/or patients.… Psychologists, Marriage Counselors and Licensed Professional Counselors throughout the nation are suddenly experts on providing DSM-IV diagnoses and counseling or psychotherapy for physicians."[13]

The most common psychiatric diagnoses applied to physicians who have had the misfortune of being forced to go to one of the self-proclaimed treatment centers for disruptive physicians under threat of "voluntary" termination of privileges if they refuse to go, are narcissistic personality disorder, obsessive compulsive disorder, and personality disorder not otherwise

specified (NOS). The last diagnosis, personality disorder NOS, follows the Humpty Dumpty rule from *Through the Looking Glass* by Lewis Carroll: "When I use a word, it means just what I choose it to mean—neither more nor less." The "disruptive physician" label is thus often equated with mental impairment. In the view of hospital authorities/physician leaders, and psychiatrists they hire to perform physician evaluations, a physician whistleblower who is willing to risk his medical career by speaking out and advocating for actions to correct unsafe care or poor-quality care in the hospital, must surely be mad.

The Federation of State Medical Boards publishes a "Directory of Physician Assessment and Remedial Education Programs," which lists programs that claim to assess and treat physicians in the following areas (the number in parentheses indicates number of times those subjects are listed in the Directory): disruptive behavior (10), burnout (5), distressed physicians (2), anger management (7), professionalism/unprofessional behavior (10), personality disorders (3), and communication skills/difficult communications (4).[14]

The abuse of psychiatry in aiding and abetting the elimination of physicians from the hospital is uncomfortably similar to the rampant abuse of psychiatry that occurred in the former Soviet Union to quash political dissenters and those who failed to submit to authoritarian rule.

The most common psychiatric "diagnosis" used to suppress political dissent in the former Soviet Union was "sluggish schizophrenia." As discussed in a review article on the political abuse of psychiatry:

> Historically seen, using psychiatry as a means of repression has been a particular favorite of Socialist-oriented regimes…. [In] the Soviet Union of the 1970s, where many were not happy and society was far from ideal, many psychiatrists still believed that those who turned against the regime must be mad…. The political abuse of psychiatry in the Soviet Union originated from the concept that persons who opposed the Soviet regime were mentally ill because there was no other logical explanation why one would oppose the best sociopolitical system in the world. The diagnosis "sluggish schizophrenia," an old concept further developed by the Moscow School of Psychiatry and in particular its leader Prof Andrei Snezhnevsky, provided a very handy framework to explain this behavior…. [The] symptoms of sluggish schizophrenia could be "reform delusions," "struggle for the truth," and "perseverance."[15]

Creating a Hostile Work Environment

Independent physicians are often subjected to a very hostile work environment at the hospital. This includes actions such as:

- Constant scrutiny of 100% of patients treated, despite no evidence of any competency issue, desperately searching for something that can be criticized and used against the targeted physician;
- Constantly imposing more and more unwarranted requirements costing the independent physician time, stress from constant harassment, and expense (e.g. communications courses, medical documentation courses, 360 surveys conducted solely on the independent physician, professional coaching sessions, unjustified competency evaluations provided by physician assessment, and remedial education programs);
- Putting the subject of the independent physician's whistleblower complaints in charge of the whistleblower physician's on-call schedule (the whistleblower physician will likely be assigned most if not all of the holidays);
- Attacks on the independent physician's autonomy (e.g. establishing a hospital ICU policy whereby internists and intensivists are allowed to overrule a specialty surgeon's assessment of prognosis and certain treatment decisions, or allowing the independent physician's patients to be inappropriately labeled DNR and transferred to hospital-owned hospice services from which the hospital profits);
- Selectively interpreting and applying a hospital ICU policy to an independent physician whereby the independent physician is forbidden to talk with his own patients or their families in the hospital or in his own private office unless a member of the "ICU team" is present;
- Requiring a physician to have a designated cross-covering physician, while simultaneously directing hospitalist (hospital-employed) physicians to refuse to provide cross-coverage to independent physicians for vacations and continuing medical education seminars. When there are only a few independent physicians left at the hospital, this puts pressure on them to work all the time with no breaks or lose their hospital privileges if they choose to remain independent; and
- Removing specially trained operating room staff from the surgeon's cases and replacing them with less qualified nurses and staff (increasing the risk of negative patient outcomes for which the targeted physician can be blamed).

Chronic stress caused by subjecting a physician to constant harassment and abuse over a long period of time via sham peer review has sometimes resulted in death due to suicide or exacerbation of a medical condition leading to death. In 2017, a surviving widow of a well-respected pediatric cardiothoracic surgeon, who was a physician whistleblower, filed the first-of-its kind lawsuit claiming death caused by sham peer review.[16] The severe stress of working in a hostile work environment/workplace bullying (e.g. sham peer review) is known to increase the risk of Type 2 diabetes mellitus and cardiovascular disease (e.g. heart attack and stroke).[17]

Financial Attacks on the Independent Physician

Inflicting financial harm on the independent physician is part of the "purge" process. In one case involving an independent physician, whose privileges were summarily suspended based on a sham peer review, a member of the hospital administration specifically told the targeted physician that his income was going to go down. Hospitals engaged in "purging" independent physicians use a variety of tactics designed to damage the physician's business and inflict financial harm. This includes actions such as:

- Reducing operating room times (this can have a financially devastating effect on a surgeon);
- Reducing the independent physician's emergency on-call schedule (specialists and surgeons often depend heavily on emergency call for new patients);
- Eliminating independent physicians from the rotating schedule for reading tests such as electrocardiograms;
- Shifting referrals away from the independent physician to hospital-employed or favored physicians/specialists (this can be achieved overtly by hospital policy or covertly by using

hospital employees to spread negative gossip, rumors, or innuendo about the physician's status or abilities);
- Recognizing that independent physicians also incur significant costs associated with litigation needed to fight back against unjust actions by a hospital; or
- Establishing a policy whereby only hospital-employed hospitalists would be allowed to admit and treat patients in a hospital. ("The plan would eliminate admission privileges for independent doctors at [the hospital]."[18] Following a unanimous vote of "no confidence" by the medical staff, the CEO who initiated this policy resigned.[18])

Physicians Have a Negative View of the Shift from Independent Practice to Hospital Employment

Despite the widespread shift from independent practice to hospital employment, the majority of physicians view the trend negatively. Fears that "employment by hospitals will lead to a loss of clinical and administrative autonomy" appear well-justified.[2] A 2018 Survey of America's Physicians reported that 57.5% of physicians "do not agree that hospital employment of physicians is a positive trend likely to enhance quality of care and decrease costs." Among hospital-employed physicians, 34.6% report that the shift is not a positive one.[2]

In rating the state of relations between physicians and hospitals, 58.6% of independent physicians and 38.7% of hospital-employed physicians view the relationship as somewhat/mostly negative. A significant percent of primary-care physicians (40.3%) and specialists (49.1%) also view the relations between physicians and hospitals as somewhat/mostly negative.[2]

Conclusions

Although it is likely that most physicians try to treat patients to the best of their ability despite adversities they may encounter, some have sacrificed much of their clinical autonomy for what they may view as income security and more work-life balance provided by hospital employment. Young physicians in particular, who have been indoctrinated in medical school and residencies to focus on models that emphasize population-based medicine, tend to opt for hospital-employed positions. They have become accustomed to shift work and to following the dictates of employers and bureaucrats in the practice of medicine, including the prominent role of electronic health records.

Emerging from residency or fellowship with a high student loan debt leads graduates to choose a hospital-salaried position with some assurance that they will be able to meet their financial obligations. That choice, however, forces those physicians to sacrifice some of their clinical decision-making to the detriment of patients.

Primary-care physicians who have a longstanding relationship with their patients have a unique understanding of their patients' medical history, social history, and life goals. This is a core feature of continuity of care that suffers in a system where a patient's care is passed off from one shift worker to the next in the hospital.

In the absence of a true understanding of the patient's life, decisions are made according to cookbook protocols, co-management policies, and guidelines that tend not to serve the best interests of individual patients.

Hospitals should not function like hotels where the overriding goal is to fill beds so as to maximize profits. Physicians employed by hospitals who are paid a monthly stipend for being loyal to the hospital should not function as salesmen to fill hospital beds.

Patients should be allowed to choose their own personal physician to treat them when they are admitted to a hospital. Likewise, physicians should choose a practice model that best serves their patients.

Lawrence R. Huntoon, M.D., Ph.D., is a practicing neurologist and editor-in-chief of the *Journal of American Physicians and Surgeons*. Contact: editor@jpands.org.

REFERENCES

1. Butterfield S. A shift in hospital-physician affiliations. *ACP Hospitalist* (Archives), November 2016:1-3. Available at: https://acphospitalist.org/archives/2016/11/q-a-hospitalist-employment-models.htm. Accessed Feb 7, 2019.
2. Merritt Hawkins. *2018 Survey of America's Physicians: Practice Patterns and Perspectives.* The Physicians Foundation; 2018. Available at: https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf. Accessed Feb 8, 2019.
3. Wedekind L. Power to the physicians, not the hospitals. *IntegraNet Health*, Jan 6, 2015:1-9. Available at: http://www.integranethealth.com/news-media/power-to-the-physicians-not-the-hospitals. Accessed Feb 7, 2019.
4. Hallman B, Forster N. The business of dying has never been more lucrative. *Huffington Post*, Jul 24, 2015. Available at: https://www.huffingtonpost.com/entry/hospice-report_us_55b1307ee4b0a9b94853fc7a. Accessed Feb 10, 2019.
5. Harris M. The big (and profitable) business of dying. *CBS News*, May 24, 2011. Available at: https://www.cbsnews.com/news/the-big-and-profitable-business-of-dying/. Accessed Feb 10, 2018.
6. Goldsmith J, Hunter A, Strauss A. Do most hospitals benefit from directly employing physicians? *Harvard Business Review*, May 29, 2018. Available at: https://hbr.org/2018/05/do-most-hospitals-benefit-from-directly-employing-physicians. Accessed Feb 7, 2019.
7. Dyrda L. The cost/benefit of employed physicians for 18 specialties. *Becker's Hospital Review*, May 26, 2017:3-7. Available at: https://www.beckershospitalreview.com/hospital-physician-relationships/the-cost-benefit-of-employed-physicians-for-18-specialties. Accessed Feb 7, 2019.
8. MacDonald I. Hospital-based primary care clinics more likely to order unnecessary tests and services. *FierceHealthcare*, Apr 11, 2017:1-3. Available at: https://www.fiercehealthcare.com/healthcare/hospital-based-primary-care-clinics-more-likely-to-order-unnecessary-tests-and-services. Accessed Feb 7, 2019.
9. Willey SR. Advisory board can't resolve dispute between doctors and Christus Spohn, member says. *Bee-Picayune*, Nov 10, 2006.
10. Huntoon LR. Sham peer review: violations of due process and fundamental fairness. *J Am Phys Surg* 2018;23:66-68. Available at: http://www.jpands.org/vol23no3/huntoon.pdf. Accessed Feb 9, 2019.
11. The Joint Commission. Behaviors that undermine a culture of safety. Issue 40, Jul 9, 2008. Available at: https://www.jointcommission.org/assets/1/18/SEA_40.PDF. Accessed Feb 8, 2019.
12. Great-West Life. Centre for Mental Health in the Workplace. Verbal vs. non-verbal communication. Managing Mental Health Matters. Available at: https://www.workplacestrategiesformentalhealth.com/mmhm/pdf/full_communicating_0.pdf. Accessed Feb 8, 2019.
13. Anderson G. How to find a JCAHO consistent program for disruptive physicians. Available at: http://andersonservices.com/download/anderson_articles/How%20to%20find%20a%20JCAHO%20Consistent%20Program%20for%20Disruptive%20Physicians.pdf. Accessed Feb 8, 2019.
14. Federation of State Medical Boards. Directory of Physician Assessment and Remedial Education Programs; last updated Jan 9, 2019. Available at: https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf. Accessed Feb 8, 2019.
15. Van Goren R. Political abuse of psychiatry—an historical overview. *Schizophr Bull* 2010;36(1):33-35. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2800147/. Accessed Feb 9, 2019.
16. Davies J. Sham peer review in Israeli hospitals and expert testimony in medical malpractice litigation. Presented at: American College of Legal Medicine; Mar 4, 03/04/2018. Available at: http://www.med-law.co.il/userfiles/Sham%20Pee%20Reveiw%20in%20Israeli%20Health%20Care%20System%20(003).pdf. Accessed Feb 11, 2019.
17. Xu T, Hanson LLM, Lange T, et al. Workplace bullying and workplace violence as risk factors for cardiovascular disease: a multi-cohort study. *Eur Heart J* 2018;00,1-12. doi:10.1093/eurheartj/ehy683. Available at: https://www.uke.de/dateien/.../journal.../xu-2018_gewalt_mobbing-und-khk.pdf. Accessed Feb 11, 2019.
18. Vincent C. NCH CEO resigns after unanimous vote of 'no confidence.' *NBC2 News*, Jan 23, 2019. Available at: https://www.nbc-2.com/story/39841635/nch-ceo-resigns-after-unanimous-vote-of-no-conficence-naples-community-hospital. Accessed Feb 13, 2019.