Oversight of Clinical Decision Making

Report of the FSMB Workgroup on Oversight of Clinical Decision Making
Adopted by the FSMB House of Delegates, May 2026

Executive Summary

Medical practice in the United States has undergone dramatic transformation. Consolidation, corporatization, and increasingly complex ownership and management structures have fundamentally altered the context within which patients receive care and physicians practice medicine. These organizational structures can provide important benefits for patients, including enhanced infrastructure, advanced technology, coordinated multi-state services, and support for clinical research. However, when not structured appropriately, they may also introduce potential conflicts between the ethical responsibilities of physicians towards their patients and the financial or operational interests of the organization.

The FSMB's Workgroup on Oversight of Clinical Decision Making was established by FSMB Immediate Past Chair Katie L. Templeton, JD, in 2024 to better understand systemic factors impacting a physician's clinical decision making, review the potential influence of various entities on standards of care, and evaluate the associated administrative burdens on the physician workforce, including physician well-being. This report summarizes the Workgroup's findings and recommendations to assist state medical boards, physicians, and other parties as they navigate an increasingly complex environment while maintaining fidelity to core professional obligations, especially the safety of patients.

The recommendations contained in this report are grounded in the fundamental principle: the primacy of patient safety. This principle holds that the fundamental role of all physicians is to safeguard the best interests of their patients above all other considerations, including personal, financial, or third-party interests. This principle derives from the social contract between the medical profession and society, which grants physicians significant autonomy and participation in regulation through state medical boards in exchange for their commitment to place patient welfare foremost.

This report recommends that state medical boards support strengthening of protections for physicians' clinical independence to reaffirm that patient safety and welfare are the primary drivers of clinical decisions. It calls for a better understanding by all parties of the guardrails needed when physicians partner or

contract with non-physician entities, and how to ensure accountability when physician independence is compromised. The report further urges boards to integrate concerns about institutional and financial pressures into broader physician well-being and burnout initiatives, recognizing that these are core patient-safety issues. Taken together, these recommendations operationalize the profession's social contract by translating physicians' fiduciary duties into clear ethical expectations for licensees and actionable oversight strategies for boards. In doing so, the recommendations seek to preserve public trust in medical regulation in an era of rapid corporatization.

For state medical boards, these recommendations offer practical tools to address corporate influence in clinical care within existing statutory authority. For physicians, they clarify professional obligations and provide regulatory support when they advocate for patients in challenging practice settings. For patients and the public, they reinforce the expectation that clinical decisions will be guided by patients' medical needs, not corporate or financial pressures. Even as new corporate, technological, and financial factors enter the health care landscape, the fundamental professional duties of physicians to their patients remain unchanged.

Section One: Introduction and Workgroup Charge

The Social Contract Between Medicine and Society

The practice of medicine rests upon a social contract, as described by sociologist Paul Starr in the 1980s,[1] between the medical profession and society. Under this implied contract which operates within and through state regulatory frameworks, society grants physicians significant autonomy, participation in regulation, and professional privileges. In return, the medical profession accepts obligations to maintain competence, demonstrate integrity, place patient interests above self-interest, and enforce these standards at the level of clinical practice.[2]

Central to this social contract is the physician's fiduciary duty to patients: an ethical obligation of undivided loyalty that requires physicians to act in patients' best interests even when doing so conflicts with their own interests or the interests of third parties.[3,4,5] This fiduciary relationship is foundational to patient trust, which is itself essential to effective medical care and patient safety.

The social contract and the ethical duties that it encompasses entail several core responsibilities for physicians:

- To place patient welfare above personal or institutional financial interests
- To maintain clinical independence and professional judgment
- To ensure transparency with patients regarding factors that may influence care
- To advocate for patients' access to appropriate, medically necessary care, and
- To report circumstances that compromise the ability to provide appropriate care

While professionalism is expressed through the actions of individual physicians, it is sustained—and impacted—by the institutions of medicine. Professionalism is demonstrated by individual physician actions, but is also shaped and reinforced by the institutional frameworks in which care is delivered. Medical schools, residency programs, health systems, group practices, payors, professional associations, and regulatory bodies each play a critical role in establishing and maintaining environments that support ethical practice. Accordingly, promoting

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[1] Starr, P. (1982). *The social transformation of American medicine*. Basic Books.
[2] Cruess, S. R., Cruess, R. L., & Steinert, Y. (2010). Linking the teaching of professionalism to the social contract: A call for cultural humility. *Medical Teacher*, 32(5), 357-359.
[3] Ludewigs, S., Narchi, J., Kiefer, L., & Winkler, E. C. (2025). Ethics of the fiduciary relationship between patient and physician: The case of informed consent. *Journal of Medical Ethics, 51*(1), 59–66.
[4] Rodwin, M. A. (1995). Strains in the fiduciary metaphor: Divided physician loyalties and obligations in a changing health care system. *American Journal of Law & Medicine*, 21(2-3), 241-257.
[5] Chervenak FA, McCullough LB. (2003) Physicians and hospital managers as cofiduciaries of patients: rhetoric or reality? *J Healthcare Manag.* 48(3), 172–9.

professionalism is a shared responsibility, requiring alignment between individual obligations and the broader systems that shape clinical care.

Workgroup Charge

The Workgroup on Oversight of Clinical Decision Making was established by FSMB's Immediate Past Chair, Katie L. Templeton, JD, in 2024 and charged with assessing systemic factors impacting physicians' clinical decision making, analyzing the influence of payors and third parties on standards of care, and evaluating associated administrative burdens on the physician workforce, physician well-being, and patient safety. The Workgroup was further charged with examining the effect that these factors have on state medical boards' ability to effectively carry out their statutory missions and to provide guidance for board efforts in support of ethical practice and the fulfillment of fiduciary duties to patients.

The Workgroup engaged in extensive deliberation, reviewing legal and policy literature, examining enforcement actions, consulting with experts, and considering the perspectives of multiple interested parties. The Workgroup recognized that modern health care delivery requires sophisticated management, finance, and economics expertise, and that organizational partners and outside capital have, in many settings, supported research, facility expansion and renovation, and modernization of electronic medical records and health data infrastructure.[6] The challenge shared by the medical profession and society is to preserve these benefits while preventing improper interference with clinical decision making. The Workgroup identified several recurring themes: the potential for tension between institutional interests and a physician's professional obligations; the importance of clinical independence; the value of transparency; and the fundamental principle that patient safety must take primacy over all other considerations.

Scope and Limitations

These recommendations are intended as model guidance and should be implemented consistent with each state medical board's statutory authority and limitations. In jurisdictions where boards are not permitted to issue detailed clinical or practice guidance, the principles and recommendations in this report may be understood as internal frameworks to inform processes and, where appropriate, as model language for consideration by legislatures or other regulatory authorities, rather than as directives to individual physicians.

In interpreting this report, state medical boards should concentrate on tools and strategies that are realistically within their jurisdiction, while identifying areas where collaboration with other state and federal actors is necessary.

[6] Lo Sasso, A. T. (2024, March 21). *Private equity is not the boogeyman in healthcare*. RealClearMarkets. https://www.realclearmarkets.com/articles/2024/03/21/private_equity_is_not_the_boogeyman_in_healthcare_1019369.html

Section Two: Evolution of Practice Structures and Emerging Challenges

Historically, most physicians in the United States practiced independently or in small physician-owned groups. Over the past several decades, the health care delivery landscape has undergone a fundamental transformation. Rather than own their practices, physicians increasingly practice as employees of hospitals, health systems, or in practices closely aligned with a private investor or non-physician entity. While some physician employment by hospitals dates to the mid-20th century, the pace of consolidation has accelerated significantly since the 1990s. According to an Avalere report from early-2024, about 77.6% of all practicing physicians in the United States were employees of hospitals, health systems, and other entities.[7]

These changes have occurred in response to multiple factors: increasing practice overhead and administrative complexity, student loan burdens, a desire for work-life balance, and perceived advantages to physicians of organizational affiliations.[8] While these models may offer important benefits— including enhanced infrastructure, advanced technology, coordinated multi-state services, and support for clinical research—they also can, without proper guardrails, introduce potential conflicts between physicians' professional obligations and the financial or operational interests of the affiliated non-physician entities.

State medical boards have shared examples of influence on care that raise the following issues:

- Financial and billing practices that undermine transparency and patient trust, such as facility or other fees that patients experience as unexpected or inadequately disclosed and that are outside the individual physician's control.
- Constraints that block or delay clinically appropriate care recommended by the physician, including coverage denials, restrictive admission or utilization criteria, and market pressures that make it difficult for physicians (including solo practitioners) to sustain practice models that support patient-centered care.
- Control over key aspects of the physician-patient relationship that interferes with fiduciary duties and accountability, such as control over medical records or practice infrastructure that creates barriers to patient

[7] Physicians Advocacy Institute, & Avalere Health. (2024, April). *PAI-Avalere study on physician employment–practice ownership trends 2019–2023*. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023

[8] Darves, B. (2014, July 23). *Understanding the physician employment "movement"*. NEJM CareerCenter. https://resources.nejmcareercenter.org/article/understanding-the-physician-employment-movement/

access, obscures who is responsible for care decisions, or limits physicians' ability to advocate effectively for their patients.

Several specific structural developments and external influences can present tradeoffs and tensions between physicians' clinical decision making and the priorities of non-physician actors or entities, including ownership, financing, and employment arrangements that shape how physicians practice. While the following developments may alter how care is organized and financed, they do not alter the underlying professional obligations of physicians, which continue to require that clinical decisions be made in the best interests of patients.

1. **Integrated Professional Corporation-Management Services Organization[9] (PC-MSO) Structures:** Hospitals, virtual care entities, managed care, and practices aligned with private investment often rely on a model wherein the professional corporation (PC) owned by licensed physicians has a management services agreement with a lay-owned management services organization (MSO). The management service agreement should recognize the PC's control over all clinical decisions and the medical practice itself, while delegating administrative and operational services to the MSO. While properly structured and implemented PC-MSO arrangements are designed to comply with corporate practice of medicine (CPOM) prohibitions, these structures may sometimes result in effective control over clinical operations by non-physician entities when physician owners are not meaningfully engaged or when contractual arrangements are structured to circumvent protections.[10]
2. **Increased Need for Private Investment:** Whether developing an innovative new care model or wanting capital for new equipment or facing revenue shortfalls, many physician practices have increasingly turned to outside investment sources, including private equity or venture capital financing. In some instances, aligning with outside investment can enable practice growth, improve operational efficiencies, modernize the practice's technology, and help struggling practices stay open rather closing or consolidating with a larger health system. However, third-party investors do not have the same fiduciary or ethical duties to patients as physicians do. In private equity, for example, investments typically involve aggressive debt financing and expectations for rapid return on investment, potentially creating pressure to prioritize profitability over patient care.[11]

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[9] In some jurisdictions, such as New York, more precise terminology such as 'administrative services organization' (ASO) or 'administrative services arrangement' is used to emphasize that these entities provide support services without exercising control over clinical decision making.

[10] In most jurisdictions with corporate practice of medicine restrictions, hospitals are statutorily exempt or otherwise excluded from CPOM prohibitions, meaning that hospital entities may employ physicians directly even where lay-owned corporations are restricted.

[11] Borsa, A., Bejarano, G., Ellen, M., & Bruch, J. D. (2023). Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: Systematic review. *BMJ, 382*, e075244. **https://doi.org/10.1136/bmj-2023-075244**

3. **Employment by Health Systems, Hospitals, and Payors:** Physicians increasingly practice as employees of health systems, hospitals, or payors rather than as independent practitioners. While appropriate alignment between physicians and organizational goals—such as in value-based care models emphasizing quality metrics and care coordination—can benefit patients, employment arrangements may also create conflicts when institutional financial and operational priorities override clinical judgment. The challenge is to preserve clinical independence while allowing beneficial care delivery innovations and responding to patient demand for transparency and cost-effective options.. Examples of concerning arrangements include:
    - Hospital and health system employment structures that tie clinical authority and resource allocation to centralized administrative leadership, which may prioritize service line growth, throughput, or cost savings.
    - Employment by payors or payor-affiliated entities, in which physicians' roles and performance expectations may be closely linked to utilization reduction, cost-containment goals, or adherence to payor-designed care pathways.
    - Productivity-based compensation models, such as those relying heavily on relative value units (RVUs) or visit volume targets (VVTs), which can pressure physicians to increase encounters, favor higher-reimbursed services, or limit time per patient, creating tension with individualized, patient-centered care and jeopardize the physician-patient relationship.
4. **Employment Agreements Can Include Restrictive Covenants:** Physicians sign employment agreements containing restrictive covenants, non-disclosure agreements, and non-disparagement clauses. While practices might have legitimate interests in protecting their investments in workforce and promoting stability, these contractual provisions may inhibit their ability to advocate for patients, report safety concerns, or exercise independent professional judgment.[12]
5. **External Payor Controls on Treatment Through Utilization Management:** Though different from ownership or employment structures, third-party payors exert influence over clinical decisions through prior authorization requirements, utilization review, and other cost-containment mechanisms. While some oversight of medical necessity may be

[12] American Medical Association. (2025). *Legislative approaches to curb corporate influence in health care: State-level policy options to protect the integrity of medical practice amidst increased investment in health care by private equity firms and other corporate entities*. American Medical Association. **https://www.ama-assn.org/system/files/state-leg-approaches-to-curb-corporate-influence-in-health-care.pdf**

appropriate, aggressive utilization management can interfere with physician judgment and delay or deny medically appropriate care.[13,14]

These systemic changes and structural developments in the practice of medicine pose a series of oversight issues for medical boards to address:

Overall Challenges

1. Insufficient transparency regarding ownership and control structures of clinical practices
2. Difficulty determining accountability when clinical decisions involve multiple parties
3. Lack of updated guidance reflecting contemporary practice realities and ensuring licensees understand their legal and ethical duties when facing institutional or financial pressure
4. Limited jurisdiction over non physician entities influencing clinical care.

PC-MSO Model Considerations

1. Determining whether arrangements comply with state CPOM laws
2. Identifying the party truly controlling clinical decisions when harm occurs
3. Addressing situations where the controlling entity is outside state medical board jurisdiction
4. Enforcing ethical obligations when contractual arrangements constrain physician autonomy

Payor Coverage Considerations

1. Determining whether physicians who fail to advocate for patients when care is inappropriately denied have violated their professional duties
2. Deciding whether utilization review physicians practicing in other states should be subject to licensure requirements
3. Appropriately addressing situations where payor denials lead to patient harm
4. Clarifying physicians' ethical obligations when they disagree with coverage determinations

[13] Pickern, J. S. (2025). Prior authorizations and the adverse impact on continuity of care. *The American Journal of Managed Care, 31*(4), 163–165. **https://doi.org/10.37765/ajmc.2025.89721**
[14] American Medical Association. (2025). *2024 AMA prior authorization physician survey*. American Medical Association. **https://www.ama-assn.org/system/files/prior-authorization-survey.pdf**

Employment Contract Considerations

1. Offering guidance about whether specific contractual provisions that prevent physicians from reporting concerns or advocating for patients violate professional obligations
2. Protecting physicians from retaliation who report concerns in good faith
3. Deciding whether boards should prohibit certain contractual provisions as inconsistent with professional obligations

Physician Education and Resources for Well-Being

1. Understanding systemic factors that contribute to physician burnout, impairment and suboptimal performance
2. Ensuring board policies do not exacerbate burnout but promote well-being
3. Recognizing that physicians struggling under unsustainable conditions often need support, rather than discipline

Section Three: Principles

The primary recommendations in this report rest upon the following core principles, which should guide state medical boards, licensees, and other entities in addressing the challenges posed by contemporary practice structures.

Principle 1: Primacy of Patient Safety and Best Interests

The fundamental obligation of every physician is to safeguard the best interests of patients above all other considerations, including personal, financial, or corporate interests.

This principle is the bedrock of medical professionalism. It means that when conflicts arise between patient welfare and other interests—whether the physician's financial gain, an employer's profitability, or cost containment efforts—the patient's interest must prevail. The primacy of patient safety is not merely aspirational; it is a binding professional duty that is enforceable by state medical boards. Upholding this principle is not the sole responsibility of individual physicians; institutions that employ, train, or contract with physicians share responsibility for structuring care environments that allow patient welfare to remain paramount.

Principle 2: Clinical Independence and Professional Judgment

Physicians, in conjunction with patients in a shared decision-making process, must retain ultimate authority over clinical decisions and must not allow non-physicians or corporate entities to interfere with, control, or unduly influence their professional medical judgment.

Clinical independence means that decisions regarding diagnosis, treatment, referrals, and other medical matters must be made by licensed physicians based on their professional judgment, adherence to evidence-based standards and accepted clinical protocols, prevailing evidence and standards, and the individual patient's circumstances. While physicians may appropriately consider input from colleagues, institutional protocols based on evidence and resource constraints, the ultimate clinical decision must largely remain with the physician, free from improper interference.

Principle 3: Fiduciary Duty and Undivided Loyalty

Physicians owe ethical duties to their patients, requiring them to act with undivided loyalty to patient interests and to avoid (or appropriately manage) conflicts of interest that may arise through their employment arrangement.

The physician-patient relationship is fiduciary in nature. Physicians must disclose conflicts of interest to patients, avoid arrangements that compromise their loyalty to patients, and structure their practices to minimize the influence of financial incentives that diverge from patient welfare. When conflicts are unavoidable, they must be transparently disclosed and carefully managed.

Principle 4: Transparency and Informed Consent

Patients have the right to know who is making decisions about their care, what factors may influence those decisions, and what organizational or financial relationships may affect the care they receive.

Transparency is essential to informed consent and to maintaining patient trust. Patients have a right to know about limitations on treatment options imposed by institutional, payor, or other policies. This transparency enables patients to make informed choices about their care.

Principle 5: Physician Duty to Advocate and Report

Physicians have a professional obligation to advocate for their patients' access to a range of medically appropriate care options at various price points, and to report circumstances that improperly interfere with clinical decision making or compromise patient safety.

Physicians must not be passive participants when corporate policies, payor restrictions, or other systemic factors improperly interfere with patient care. Physicians have an ethical duty to advocate for their patients and, when necessary and required by state law, to report improper interference to their state medical board or other appropriate authorities. The ethical duty involves making reasonable, good-faith efforts through available channels and does not guarantee a particular outcome in every case. State medical boards should protect physicians who report in good faith from retaliation. Retaliation against physicians for such reporting undermines the public protection work of state medical boards

and may itself require referral to other regulatory authorities with jurisdiction over employers or facilities.

Principle 6: Accountability and Collective Professionalism

Professionalism is a collective enterprise. All parties involved in health care delivery—physicians, health care organizations, payors, and others—share responsibility for ensuring that patient safety is protected and that physicians can fulfill their professional obligations.

While physicians bear primary responsibility for their clinical decisions, accountability must extend to organizations and entities that structure practice arrangements, impose productivity expectations, implement utilization management programs, or otherwise influence clinical care. When those institutions normalize practices that conflict with accepted standards, the profession's collective credibility is at stake. State medical boards should work to ensure that these entities do not undermine physicians' ability to meet professional obligations.

Principle 7: State Medical Board Authority and Responsibility

State medical boards have the authority and responsibility to regulate physicians in a manner that protects patient safety, maintains professional standards, and holds licensees accountable for fulfilling their fiduciary duties to patients, regardless of practice setting or employment structure.

State medical boards' fundamental mission—protecting the public—does not change when physicians enter employment relationships or when corporate entities become involved in health care delivery. Where possible, boards should adapt their oversight approaches to address contemporary practice structures while maintaining clear expectations for licensee conduct. This report also recognizes that many system-level factors lie outside individual licensees' direct control and it may therefore be inappropriate to place disproportionate responsibility on individual physicians for structural issues created by corporate entities.

Section Four: Recommendations

The following recommendations, intended as model guidance for consideration, are offered primarily to state medical boards in support of their efforts to regulate the practice of medicine in the interest of protecting patients. Additional recommendations are offered to licensees. All recommendations below are offered with the aim to preserve physician clinical independence, ensure accountability, promote transparency, and ultimately protect patient safety. Although the recommendations that follow are addressed primarily to state medical boards and individual licensees, the preservation of professionalism in an era of corporatization and consolidation cannot rest on individuals alone; it

requires concerted participation by the institutions of medicine to design practice environments where ethical and fiduciary duties are realistic to fulfill.

Many of the practice structures described in this report involve non-physician entities that may lie outside the direct jurisdiction of state medical boards. Boards should implement these recommendations only to the extent consistent with their statutory authority. Where such authority does not exist, boards should focus their enforcement efforts on licensees, collaborate with other regulators, and consider legislative advocacy, where permitted.

Recommendation 1: Affirm the Primacy of Patient Safety in All Practice Settings

State medical boards should clearly articulate that physicians' professional and ethical obligations to patients apply broadly and regardless of practice setting, employment structure, or contractual arrangements.

All licensees must understand that entering an employment relationship or contracting with non-physician entities does not diminish their ethical duties to patients. State medical boards should:

- Issue clear policy statements or guidance documents affirming that professional obligations persist across all practice structures
- Communicate regularly with licensees about these expectations
- Include discussion of professional obligations in varied practice settings in board publications, licensee communications, and continuing education programs
- Hold licensees accountable when they fail to uphold professional standards, while simultaneously considering mitigating systemic factors

Recommendation 2: Strengthen Oversight of Corporate Practice of Medicine

State medical boards in jurisdictions with corporate practice of medicine statutes should work with relevant state agencies, state legislatures, state attorneys general and Governors, where permitted by law to do so, to review their state's enforcement approach. Collaboration is strongly recommended to strengthen guidance to licensees and enforcement actions against improper arrangements.

In simple terms, corporate practice of medicine laws should be intended to prevent non-physicians from controlling clinical decision making, even when they own or manage a practice. When improper corporate control over clinical decisions (as opposed to administrative support) is identified, boards should, where permitted by law, propose remedies directed at the entities and individuals responsible for structuring and enforcing such arrangements, rather than placing

sole or disproportionate responsibility on employed physicians functioning within constrained practice settings.

Specific actions may include:

- Evaluating whether current statutes, regulations, and enforcement practices adequately protect against improper corporate influence over clinical decisions and whether additional guardrails are needed
- Coordinating, where authorized, with state attorneys general, insurance regulators, and other agencies to address patterns of corporate behavior that systematically undermine physician clinical independence or patient safety.
- Providing clearer guidance to licensees regarding what constitutes "control" over clinical operations and appropriate physician involvement in practice governance
- Developing educational materials explaining CPOM requirements and potential pitfalls when practice structures are inappropriately implemented
- Collaborating with state attorneys general and other enforcement agencies on CPOM violations
- Considering registration requirements for management services organizations that contract with physician practices
- Encouraging practice entities and physician owners to adopt shared accountability in contractual arrangements, including clear delineation of responsibilities for preserving clinical independence and patient safety

When offering explanations of practice arrangements, boards should distinguish between appropriate administrative support functions (billing, credentialing, facilities management, technology infrastructure) and inappropriate control over clinical decision making (dictating treatment protocols, mandating discharge timing, prohibiting referrals, retaliating for patient advocacy).

Recommendation 3: Establish Standards for Clinical Independence

State medical boards should articulate clear expectations regarding physician clinical independence and improper interference by non-physicians in clinical decision making. By clearly articulating these boundaries, boards reinforce that the profession's autonomy is justified only when it is exercised in service of patient welfare.

Such guidance may specify that in all practice settings:

- Physicians should retain ultimate authority over clinical decisions, including diagnosis, treatment, referrals, prescribing, and care coordination
- Non-physicians and corporate entities should not interfere with, control, or unduly direct physicians' professional medical judgment, including in

mandating specific treatment decisions and establishing patient volume or unreasonable time limits

- Physicians should not allow productivity metrics, financial incentives, or institutional policies to compromise their clinical judgment or patient safety
- Employers and non-physician entities should not discipline, terminate, or retaliate against physicians for making clinical decisions in patients' best interests
- Contractual provisions that prevent physicians from exercising independent professional judgment may be contrary to public policy and professional obligations[15]

Examples of impermissible interference may include:

- Mandating specific treatment decisions, such as requiring discharge before it is medically appropriate or prohibiting certain referrals
- Establishing patient volume or time limits that prevent physicians from providing adequate care
- Retaliating against physicians who advocate for patients or raise safety concerns

Recommendation 4: Require Meaningful Physician Ownership and Involvement

In jurisdictions with corporate practice of medicine laws, state medical boards should require physician owners to demonstrate meaningful ownership through substantial engagement in delivering care or managing the practice.

Meaningful ownership and substantial engagement may be defined as requiring more than holding title to shares in the practice. It may include requirements that physician-owners:

- Be duly licensed in the state where the practice operates
- Be actively engaged in delivering medical care or substantively involved in practice management
- Retain ultimate authority over key practice decisions, including clinical policies, hiring/firing of clinical staff, contracting with payors, and financial distributions

[15] State medical boards generally do not pre-approve or adjudicate individual employment contracts, but they may identify categories of provisions that, if accepted or followed, could place licensees at risk of violating their professional obligations to patients. Where authorized by law, boards may declare that certain types of contractual clauses are inconsistent with professional obligations or contrary to public policy.

Recommendation 5: Address Licensure of Out-of-State Physician Practice Owners

It is strongly recommended that state medical boards consider whether physicians who own or govern medical practices providing care in their state should be required to hold licensure in that state, thereby subjecting them to the board's jurisdiction and ethical standards.

Currently, several states with CPOM statutes do not require practice owners to be licensed in the state where the practice operates, so long as the owner holds an active medical license elsewhere. This creates accountability gaps when out-of-state owners exert control over practices but are not subject to the state medical board's authority. Subjecting owners who control clinical policies to board oversight closes critical accountability gaps and aligns legal authority with practical control.

State medical boards should:

- Evaluate whether requiring in-state licensure for practice owners and directors would improve oversight
- Consider alternatives such as registration requirements or written attestations of compliance with state laws and professional standards
- Collaborate with other state medical boards and the FSMB to address multistate practice ownership issues

Recommendation 6: Clarify Physicians' Duty to Advocate and Report

State medical boards should remind physicians that they have a professional and ethical duty to advocate for patients when care is inappropriately restricted and to report circumstances to relevant bodies that improperly interfere with clinical decision making or present risks to patient safety, whether by other physicians or non-physician entities. In doing so, boards should design expectations and processes that do not impose disproportionate administrative burden on individual physicians or create additional barriers to reporting.

Guidance should specify that:

- Physicians have a duty to report patient harm or risks to patient safety, whether presented by non-physician entities, or by other practicing physicians
- When payors deny or delay medically necessary care and place patients at high risk of harm, physicians should advocate for their patients, including through appeal processes
- When employers, practice owners, or non-physician entities create unsafe conditions, physicians should raise concerns through appropriate channels

- Physicians have a duty to report to the state medical board situations where non-physicians improperly and unduly control clinical decisions or where a practice's policies systematically compromise patient safety
- Physicians who report in good faith are exercising their professional obligations and should be protected from retaliation
- Non-disclosure and non-disparagement agreements that, in effect, prevent physicians from reporting patient safety concerns, quality problems, or regulatory violations may be contrary to professional obligations and public policy
- Refusal to sign impermissible contractual provisions is consistent with licensees' professional and ethical obligations

Boards should establish clear, fair reporting and investigative mechanisms that allow all parties—including employers, practice organizations, and physicians—to present relevant information. While physicians have a duty to report in good faith, boards should also investigate claims appropriately and distinguish between legitimate professional advocacy and attempts to leverage reporting mechanisms for improper financial or contractual advantage.

Recommendation 7: Promote Transparency in Ownership and Practice Arrangements

State medical boards should encourage transparency regarding practice ownership structures in order to support patients' right to know about factors that may influence clinical decisions. Wherever possible, the primary reporting burden for ownership and control information should fall on corporate entities, facilities, or practices, rather than individual employed physicians.

Enhanced transparency empowers patients to make informed choices about their care and enables boards to identify potentially problematic arrangements.

Recommendation 8: Educate Licensees About Practice Structures and Professional Obligations

State medical boards should develop educational materials to help physicians understand the professional and legal implications of various practice structures and employment arrangements. Educational materials for licensees about patient advocacy with non-physician partners should also be considered. Recognizing limited resources and limitations on the authority to issue educational guidance, boards may prioritize a limited set of high-impact educational materials or leverage partners such as state medical societies, specialty organizations, and academic institutions, to disseminate appropriate guidance for their jurisdiction.

Educational initiatives should:

- Explain CPOM requirements and the rationale for these protections
- Provide guidance on evaluating employment contracts and identifying problematic provisions
- Clarify professional obligations regarding clinical independence and patient advocacy
- Offer case examples illustrating appropriate and inappropriate practice arrangements
- Provide resources for physicians who encounter improper interference with clinical decisions
- Provide resources to underscore the responsibilities and obligations of physician owners

Education is particularly important for residents, early-career physicians, and those transitioning from training to practice, who may be most vulnerable to entering problematic arrangements.

Recommendation 9: Collaborate with Other Regulators and Interested Parties

State medical boards should work collaboratively with state attorneys general, state insurance departments, federal agencies, and others to address systemic issues affecting clinical decision making.

Collaboration could include, where permitted by law:

- Development of mechanisms (such as memoranda of understanding) to share information about practices that systematically, repeatedly or consistently interfere with clinical decision making or retaliate against physicians who raise patient safety concerns
- Joint enforcement actions against entities that violate CPOM laws or engage in improper interference with clinical decisions
- Coordinated policy development to address emerging challenges
- Engagement with professional associations, specialty societies, and physician advocacy organizations
- Participation in federal and state legislative efforts to protect physician clinical independence and patient safety

Many of the challenges identified in this report exceed the jurisdiction of any single regulatory body and require coordinated responses.

Recommendation 10: Address Utilization Management and Prior Authorization Concerns

State medical boards should clarify physicians' professional obligations in the context of utilization management and, recognizing that insurers are primarily regulated by other state and federal agencies, advocate, where permissible by law, for reforms to ensure that utilization review does not improperly interfere with clinical decision making and medically necessary patient care.

State medical boards should:

- Clarify that physicians retain responsibility for ensuring patients receive medically necessary care, even when payors initially deny coverage and/or payment
- Support physicians in advocating for patients through appeal processes when care is inappropriately denied and patients are put at risk of harm
- Consider whether out-of-state physicians performing utilization review for patients in the board's jurisdiction should be required to hold licensure in that state, in accordance with state insurance regulations.
- Advocate for state legislation requiring that medical necessity determinations be made by physicians licensed in that state and practicing in the same or a similar specialty
- Support efforts to streamline prior authorization processes and reduce unnecessary administrative burdens on physicians and patients
- Work with state insurance departments to address situations where utilization management systematically compromises patient care

State medical boards should recognize that while utilization review serves legitimate purposes, it must not become a mechanism for improperly overriding physician clinical judgment or denying medically appropriate care. Boards have direct authority over licensed physicians, including those performing utilization review, and broader changes to payor practices will likely require collaboration with insurance regulators and legislators.

Recommendation 11: Integrate with Physician Well-being and Burnout Initiatives

State medical boards should recognize that systemic interference with clinical decision making and clinical care may contribute to physician burnout and should integrate these concerns into well-being initiatives.

Burnout, a phenomenon which is distinct from impairment resulting from illness, is typically driven by systemic and organizational factors affecting medical practice. Burnout has been linked to increased medical errors and compromised quality of

care.[16,17] Many physicians experiencing burnout require workplace and systems-level interventions such as limits on patient volumes and restrictions on patient visit interactions.

As articulated in FSMB's policy on Physician Wellness and Burnout, adopted by FSMB's House of Delegates in 2018, state medical boards have a role to play in supporting physician well-being that is directly related to their statutory mission to protect the public and maintain the physician workforce. With respect to clinical decision-making challenges, boards should:

- Acknowledge that systemic factors—productivity pressures, administrative burdens, financial pressure, moral distress from inability to provide appropriate care—contribute to burnout
- Consider systemic factors as mitigating circumstances when evaluating physician performance or conduct issues
- Support physicians who report unsafe working conditions or improper interference with clinical judgment
- Collaborate with physician health programs (PHPs) when impairment or safety risk is suspected and, when services related to burnout are offered by a PHP, to address burnout related to practice structure challenges
- Advocate for systemic reforms to reduce administrative burdens and support sustainable practice conditions

Protecting physician well-being and protecting patient safety are complementary goals.

Recommendations for Licensees

While the primary recommendations listed above are directed to state medical boards, licensed physicians themselves also bear responsibility for upholding professional standards and fulfilling fiduciary duties to patients. The following guidance is offered to licensees:

Recommendation 12: Understand Your Professional Obligations

Physicians must recognize that professional and ethical obligations persist regardless of employment status or practice structure. Fiduciary duties to patients

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[16] Tawfik, D. S., Profit, J., Morgenthaler, T. I., Satele, D. V., Sinsky, C. A., Dyrbye, L. N., Tutty, M. A., West, C. P., & Shanafelt, T. D. (2018). Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. *Mayo Clinic Proceedings, 93*(11), 1571–1580. https://doi.org/10.1016/j.mayocp.2018.05.014

[17] Wallace, J. E., Lemaire, J. B., & Ghali, W. A. (2009). Physician wellness: A missing quality indicator. *The Lancet, 374*(9702), 1714–1721. https://doi.org/10.1016/S0140-6736(09)61424-0[4]

are not negotiable, cannot be overridden by employer or payor demands, and cannot be waived by contract.

Recommendation 13: Carefully Evaluate Practice Arrangements and Employment Contracts

While state medical boards generally do not approve or adjudicate individual contracts, physicians should understand that certain contractual provisions may expose them to professional licensure risk if those provisions prevent them from meeting their fiduciary duties to patients.

Before entering employment agreements or contracting with non-physician entities, physicians should:

- Thoroughly review all contractual provisions, preferably with an attorney familiar with that state's health care law and medical practice regulations
- Where feasible, seek shared accountability provisions in contracts, such as mutual commitments by the physician and the organization that neither party will enforce terms in a way that interferes with clinical independence, patient advocacy, or reporting of safety concerns
- Evaluate whether the arrangement preserves clinical independence and allows fulfillment of professional obligations
- Scrutinize restrictive covenants, including non-disclosure, non-compete, and non-disparagement provisions, particularly where they may inhibit reporting of safety concerns, undermine continuity of care limit patient access to care, or restrict clinical autonomy
- Ensure that compensation arrangements do not create problematic incentives to undertreat or overtreat
- Verify that the practice structure complies with state corporate practice of medicine laws

Physicians should be wary of arrangements that seem "too good to be true" or that offer nominal ownership without meaningful authority.

Recommendation 14: Maintain Clinical Independence

Physicians should retain ultimate authority over clinical decisions. When employers, non-physician entities, other physicians, or payors attempt to interfere with clinical judgment in ways that compromise patient care, physicians should:

- Advocate firmly for their patients' best interests
- Raise concerns about directives that violate professional obligations or compromise patient safety
- Document attempts to interfere with clinical decision making

- Report improper interference through appropriate channels, including to the state medical board, as may be necessary

Recommendation 15: Fulfill the Duty to Advocate and Report

Physicians have an affirmative obligation to advocate for patients and to report circumstances that improperly interfere with clinical care. This includes:

- Appealing prior authorization denials when care is medically necessary
- Raising concerns with employers when institutional policies compromise patient safety
- Reporting to the state medical board situations where non-physicians control clinical decisions or where corporate entities systematically prioritize profits over patient welfare

Physicians should not allow fear of retaliation to prevent them from fulfilling these duties.

Recommendation 16: Ensure Transparency with Patients

Upon patient request, physicians should make reasonable efforts to inform patients about factors that may affect care. Informed consent generally requires that patients be informed and understand who is making decisions about their care and what factors may influence those decisions.

Recommendation 17: Seek Support When Facing Moral Distress or Ethical Conflicts

When systemic factors create moral distress or ethical conflicts, physicians should seek support from colleagues, professional organizations, ethics consultants, or physician health programs. The state medical board may also be able to provide guidance on professional obligations.

Recommendation 18: Participate in Shared Professionalism

Physicians should, where feasible, participate collectively in institutional and professional efforts to strengthen ethical practice environments. Examples of participation may include serving on ethics committees, safety or quality councils, or professional society workgroups; contributing to peer-support and well-being initiatives; and providing feedback to state medical boards and hospital leadership about how policies affect their ability to meet professional obligations.

Conclusion

The FSMB recognizes that transformation of medical practice has created challenges for physicians seeking to fulfill their professional obligations, for patients navigating an increasingly complex health care system, and for state

medical boards charged with regulating the medical profession. Corporate entities may exercise influence over clinical care, in ways that can create tension between the professional values held by licensed physicians and financial expectations.

The FSMB also supports the vital role state medical boards play in upholding the values of the profession in light of evolving practice structures, while maintaining fidelity to the social contract between medicine and society. State medical boards are important institutions among many, that protect clinical decision making, and this will be most effective when they are aligned with, and supported by, the wider ecosystem of organizations that shape how medicine is practiced.

It is the intent of the FSMB by issuing the recommendations in this report to support state medical boards and their partners in professionalism and patient safety, provide clarity to licensees, hold all parties accountable, and ensure that the privilege of practicing medicine remains coupled with the responsibility to place patient welfare above all else.

Appendix A: Glossary of Key Terms

Administrative burden: Cumulative non-clinical tasks and requirements (such as prior authorization, extensive documentation, productivity tracking, and electronic health record workflows) that consume physician time and attention, contribute to burnout, and may detract from patient care.

Clinical independence: The ability and authority of a licensed physician to make diagnosis, treatment, referral, and care-coordination decisions based on professional judgment and the individual patient's needs.

Corporate practice of medicine (CPOM): A legal doctrine, recognized in many states, that restricts or prohibits unlicensed individuals and lay corporations from owning medical practices or employing physicians, to prevent non-physician control of clinical decision-making and to safeguard patient welfare.

Fiduciary duty: The ethical obligation of physicians to act with undivided loyalty in the best interests of their patients, placing patient welfare above personal, financial, or institutional interests and managing or avoiding conflicts of interest.

Management services organization (MSO): A non-clinical entity, typically owned by non-physicians or corporate investors, that contracts with physician practices or professional corporations to provide administrative, managerial, and business services.

Meaningful ownership: A form of physician ownership in which the physician not only holds an equity interest but also exercises real authority over key clinical and organizational decisions, participates in governance.

Moral distress / moral injury: The psychological and professional harm experienced by physicians when systemic or organizational constraints prevent them from providing care they believe is ethically or clinically appropriate, or when they are pressured to act contrary to their professional judgment.

Non-compete covenant: A contractual provision that limits where, when, or in what capacity a physician may practice medicine after leaving an employer or practice.

Non-disclosure agreement (NDA): A contractual clause or standalone agreement that restricts a physician from sharing specified information.

Non-disparagement clause: A contractual provision that prohibits a physician from making statements that could be perceived as critical of an employer or affiliated entity.

Physician burnout: A work-related syndrome characterized by emotional exhaustion, depersonalization or cynicism, and a reduced sense of professional effectiveness, often driven by administrative burdens, productivity pressures, and

moral distress, and associated with increased risk of medical errors and workforce attrition.

Prior authorization: A utilization-management process by which a payor requires advance approval before agreeing to cover a prescribed medication, test, or service.

Restrictive covenant: A contractual term that limits a physician's actions during or after employment—such as non-compete, non-disclosure, or non-disparagement provisions.

Straw ownership: An arrangement by which a physician is a nominal owner of a professional entity but lacks real authority over clinical or key business decisions, with effective control residing in a non-physician entity.

Utilization Management / Utilization Review: Processes used by payors and related entities to evaluate the medical necessity, appropriateness, efficiency, or cost of health care services, often including prior authorization, concurrent review, and retrospective review.

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