Obligations and Opportunities: The Role of Clinical Societies in the Ethics of Managed Care

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Imagine this: A white, middle-aged, overweight male with unknown family history has a terrible accident while balancing on a masonry structure. Or, to be more precise, he has a great fall. Yes, he is shaped like an egg. It is Humpty Dumpty, flat on the ground with two individuals in attendance, one of whom is speaking. Only, in a recent cartoon, the caption reads: “He’s in an HMO. Get some of the King’s horses and a few of the King’s men.”

Does it matter if the speaker is a member of the medical profession? We assert that it does and that clinical societies need to provide ethical guidance to their members and be resources and advocates for the public, especially in times of health system organizational change. Setting ethical standards, promoting ethical behavior, and maintaining professionalism must be at the core of the professional society’s mission and its activities.

What is a profession? A profession is characterized (1) by a learned body of knowledge that its members must increase and teach, (2) by a code of ethics that includes a duty of service, (3) by principles and actions that put performance above reward, and (4) by self-regulation, a privilege granted by society.1

Being part of the medical profession entails certain ethical obligations. Physicians, as fiduciaries,2,3 are entrusted on a daily basis with life, death, and the most personal of matters, stand in an unequal relationship with patients often vulnerable with illness or disability, and are expected to act to benefit the patient and to loyalty apply expertise and clinical judgment. Individual practitioners have ethical obligations to their patients and to society, and the profession has a collective obligation as a matter of professional oath, history, and tradition to care for and to be advocates for the sick and those who need assistance.3

ETHICAL ISSUES ARE INHERENT IN ANY HEALTHCARE DELIVERY APPROACH

All healthcare delivery systems influence how care is provided, affecting, in turn, the patient-physician relationship. This relationship has been and must remain at the center of health care. It entails ethical and legal rights and responsibilities for both the patient and the physician. The patient-physician relationship is how patients seek care and comfort and is a large part of why many physicians practice medicine.4

Americans have a strong sense of what the patient-physician relationship should be.5 Six factors have been suggested as guides for evaluating how the relationship is faring in an era of system changes: choice, competence of the physician, communication, compassion, continuity of the relationship, and (no) conflict of interest.5

Financial conflicts and incentives often capture our ethical attention. At the level of the individual physician, conflicts include incentives to the physician to overtreat and overtreat in the case of fee-for-service medicine, and, under managed care, to underutilize or limit care.6 The question is not whether plans and plan incentives influence care—they do. Rather, it is whether incentives and other challenges to loyalty unduly influence physician judgment and patient care.7 In reality, neither traditional indemnity models nor managed care organizations, which take a vast array of forms,8,9 are clearly good or bad.

Why do potential managed care conflicts generate so much attention? After all, under fee-for-service, more tests mean more fees (although the value of truism such as this is limited in describing the complex endeavor of healthcare delivery). Some commentators believe that potential conflicts inherent in fee-for-service practice are ones patients can readily identify because the patient knows that the more the doctor does, the more the patient’s insurer pays. The patient can also, at least in theory, obtain a second opinion, serving as a “check” on physician behavior.9 No such check is available if the patient does not know what is missing (that is, what care has not been provided or offered). Others have said that incentives to provide care are less problematic than are incentives to limit care because “patients generally prefer the risk of too much care to the risk of too little care.”10 This patient preference, however, is far from clear; many patients might well be concerned about over-testing, over-treatment, and iatrogenic illness.11 None of these explanations, of course, could convert ethically unacceptable practice into ethically acceptable practice.

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1 Although certain relationships such as lawyer-client and trustee-beneficiary have been explicitly defined as fiduciary under the law, physicians have been found to be fiduciaries for patients only in limited contexts although the general belief is that they should act as fiduciaries.

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*One author has offered that three critical distinctions among managed care organizations that influence ethical debate are profit status, the relationships of physicians to the organizations, and the nature of the capitation arrangement.*
Ethical scrutiny of healthcare organizational structures and processes should not be reserved for managed care. Nor should it be limited to financial incentives. It must be done by including medical professional societies.

ETHICAL IMPLICATIONS FOR THE PATIENT-PHYSICIAN RELATIONSHIP AND FOR PRACTICE

The American College of Physicians (ACP) is developing policy in this area. One component of this is a new chapter on the changing practice environment, including managed care, for the 4th edition of the ACP Ethics Manual. Physicists must practice in the real world. To do so appropriately, they must be conscious of all potential influences on the care they recommend and provide, and they must use scientifically valid and ethical clinical judgment as their guide. Many core principles, applicable under any system of care, are asserted by ACP. Among them are the following.

Reaffirmation that physicians must be advocates for their patients, forthrightly helping patients to understand clinical recommendations and helping them to make informed choices among all appropriate care options. This advocacy also includes managing the conflicts of interest and multiple commitments that arise in any practice environment, especially in an era of cost concerns. Health care takes place in a broader context beyond the patient-physician relationship. A patient’s preferences or interests may conflict with the interests or values of the physician, an institution, a payer, the other members of a managed care plan who have comparable claims to the same health care resources, or society.

Reaffirmation that the patient-physician relationship, its fiduciary nature, and the principles that govern it should be central to the delivery of care. These principles include beneficence, honesty, confidentiality, privacy, and advocacy. The physician’s first and primary fiduciary duty is to the patient. Physicians must base their counsel to patients on the interests of the individual patient, irrespective of the insurance or medical care delivery setting in which they find themselves. Whether as a result of the incentives present in the fee-for-service system to do more rather than less, or as a result of managed care arrangements that encourage the physician to do less rather than more, physicians must not allow such considerations to affect either their clinical judgment or their counseling regarding treatment options, including referrals, for the patient. The physician’s professional role is to make recommendations based on medical merit and to pursue those options that comport with the patient’s unique background and preferences.

Physicians should also contribute to the responsible stewardship of healthcare resources. With clinical authority and discretion comes responsibility. Parsimonious care that respects the need to use resources wisely is consistent with medical professionalism. Physician recommendations to patients should be justifiable on clinical or theoretical scientific grounds.

Information to patients should not be restricted. Plans must have in place a fair appeals procedure. In instances of disagreement between patient and physician, the physician has an obligation to educate the patient and to meet the patient’s needs for comfort and reassurance.

The physician’s fiduciary duty further requires that the physician serve as the patient’s agent in the health care arena as a whole. In the managed care context, for example, advocacy can operate at multiple levels. At the individual level, the physician advocate must pursue treatment essential to the individual patient’s care, irrespective of the barriers that may discourage the physician from doing so. Likewise, when barriers diminish care for a class of patients because the patients themselves are less capable of self-representation, physicians must advocate on their behalf for equitable treatment.

Although the physician must provide information to the patient about all appropriate care and referral options, he or she must also be sure the health plan discloses all relevant information about benefits, including any restrictions, as well as information about financial incentives that might negatively affect patient access to care. Honest disclosure of such information is essential to trust even when care is not directly affected.

OBLIGATIONS AND OPPORTUNITY FOR CLINICAL SOCIETIES IN THE SERVICE OF PATIENTS

Setting ethical standards, promoting ethical behavior, and maintaining professionalism must be at the core of the clinical society mission and its activities lest we be and be seen as mere trade associations or membership clubs. Clinical societies must anticipate change and engage in responsible policy advocacy for the benefit of patients and the public. We must also promote clinical standards to our members and the clinical authority and independence of our members. Furthermore, we must not lose sight of the privileges and responsibilities that flow from being members of a learned profession.

These can be difficult times, but challenges also provide opportunities for improvement in patient care. The patient-physician relationship must be defended against undue interference as we sort out the effect of other interests that bear on the relationship and the weight to accord those interests. It is a relationship that must be based on trust. In order to establish and maintain that trust and to perform the role of advocate, physicians must apply their skills, training, experience, and judgment to serve the patient and his or her needs — not society as a whole, payers, or other interests, including the doctor’s own interests, although physicians must be conscious of, and deal with, those factors as well.

Arguments have been made for the development of ethical standards for healthcare organizations. Physicians can and should optimize individual patient care in a system that strives to be efficient; one author likens this to the defense attorney who seeks acquittal in a system that seeks justice.

Likewise, society must recognize the ethical obligations of the physician as patient advocate within the healthcare system. Proposals for a new category of healthcare professional — such as the medical advocate who would be the true proponent of patient interests in these changing times — are misguided. Physicians are not merely medical technicians or “body mechanics,” but they bring judgment and experience to their education, training, and skills. They should also bring compassion and empathy to patients.

In a seminal article entitled “Arrogance,” Franz Ingelfinger reflected that “efficient medical practice, I fear, may not be empathetic medical practice, and it fosters, if not arrogance, at least the appearance of arrogance.” The article is particularly forceful in its account of Dr. Ingelfinger’s experiences with cancer. He describes his agony in trying to determine how to proceed, a “barrage of well-intentioned but
contradictory advice” from physician friends, and the confusion he felt until a “wise friend” offered a piece of advice: “What you need is a doctor.”

At one time or another what every individual will need is a doctor. Clinical societies should help physicians meet the continuing obligations and opportunities inherent in membership in this learned profession. Putting patients first should continue to be the goal of every physician and every healthcare professional society.

REFERENCES