Commentary

Dual-Loyalty: The Wicked Problem of Corporatization in Health Professions

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ABSTRACT:

Increasingly, for-profit corporations are delivering a greater portion of healthcare services. While this may enhance operational efficiency and organizational effectiveness, it may raise questions about safeguarding of patients' interests and supporting the autonomy and professional judgement of individual professionals who may work as employees. In such corporate healthcare settings, there may often be leaders who themselves are licensed professionals. These individuals may not personally provide care to patients but direct the work of other professionals or establish corporate policies, practices, and cultures that shape the practice of others. In such situations, the problem of "dual loyalties" may arise, in which licensed healthcare professionals must simultaneously reconcile a professional/ethical and fiduciary responsibility to act in the best interests of patients with a corporate responsibility to maximize shareholder value. While many different agencies—including governments, accreditation bodies, and industry agencies—participate in the regulation of corporatized healthcare, the specific responsibilities and opportunities for licensing bodies to ensure appropriate management of dual loyalties has not been widely discussed. The multi-faceted and highly interconnected nature of this wicked problem opens opportunities for discussion and reflection within licensing bodies regarding how best to use mechanisms such as Codes of Ethics, Standards of Practice, and complaints/investigation systems in the context of dual loyalties in corporatized practice settings.

Introduction

Corporatization is the process of transforming state-owned or non-profit assets or entities into independent, for-profit, commercial entities,[1] namely corporations. These entities may or may not have the features of corporations such as boards of directors, professional management, and shareholders; entities such as sole proprietorships or partnerships may function effectively without some or all of these elements.[2] Across diverse health professions including medicine,[3] dentistry,[4] pharmacy,[5] optometry,[6] and physiotherapy,[7] corporatization is becoming increasingly commonplace. In some quarters, this is raising alarm bells regarding professional ethics, competence, and conflicts of interest.[8] As a result, there are increasing calls for greater "regulation" of corporatized healthcare.[3,5,8] Such calls raise important but complex jurisdictional questions: there are many different forms of regulation and kinds of regulators (including those in organizations such as state boards who regulate professional practice, as well as those in accreditation bodies, industry-specific groups, and governmental agencies). How can state boards use their available toolkits to better manage issues of corporatization in professional practice—if indeed this is something they should even consider at all? While each licensing jurisdiction may vary considerably in its ability to address this issue, increasing public concerns regarding corporatization in healthcare suggests there is value for licensing bodies to be mindful/intentional in their approach to this issue.[8]

The reason for corporatization in the context of health professions is often directly connected to two key factors: remuneration models and liability concerns.[8] Professionals (such as physicians and dentists) who may work in a fee-for-service model (rather than as salaried employees) will often find advantageous taxation benefits to delivering professional services through a corporation.

Further, incorporation can provide tax and certain commercial protections, but in most jurisdictions, profesional corporations do not shield clinicians from personal liability for their own malpractice. More general financial and investment considerations create a professional practice environment where many health professionals realize significant monetary advantages in creating their own small corporations or working within a larger corporate environment as a form of self-protection.[9] In the United States the concept of "Corporate Practice of Medicine" has been introduced that provides some jurisdiction-specific guardrails to ensure public protection, but the adequacy of these guardrails and consistency of application has been questioned.[8]

Increasingly, the work of healthcare is being delivered through individual practitioners working in self-incorporated or large corporate settings. This is not simply an artifact or "bug" of the American health system; it is also prevalent in countries with universal public healthcare systems (such as Canada or Australia). Corporatization of health professional work is extensive and expanding for the same reasons noted above.[10] While it is commonplace to decry the greed of corporations and the adverse influence of money on clinical decision-making, the global reality today is that without corporations, healthcare delivery would be severely constrained.[11] Indeed, the efficiency and business discipline of corporatized healthcare has been cited by some as an irreplaceable asset to allow for financially sustainable healthcare delivery in both public and private systems.[12]

We do not argue the merits or demerits of corporatization or the profit motivation in healthcare delivery, as these issues are highly context and culture specific. Importantly, across diverse jurisdictions with different health system models and cultures, the "problem" of corporatization and its impact on the regulation of health professions is becoming increasingly concerning. Regulators in Canada, Australia, New Zealand, the United Kingdom, and the United States are all facing issues that are rooted in what we refer to as the problem of "dual loyalties." This problem arises when an individual is simultaneously both a practitioner/professional, having duties toward patients and the healthcare system, and leader/director/manager in a corporate setting, having duties toward the corporation and shareholders.

This problem can be characterized as part of the broader concept of "wicked problems,"[13] as it is multi-faceted, exists at the intersection of technical, ethical, and situational factors, defies easy solutions, and, where solutions are offered, unanticipated consequences are likely to result. Corporatized healthcare itself is a complex entity, subject to a diverse array of regulatory influences, including licensing bodies, accreditation bodies, state and federal laws, tort proceedings, etc. No single group or agency has unilateral control over regulatory mechanisms and coordination across these different bodies and agencies makes it challenging to understand whether or not action is required, and if it is, how best to proceed given the overlapping, intersecting, and sometimes contradicting mandates of different agencies.

Nonetheless, regulators working in licensing bodies are facing some political and public pressures to "rein in" corporations, [3,5,8] and bring healthcare professionals who act as corporate leaders to account using regulatory mechanisms rooted in woolly principles such as "fitness-to-practice," "competence," or "complaints." Traditional mechanisms used by licensing bodies may be fundamentally misaligned with the problem of corporatization and have not been designed to effectively manage it. Corporatization, like all wicked problems, requires licensing bodies to embrace a nuanced and innovative approach to regulation and, most of all, to step outside of their comfort zones.

The Dual Loyalty Challenge

The concept of dual loyalty is distinct from conflict of interest, despite being superficially similar.[14] Conflict of interest is now well understood and frequently defined by organizations or in legal terms.[15] Generally, this involves an individual utilizing their position in an improper manner for their own benefit or the benefit of a person who is not at arm's length. For example, a physician who may personally profit by referring a patient to a rehab clinic she owns would be required to be transparent and disclose her material interest in the clinic to the patient.

Even within corporate settings, conflict of interest provisions are well-defined, and include provisions around recusal from discussions and refraining from voting. Core principles for management and mitigation of conflicts of interest relate to transparency and disclosure. Governance documents typically include specific penalties or sanctions that are applied where conflicts of interest are not disclosed or managed effectively.

Where conflicts of interest do or could possibly exist, the mitigation action rarely involves actual changes in an individual's status or position. For example, it is not necessarily inappropriate for a physician being paid by a pharmaceutical company to deliver a continuing education presentation. The physician is simply asked to be transparent about the sponsorship and disclose this relationship such that it is transparent to audience members, enabling them to make informed decisions about the content presented. The physician is not required to refuse financial support from a for-profit entity (though some may argue there ought to be) and no sanction is applied so long as disclosure is sufficient.

The problem of dual loyalty is different from conflict of interest. While conflicts of interest are more strongly associated with specific activities or actions, dual loyalty is a more existential phenomenon which consequently defies statutory codification, and which therefore cannot easily be mitigated by reporting requirements.[14,16] This makes it more of a wicked problem.

The nature of dual loyalties speaks to the core of an individual's allegiances and duties. It is thus inexorably linked to an individual's personal and professional identity. As a result, it is difficult to operationalize "transparency" and "disclosure" in this context due to the subconscious and unconscious biases that are inherent with "loyalty," and the difficulty (or impossibility) in articulating or enumerating an individual's specific interests or allegiances. In short, the "dual loyalty" of an individual is not so easily bifurcated or compartmentalized as a situation-specific conflict of interest might be.

Historically, the "loyalty" of health professionals has been rooted in the legal and ethical concept of a duty of care.[14] This concept has evolved over centuries as a distillate of the concept of a fiduciary duty, or a duty of "utmost good faith."

A fiduciary duty typically relates to an individual's foremost duty (that person being a fiduciary/trustee) to prioritize the interests and well-being of another person (eg: a client or a patient) over personal self-interest (and especially financial self-interest), particularly when that other person may have some inherent vulnerability in terms of power, knowledge, or skill.[14] For example, a parent is considered to be a fiduciary to a minor child in legal matters.

In the healthcare context, healthcare professionals inherently owe a fiduciary duty, and are fiduciaries, to patients. The social contract professionals have with their societies reflects the reality that professionals have unique knowledge and skills, and by virtue of this are given special powers, which place them in an inherent position of authority and power over patients who, by consequence, are inherently vulnerable. As a corollary to the responsible application of that power and authority, society confers honour and prestige on these professionals.[16]

THE REASON FOR CORPORATIZATION IN THE CONTEXT OF HEALTH PROFESSIONS IS OFTEN DIRECTLY CONNECTED TO TWO KEY FACTORS: REMUNERATION MODELS AND LIABILITY CONCERNS.

The check-and-balance in this contract between society and the health professional is the fiduciary duty of care health professionals owe to patients. This has elucidated in law, regulation, codes of ethics, and generations of professional socialization. Ethical concepts such as beneficence, non-maleficence, and respect for autonomy are all practical ways of articulating the core aspects of the fiduciary responsibility and duty to care fiduciaries owe to patients and are the foundation of professional regulation worldwide.

In addition to their inherent fiduciary duty owed to patients, health professionals working in corporate settings—particularly those health professionals in corporate leadership roles—have another well recognized fiduciary responsibility to their corporations. The "corporate veil" is a term that is sometimes used to differentiate corporations from the individuals who own them and profit from them (ie: shareholders). Corporations are "legal persons" who exist independently of their shareholders and are operated by directors appointed or elected by shareholders.[1,8] This shields shareholders (the owners of the corporation) from liability for the corporation's actions and is advantageous for the purposes of tax planning.

The legal and financial safeguards that arise from the corporate form thus makes it an important way for health professionals to organize their individual practices. Over time, however, small corporations with concentrated shareholdings used primarily for

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tax planning and to shield professionals for liability have evolved into massive, bureaucratic, trans-jurisdictional organizations with dispersed and diluted shareholdings amongst many individuals, some of whom may not be health professionals. Today, in many settings, practitioners delivering front-line healthcare to patients work within such large corporate settings and are—in essence—salaried employees or operate their professional corporations as subcontractors delivering specified services to a larger corporation.

In many professions, the corporate leaders, decision and policymakers, and managers are simultaneously registered/licensed healthcare professionals who themselves do not provide direct patient care but create the structures and environment in which other healthcare professionals do so. This not only is essential for institutional knowledge of a profession and efficient operations but contributes to the corporate leader's legitimacy and shareholders' confidence in the corporation. In this kind of corporate workplace setting there is a clearly defined fiduciary duty of corporate stewardship toward the "owners" of the corporation: shareholder wealth maximization. It is a well-established principle that corporations—though they may be legally constructed as "legal persons"—have a primary obligation to "maximize shareholder value."[1] While some debate exists as to what different forms of maximal value exist (eg: money, reputation, influence etc), the financial imperatives of the corporate fiduciary responsibility are clear in most cases.[1,8]

A problem of "dual loyalties" arises when the clinical duty of care owed to patients and the corporate duty of shareholder wealth maximization simultaneously co-exist, as they necessarily do with respect to health professionals in corporate leadership roles. These individuals necessarily must abide by both forms of fiduciary responsibility. While the primacy (or balancing) of either duty may be a speculative and philosophical debate for some, there are practical implications for regulators.

Practical Implications for Regulators

Breaches of the fiduciary clinical duty of care owed to patients by healthcare professionals have a well-established enforcement and disciplinary mechanisms within regulatory and licensing bodies. Usually these involve some form of complaint, investigation, adjudication, and where appropriate, a disciplinary or fitness to practice proceeding, and sanctions resulting thereof. This pathway is rooted in administrative law principles that prioritizes procedural fairness, evidence, the demonstration of harm, restorative justice, remediation, and the need to send a message of deterrence to the profession itself.

What is less well established, but becoming of increasing importance, are regulatory pathways that can be used to address and mitigate the impact of dual loyalty issues. The regulatory framework adopted by most regulators, while able to deal with conflicts of interest, are fundamentally ill-suited to resolve the quandary faced by corporate leaders who are also healthcare professionals. What happens when one's fiduciary clinical duty of care conflicts with one's fiduciary corporate duty to maximize shareholder value?

HISTORICALLY, THE "LOYALTY" OF HEALTH PROFESSIONALS HAS BEEN ROOTED IN THE LEGAL AND ETHICAL CONCEPT OF A DUTY OF CARE.

Consider the following case, drawn from the profession of pharmacy (though readily applicable to other professions, including medicine): A corporate leader (who is a licensed pharmacist, and a shareholder in a large multi-jurisdictional pharmacy chain) implements a policy that requires front-line staff pharmacists to perform a specified number of medication reviews per month as a condition of ongoing salaried employment in the corporation. This "quota" is presented to ensure optimal medication use, despite repeated concerns and evidence presented by staff that they had insufficient time and resources to meet the quota requirement. The medication review itself is a fee-for-service, paid activity that is charged directly to a patient's insurance company. The insurer's intention in paying for this service is to reduce the risk of drug interactions and adverse drug events and reduce unnecessary polypharmacy consequences and costs. In response to the "quota" and associated increased workload, front-line pharmacists begin triaging patients. To manage the workload, these front-line pharmacists perform the required quota of medication reviews on patients who—medically—are at lowest risk of medication-related problems and are taking the fewest number of medications. These reviews take

the least amount of time, result in the fewest number of follow-up issues, but still meet the quota requirement imposed by the corporate leader.

The delivery of an unnecessary health service—in this case, a medication review for a patient at little or no risk of harm—can be construed as a form of professional misconduct that would likely warrant further regulatory investigation or follow-up. An insurance company (or government) that feels it is not getting value for its money and believes that the spirit/intention of its funded program is being abused (even if it is not technically illegal) could reasonably be expected to complain to a regulator or licensing body and seek a remedy.

The corporate leader may reasonably state that their intention in implementing a "quota" was not to have front-line workers circumvent the spirit/intent of the funding program, but to promote patient care. As a result, regulatory processes and investigations would most likely default to the front-line pharmacists themselves, rather than the corporate leader, whether professional misconduct (or potentially financial impropriety) was demonstrated through inappropriate billing for an unnecessary service.

If this behaviour were limited to a few front-line pharmacists, it might be argued they were being lazy and unprofessional; however, in a situation (as is currently the case) where workloads and workplace pressures have increased, and human resource shortages abound this becomes more of a systemic issue associated with the corporation, and the corporate leader's decisions. Moreover, individual pharmacists may be acting due to the "pressure" on them and out of a sense of self-preservation and may not even be personally profiting from the revenues being accrued as a result. Particularly in the context of a unionized corporate work environment, it could be argued that this is actually a breach of the corporate leader's clinical duty of care toward patients, as a result of prioritization of his or her duty toward shareholder wealth maximization, that produced the quota requirement and that the corporate structure amplified and resulted in the behaviours of the front-line pharmacists in this case.

As this case illustrates, the corporate duty to maximize shareholder value conflicts with the clinical duty-to-care and is epitomized in the licensed pharmacist who also happens to be a corporate leader and shareholder. If this person were not a licensed pharmacist, there would be no regulatory/licensing body interest in this individual—there would be no fiduciary duty of care to patients or other stakeholders outside of corporate shareholders. However, since this particular licensed pharmacist has—through their corporate leadership role—an outsized influence on the practice environment of other licensed pharmacists, and consequently, on the care that patients receive from the individual pharmacists under their purview, what is the responsibility and interest of the licensing body in this situation?

"Corporate" misconduct has not been a widely used term in the regulatory community but is a logical extension and solution to the problem of dual loyalty. While provision and billing of unnecessary patient care services by a single professional for personal enrichment is clearly a form of professional misconduct, it is less clear whether a corporate leader who is not directly providing unnecessary services to patients but is still personally enriched by the outcome is liable under the traditional definition of "professional" misconduct. Indeed, they are not acting in their "professional" capacity but, rather in a corporate capacity, but nonetheless as a regulated professional.

The idea of corporate misconduct recognizes the outsized influence corporate leaders who are also health professionals have on the work and practice of their colleagues, and the unique power they have to direct the work of multiple other professionals in ways that may raise ethical concerns.

Corporate misconduct as an object of interest for licensing bodies

Is there a need, in the context of dual loyalty, for health professions regulators to consider corporate misconduct and to implement processes around management of instances of corporate misconduct, as in the example above?

It may be argued that other, existing legal systems and parallel mechanisms—for example, a civil lawsuit launched by insurers to recoup payments—are sufficient to both remedy the misconduct and function as general deterrent for corporate leaders. Importantly, the financially oriented outcomes associated with legal proceedings outside licensing bodies' remits do not adequately address the professional-ethical dimensions of corporate misconduct, nor do they provide sufficient control for licensing bodies over corporate practices that are properly within the ambit of professional governance. There is immense value in—and in some cases, statutory requirements that

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mandate—regulated health professionals be in corporate leadership roles. Historically this practice has evolved to recognize the unique insights and shared experiences that members of a profession have that are important in directing the work of other members of that same profession. Accountants or engineers directing the clinical work and practice of a physician would be problematic from both a practical and a reputational perspective for a corporation. As corporate leaders, licensed health professionals instill public confidence and legitimacy in a corporation; this can be a socially useful function (eg: when a new medication is released by a pharmaceutical company led by a reassuring licensed physician). The reality is that corporate leaders are frequently registered/licensed members of a health profession. This provides both unique opportunities—and responsibilities—for health professions' regulators to monitor and provide regulatory oversight for their corporate leadership practice. The same general principles that guide decision making and processes around "professional misconduct" could be readily transposed to allegations of "corporate misconduct" against corporate leaders who are health professionals. Professional misconduct frequently relies upon the judgment of peers related to determine what conduct should reasonably be deemed by members of that profession to be dishonourable, disgraceful, or unprofessional. Similar language applied to conduct that involves directing the work of other peers/professionals (but not necessarily providing care or services to patients directly) could guide assessments of corporate misconduct. Ethics, in this sense are, after all, universal principles readily applicable to any situation.

A PROBLEM OF "DUAL LOYALTIES" ARISES WHEN THE CLINICAL DUTY OF CARE OWED TO PATIENTS AND THE CORPORATE DUTY OF SHAREHOLDER WEALTH MAXIMIZATION SIMULTANEOUSLY CO-EXIST, AS THEY NECESSARILY DO WITH RESPECT TO HEALTH PROFESSIONALS IN CORPORATE LEADERSHIP ROLES.

Corporate leaders may argue that such a practice would ruinously constrain their flexibility and their options as leaders to make bold decisions and innovate and would reduce corporate leaders' ability to perform their roles. It may also be reasonably argued that cases of corporate misconduct do not portray any activity that is illegal or clearly demonstrate lack of professional competency, though such behavior remains problematic from an ethical viewpoint. As well, it could be argued that if employee-professionals object to corporate directives, they are free to assert themselves as professionals and simply look for other positions in other practices.

These arguments point out the limitations of a traditional legalistic approach to corporate misconduct rooted in civil litigation, and why a new category of administrative law to deal with such misconduct is necessary. The assertion that employee-professionals can simply vote with their feet and seek work elsewhere, while true, negates the reality of workforce life, where even well-educated professionals must balance a slew of competing personal and workplace demands. Being undermined in this attempt by corporate leaders to do so may not be illegal but it likely would be seen as "dishonourable" and "unprofessional." Provision of competent but unnecessary care is not necessarily illegal, which raises questions regarding whether redress could be achieved through a civil lawsuit or other legal remedies could even be successful in this case. Even traditional professional regulation processes and regulations would typically attribute fault on the individual professional as a lapse of professional judgment; failing to account for the pressure that individual might face and the implications of non-compliance. The notion that the actual act of medication review is not performed by the corporate leader, so therefore the corporate leader has no culpability in the matter, negates the reality that corporate leaders have profound and direct influence in establishing organizational culture and norms that influence professional practice and direct patient care; in effect, they are care providers and subject to their fiduciary duty to patients as healthcare professionals, just on a more macro level. Though not directly involved in the provision of competent but unnecessary care, they have not only enabled but actually exerted organizational power and influence over employee professionals to do so; thus, some measure of corporate misconduct appears proportionate. Ultimately, it is their breach of their fiduciary duty of care to patients that merits sanction, as it would for any healthcare professional in any context.

There are some who may express discomfort at the potential regulatory overreach that a new category of corporate misconduct may engender. Some may argue that licensing bodies do not have the wherewithal to develop these models which undoubtedly would be legally contested by large, well-heeled corporations. Those concerns are valid. The idea of going after a corporate leader's professional designation or license to practice for actions or imposing sanctions, terms, conditions or limitations may seem disrespectful or distasteful, particularly since in such scenarios, the leader-professional has not directly or personally engaged in any act that potentially could harm a specific identifiable patient. However, at the core is the foundational principle of a breach of a healthcare professional's duty to his or her patient which violates a professional's social contract and merits some form of sanction, regardless of context.

Moreover, to not attribute fault to a corporate leader in this cause would be unjust by misattributing it to the employee professional. The employee-professionals who, in situations like the one above, were the victims of corporate pressures might be investigated and disciplined by their regulatory bodies for the provision and billing of unnecessary care. In turn, they may argue that they are stuck "holding the bag" through no choice of their own because there are currently few if any provisions for corporate misconduct that are respectful of the difficult context of corporatized professional work today. Indeed, a choice between attrition and yielding to corporate pressure is no real choice at all. The corrosive effects of this perception on registrant-regulator relationships, and the impacts on workforce morale and performance are also issues that must be considered in weighing the value of a corporate misconduct approach.

Ultimately, the issues that surface because of the problem of dual loyalties may not in themselves be wicked problems. A philosophically defensible model for licensing body involvement where dual loyalties exist—a new form of corporate misconduct—can be constructed from the foundations of existing norms related to professional misconduct and modeled after existing practices and procedures relating to the same. Doing so would send an important message to the public regarding regulators' legitimate governance of healthcare workplaces and the workforce as a whole by acknowledging the reality that individual professionals can only be as good as their workplaces allow them to be.

Equally, such an approach would send a message to the profession itself, and corporations involved in the delivery of care tied to the profession, respecting the reality that professional misconduct may frequently be nested within a workplace and organizational culture where corporate misconduct is shaping day-to-day professional work. This would not only increase the accountability of individual professionals, but those same corporations.

Dual loyalties as a wicked problem for regulators—or not

The real wicked problem of dual loyalty may be in the implementation of corporate misconduct investigations into regulatory practice. At a time when "corporations" involved in health professionals' work were closely held, the delivery of professional services and corporate leadership were much more closely aligned. The dual loyalty of a small business owner was manageable because that owner usually also directly provided care to patients on a regular basis. The provision of care was directly aligned with business interests; the fiduciary duty of care with the duty of (personal) shareholder wealth maximization.

In today's era of large and ever-growing corporations, corporate leaders may be only rarely, if ever, involved in direct patient care. Licensing bodies, therefore, may not actively observe the impact of corporate leaders' leadership edicts and policies on the day-to-day experience of the profession, instead attributing fault to individual professionals. This gap in regulatory oversight reduces the risk and liability of corporate leaders for professional misconduct that may deliberately or inadvertently arise from corporate policy decisions. The resultant regulatory void gives the profession itself limited if any authority to investigate or discipline non-practicing corporate leaders for decisions and actions that could be seen as being dishonourable, disgraceful, or unprofessional. The advantages of being a licensed professional in a corporate leadership role are many—though one of these should not be immunity from regulatory scrutiny or sanction by virtue of their leadership roles, due to failings in the traditional regulatory framework.

It may be useful to consider another well-established profession where dual-loyalty issues are also commonly discussed—accountancy. The trustworthiness of Certified Public Accountants (CPAs) work is integral to their status as professionals, yet most CPAs work in for-profit contexts. One technique that

has served the accounting profession has been the development of "generally accepted accounting principles" (GAAP) which provide clients of accountants with reassurance and confidence—as well as documentation—regarding fiduciary responsibilities of that profession.[17] This well-established principle within the accounting profession may be instructive for health professionals to consider.

The category of "corporate misconduct" which flows from the understanding of dual loyalty can provide regulators with a defensible and precedentially sound option to consider addressing this gap as corporatization of professional work and life continues to proliferate. Though challenging and politically fraught to implement, there are legal, ethical, and logical reasons why such a category is necessary to ensure appropriate professional oversight of corporate leaders who are also healthcare professionals and inherently have a fiduciary duty of care toward their patients.

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