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President's Message

"The Corporate Practice of Emergency Medicine: When Exit Strategies Rob the Future and Scavenges the Scrubs"

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These are troubling times for Emergency Medicine. On one side, administrators speak of the crucial need to maintain competitive edges. They demand cost reductions, larger profit margins, higher efficiency, and consumer satisfaction. They point to "External Forces," and demand consolidation of services. Physician executives of large CMGs are quick to predict that all EPs will become in the future employees of groups such as the ones they lead. Ironically, such predictions even came from some of the multimillionaires who had led and influenced the national organization that most EPs entrust to guard their fate.

Paradoxically, to the rank and file EPs, over the last few years, this "corporatization" translated into the first reductions ever in their compensation. EM was one of only two specialties to witness a drop. Yet, every "scrub" will report working harder. Shifts never end on time. Downtime between patients and "slow shifts" have become a myth. Scrubs see annual reductions in their hourly salaries, dwindling bonuses and perks, and a rising number of tasks: authorization and post-stabilization calls, transfers, and increasingly horrendous documentation requirements. I refer to this as "the Right-sizing of EM."

The 1990s should be referred to as the beginning of "the age of retirement." During the 1990s, many EM contract holders began finding themselves nearing the "golden age." That resulted in a trend to sell contracts to the highest bidders, often referred to as "an exit strategy." As one board member in a group engaged in a lawsuit told me: "Antoine, this is my retirement fund." I actually was struck by the firmness in conviction that those funds were legitimately his/her own. The middle manager failed to see what really was being sold was the control over the practice conditions, income potential and the revenue that would be generated in the future!

Forget not that clinical revenue had already been generously used up year after year to fund the retirement of top physician executives. Their retirement fund was already furbished by the prior labor of clinicians who had worked for them through the history of these contracts. The future labor of clinicians was simply never theirs to sell.... It belongs to future residency-graduates and to currently practicing pit doctors alike.

In a majority of EP groups, the senior partner(s) or contract holder(s) have control over their management fees. They collect (undisclosed) all professional fees billed in their

clinicians' names. A single physician, a number of senior partners, or a corporate entity own these "Physician Practice Management" firms (PPMs). The PPM's control extends from one up to hundreds of EDs. Variations exist in the degree of profit sharing with partners or employees - if allowed. Some PPMs - typically truly democratic groups and partnerships - pass net revenue to the clinicians generating it. However, many contract holders keep the majority of the net profit.

In the 1990s, a different monster surfaced in EM: the proliferation of sales of contracts to either 1) larger management groups or 2) hospital corporations. Respectively referred to as "Horizontal" and "Vertical Integration," such "contract acquisition" was often funded by either PPMs going public or by Hospital corporations. Contract holder(s) would then receive cash and stock options that far exceed the net revenue they made in 1-2 years off managing the physicians working for them. As a result, many multi-millionaires have surfaced in the last decade in EM, enticing many remaining contract holders to seek such large profits through similar "exit strategies."

Bankruptcies and financial losses then began plaguing the newly emerged consolidated PPMs. Hundreds of EPs found themselves taking forced and unexpected reductions in their income, in addition to their weakened ability to practice medicine without excessive interference by non-physician administrators.

The American Academy of Emergency Medicine and its state chapter CAL/AAEM have positioned themselves against both vertical and horizontal integration. The message is clear: such integration violates laws that prohibit the corporate practice of medicine. Vertical integration, in particular, violates anti-kick back regulations. Exit strategies should be fair, and be limited to the portion of the "exiting" EP's professional charges that he/she is still owed - from the patient care that he or she had already provided at the time of departure from an ED group. Physicians in any group should be able to devise an equitable "exit" formula that applies to all of them alike. All other forms used to fund that "retirement" are illegitimate, unwarranted, and constitute nothing more than an opportunistic sale - rather theft - of the future and well being of other EPs. Such scavenging in EM must be stopped. EPs are unable to strike! They need the active intervention of their professional organizations to legally change this unfair and dangerous practice trend. We need everyone's help to do this. We do not fear reprisals. A professional society is not supposed to avoid taking stances on such issues because it may offend some members, irrespective of how powerful or useful they are. Even then, a professional organization is supposed to seek what is right and ethical for its members and to show true leadership!