

MEDICAL ETHICS FOR CHALLENGING TIMES

[Under the Current US Capitalistic System]

[Finding Your Moorings in an Era of Dramatic Change]

**Render S. Davis
David Edward Marciko**

When I do good, I feel good; when I do bad, I feel bad. That's my religion.

Abraham Lincoln

There are few who would doubt that the practice of medicine today is dramatically changing. The standards that were predominant a generation ago appear to no longer drive the rapidly evolving relationship between physicians, patients, and health care organizations. Other entities, most notably payers and regulators, have interposed themselves into the relationship and the result is a rapidly evolving approach to health care. Today, questions of cost, access, and quality drive a continuing, and at times contentious debate.

Yet, the ethical principles of beneficence, respect for autonomy, and justice that served as a foundation for the healing professions since the age of Hippocrates, remain as important today as two millennia ago. Ethical dilemmas arise, not from clear choices between good and evil, but when there are no clear choices between competing goods. Often these issues surface when ethical principles themselves are weighed in relationship to each other. When a physician's obligation to treat conflicts with a patient's right to self determination; or when an individual's demand for autonomous choice offends our society's sense of justice and fairness, are but a few examples of ethical principles in conflict.

EVOLUTIONARY SHIFTS IN THE PRIMACY OF ETHICAL PRINCIPLES

Beneficence and Nonmaleficence

For nearly 2000 years, the principle of *beneficence*, the profession's obligation to be of service to others, was the foundation of the practice of medicine. In taking the Hippocratic Oath, a physician swore that he would "perform his art solely for the cure of patients;" and patients viewed their doctors as wise, caring, and paternalistic healers unwaveringly committed to their welfare. Until the era of modern medicine dawned in the early Twentieth Century, sincere caring and compassionate service probably were the most effective instruments in the physician's meager armamentarium.

World War II and the decades that followed saw an unprecedented explosion in medical knowledge and technology. As a direct consequence, physicians were called upon to become increasingly sophisticated technicians and specialists, demands that pulled them farther from the bedside and diminished the close, personal relationship with patients they once enjoyed. This increasingly impersonal relationship, combined with the starkness and technically intimidating nature of hospitals, led to a dramatic shift in the traditional patient-physician relationship. No longer did the patient see the family doctor as the caring, paternalistic figure who held the patient's interests foremost. Instead, an overwhelming array of specialists appeared before the patient to explore illness etiology or examine a particular body part - too often appearing more interested in the malady than in the person afflicted with it.

In recent years this may have been exacerbated even further by shifts in physician practices in which the patient's personal physician, on admission to a hospital for treatment, turns the person's care completely over to "hospitalists" or "intensivists" who may have no

knowledge of the patient beyond the symptoms of the current illness or condition. In some ways this trade-off offer significant benefits as the hospital-based specialists are skilled at, and focused on, stewarding patients through the institution's complex technological milieu; thereby freeing up the community based physicians to more effectively manage their patients outside the hospital. From the patient's perspective, ongoing communication between the personal physician and the hospital-based specialists, involving the patient as fully as possible, may be a key to the success of this evolving process.

The principle of *nonmaleficence*, - often considered a corollary to beneficence, is drawn from the maxim "primum non nocere" – "first do no harm" that has long been associated with the tenets of the Hippocratic Oath that calls on physicians to "never use it (medicine) to injure or wrong" patients. In modern medicine, the principle may arise in debates over areas such as continuing burdensome or life-prolonging treatments that may have little or no lasting benefit for the patient; decisions to withdraw or withhold treatments that may lead to death; or failing to meet treatment obligations that may lead to detrimental patient outcomes. Given the challenges faced by physicians faced with treatment decisions for their patients, especially those facing terminal illnesses or injuries, or those lacking the resources to pay for needed care, this principle will remain a troubling component of our society's continuing debate over health reform.

Nonetheless, the question remains: have these evolutionary changes led to erosion of the ongoing relationship that once bonded the physician and patient? For that, only experience over time may yield an answer.

Respect for Autonomy

Beginning with the social turmoil of the 1960s, patients demanded that physicians treat

them as equal partners, both informing them of the nature of their disease and seeking their permission to initiate treatment. After all, patients reasoned, they should have the final say regarding what was done to their own bodies.

Consequently, the principle of *respect for autonomy*, an acknowledgment of an individual's right to self determination, slowly took precedence over, but did not eclipse, beneficence. Physicians still cared for their patients, only now they were obligated to take extra steps to bring patients directly into the decision-making process by explaining treatment options and requesting "informed consent" on the plan of care from the patient.

Both principles were supported in the prevailing system of fee-for-service, private-practice medicine. There were few constraints on physicians' clinical autonomy and their professional judgment remained, for the most part, unquestioned. In this climate, physicians reasoned that patients would likely benefit from more tests and procedures; patients, especially the well insured, demanded almost unregulated autonomy over their health care choices. For those with the means to pay, access to nearly all that medicine had to offer was considered an unquestioned right.

This proved to be a formula for potential economic disaster. There was an explosion in new and expanded facilities and unwavering demand for the latest technological innovations, much of it supported by the government as vital to a healthy economy. Nonetheless, a fundamental problem existed because health care was being delivered in a financial vacuum, where both physicians and patients had only a vague understanding of, or interest in, the economic consequences of the services they felt either obligated to provide or entitled to receive.

Both beneficence and respect for autonomy could be invoked to support this nearly unbridled use of health care resources in the care and treatment of individual patients. Insurers,

both private and governmental, paid “reasonable and customary” charges, almost without argument; while as patients’ advocates, physicians could garner large incomes from fees generated in providing virtually unlimited care. The inevitable financial fallout from medicine guided by these laissez-faire rules led to an unsustainable inflationary spiral in medical costs. In the forty years following the passage of the Medicare Act in 1965, the health care sector of the American economy soared from 4% of Gross Domestic Product (GDP) to over 18%, in 2011, and there remains no clear end in sight to the upward rise.

Yet, a growing number of Americans actually have seen their access to medical care diminish due to rising costs of employer-paid insurance - when it was offered at all, and tightening restrictions in eligibility requirements for Medicaid and other government safety-net programs. Even as the nation increased overall spending for medical care, many Americans continued to lose access to the system.

The critical issue of access to health care has heightened during the severe recession that began in 2007, deepened in 2008, and slightly abated by 2010. During this period, a growing number of Americans, faced with job losses due to business declines or closures, foreclosures on their homes, and personal bankruptcies, were forced out of the private insurance market and on to public insurance rolls at a time when these rolls were also dramatically affected by declining state and federal funding. In many ways, respect for autonomy becomes almost a moot point when an individual lacks the resources to effectively access the health care system.

Justice

Just as respect for autonomy superseded beneficence, the principle of *justice*, representing a new approach of balancing the health needs of an individual with the availability

of finite resources for the larger population, rose to take its place as the primary principle, becoming the force driving the movement toward managed care.

There have been a number of initiatives to address the relationship between autonomy and justice. Significant among them was work of the Harvard Pilgrim Health Care Ethics Program. In 2001, a working group convened to examine the ethical issues surrounding managed care. The team's report, published in the July 20, 2004, issue of *Annals of Internal Medicine*, noted that "managed care is a prominent venue in which questions of access, justice, limits, rationing, need, medical necessity, and quality and other controversial, poorly defined, and unresolved questions about health care are being asked. Managed care did not manufacture these questions, nor can or should it alone answer them definitively".

In an effort to provide a framework in which these critical questions might be addressed, the working group identified the following set of ethical principles:

- Relationships are critical in the delivery of health services. They should be characterized by respect, truthfulness, consistency, fairness, and compassion.
- Health plans, purchasers, clinicians, and the public share responsibility for the appropriate stewardship of health care resources.
- All parties should foster an ethical environment for the delivery of effective and efficient quality health care.
- Patients should be well informed about care and treatment options and all financial and benefit issues that affect the provision of care.

Embedded within this drive toward a fairer distribution of healthcare resources was the urgent, but highly controversial desire to rein in costs. Despite years of active suppression and

condemnation by health professionals and providers, the hard economic realities of American society's love-hate (love to have it, hate to pay for it) relationship with health care had finally reached the bedside. The result has been an irrevocable and ongoing sea-change in the landscape of American medicine.

THE PHYSICIAN'S DILEMMA: CARING FOR PATIENTS AND POPULATIONS

In today's health care environment, physicians face a myriad of dilemmas in their daily practice. Time constraints, diminished professional autonomy, declining incomes, explosive growth in technology, increasing institutional and payer pressures to lower length-of-stay and costs, and deteriorating public trust *combined with* increasing public demands for access to services, are only some of the most obvious problems plaguing practitioners. While some who have been adversely impacted by these changes were quick to lay blame at the foot of "Managed Care Organizations (MCOs)," this anger may have been, to some extent, misdirected.

While there were ample concerns with managed care as it was implemented, its theory and principles remained ethically sound. Healthcare should be "managed" - for continuity, quality, effectiveness, value, and optimal outcomes - regardless of the mechanisms by which the caregivers are paid. Practicing medicine within managed care entailed obligations to care for patients and to respect their autonomy; but providers were also placed in a disquieting role as resource managers. This role required new approaches to finding better, more cost-effective ways to meet these obligations; while being held accountable to a larger community to which the individual belonged (e.g. a health plan or employee group) for the costs incurred in delivering care.

- It is often said that the "devil is in the details" and, in the context of the ethical principles

cited above, an examination of managed care revealed an uneven and troubled landscape impacted by declining sources of revenue for non-profit managed care organizations and falling profits for the proprietary companies. Across the board, MCOs were impacted by precipitous drops in investment income in the wake of the stock market's dramatic decline in 2008-09; as well as sharp business declines during that period that led to closures or tightening restrictions on employee access to health care insurance. Consequently, to maintain adequate services or meet shareholder expectations, managed care organizations further restricted coverage and/or increased premiums to employers or enrollees. Although MCOs emphasis on health promotion and illness prevention has been viewed as very good, there remained many highly publicized instances where the health of individual patients has been jeopardized by apparently arbitrary policies and decisions made by managed care organizations, ostensibly in the name of cost containment. Among especially notable issues have been:

- Delayed referral of patients to specialty physicians, or denials of access to specialized services, primarily based on resource allocation and cost considerations;
- Rigidly enforced practice guidelines and programmatic standards that potentially penalize a physician's exercise of clinical judgment or discretion;
- Crafting of incentives that encourage physicians to withhold clinically pertinent information from patients, *and* to discourage physicians from serving as advocates for their patients;
- Declines in consumer choice of health plans and providers. Increasingly, consumers with health insurance are unwilling to demand improvements for fear of losing the coverage they have;

- Failure of many MCOs, especially those operated as proprietary entities, to acknowledge an obligation to improve community health and broaden access to services to persons such as those with handicapping or pre-existing conditions, the poor, the disenfranchised, undocumented aliens, and others with legitimate, unmet, health care needs;
- Perceived subordination of quality considerations in access and treatment, to cost containment in delivery of services.

The physician's apparently conflicting role seemed to impinge on the fundamental tenets of patient advocacy articulated in the Hippocratic Oath. By the terms of many managed care insurance plans, physicians' incomes are directly related to savings generated in the delivery of care, a tactic criticized by Marcia Angell, M.D., former executive editor of *The New England Journal of Medicine*, who noted in a Public Broadcasting interview, that "our health care system creates ethical dilemmas that no health care system should create, doctors are paid for doing less." As if in reaction to the principles of population based managed care, there is a growing call for a return to the more traditional, market based model for healthcare referred to as "consumer-driven" care. Proponents argue that medical decisions should be made by patients, in consultation with their physicians, based on the individual's self interest and resources. Components of such a system might include individually directed health savings accounts (HSAs) for routine treatments, combined with insurance for catastrophic medical expenses. Economist John Goodman argues, that in this model, "consumers occupy the primary decision-making role regarding the health care they receive. Others argue that many consumers will not have resources to adequately fund HSAs and, as a result, will defer or delay needed treatments due to high out-of-pocket costs. University of North Carolina political scientist Jonathan

Oberlander noted that this model simply shifts “the cost of health care on the backs of patients.” Especially hard hit would be consumers with chronic illnesses who may never save enough in their HSAs to meet the costs of care.

Whether it is managed care’s emphasis on care of populations or consumer-driven care’s focus on individual decisions, the issue of cost will continue to drive debate in this troubled environment. In this context, let us examine some specific dilemmas confronting physicians in their daily practice.

Patient Advocacy

Few areas of life are as personal as an individual’s health and people have long relied on a caring and competent physician to be their champion in securing the medical resources needed to retain or restore health and function. For many physicians, the care of patients was the foundation of their professional calling. However, in the contemporary delivery organization, there may be little opportunity for generalist physician “gatekeepers” or “specialty hospitalists or intensivists” to form a lasting relationship with patients. These institution-based physicians may be called upon to deliver treatments determined by programmatic protocols or algorithm-based practice guidelines that leave little discretion for their professional judgment. In addition, the physician’s personal values may be impeded by seemingly perverse financial incentives that may directly conflict with their advocacy role, especially if a patient may be in need of expensive services that may not be covered in their insurance plan, or are beyond the resources of a patient’s HSA or savings. Marcia Angell, M.D., noted during her previously referenced PBS interview that the “financial incentives directly affecting doctors...put them at odds with the best interests of their patients...and it puts ethical doctors in a terrific quandary.”

Conflicts of Interest

Conflicts of interest are not a new phenomenon in medicine. In the fee-for-service system, physicians controlled access to medical facilities and technology, and they benefited financially from nearly every order or prescription they wrote. Consequently, there was an inherent temptation to over-treat patients. Even marginal diagnostic or therapeutic procedures were justified on the grounds of both clinical necessity and legal protection against threats of negligence.

While it could be construed that this represented a direct conflict of interest, it could also be argued that most patients were well served in this system because the emphasis was on thorough, comprehensive treatment - where cost was rarely a consideration. It was a well known adage that physicians “could do well, by doing good.” In managed care, the potential conflicts between patients and physicians took on a completely different dimension. By design, in health plans where medical care was financed through prepayment arrangements, the physician’s income was enhanced not by doing more for his or her patients, but by doing less. Patients, confronted with the realization that their doctor would be rewarded for the use of fewer resources, could no longer rely with certainty on the motives underlying a physician’s treatment plans. One inevitable outcome was the continuing decline in patients’ trust in their physicians. This has been exacerbated to some degree by revelations of significant financial remuneration to physicians by pharmaceutical and medical products firms for their services as researchers or active participants on corporate-funded advisory panels, calling into question the physician’s objectivity in promoting the use of company products to their peers or patients.

Conflicts of interest may also create concerns at a much higher level, as evidenced by the

issues raised in 2008 litigation against Ingenix, a company that for more than a decade, provided information to the insurance industry on payments to out-of-network physicians for their “usual and customary rates (UCR).” As noted in court documents, Ingenix was a wholly-owned subsidiary of United Healthcare and the UCR information sold by the company to insurers may have been fundamentally biased in favor of the insurers, causing patients to pay larger out-of-pocket fees. As a result, New York attorney general Andrew Cuomo filed suit against Ingenix. This action was followed by suits brought against major insurers by the American Medical Association and several state medical groups for systematic underpayment to members, based on the biased data. To date there have been monetary settlements, but the issue continues to raise growing concerns regarding conflicts of interest among the key payers for health care.

Communications

In contemporary medicine, ethical dilemmas in communications are increasingly common and may come in many different forms:

- Physician’s failing to communicate necessary clinical information to patients in terms and language the patients truly understand;
- Physicians’ offering only limited treatment choices to patients because alternatives may not be covered by the patient’s insurance plan;
- Failure to disclose financial incentives and other payment arrangements that may influence the physician’s treatment plans and recommendations;
- Time constraints that limit opportunities for in-depth discussions between patients and their doctors; and,
- Lack of an ongoing relationship between the patient and physician that would foster open

communications.

- Physician's failure to present treatment alternatives to a patient due to conflicts with his or her personal moral or spiritual beliefs.

Another area where communication is critically important is in disclosure of medical error or cause of adverse occurrences. In the years since the 1999 publication of the Institute of Medicine's Report "To Err is Human: Building a Safer Health System", there has been increasing awareness that the growing complexity of the nation's health care system, combined with the tightening financial restrictions on treatment, sometimes results in a "perfect storm" of actions that may lead to patient harm. According to the report, more than half of the adverse events affecting hospitalized patients are the result of medical errors; and between 44,000 and 98,000 persons die each year as a consequence of such errors.

Especially challenging for physicians is the disclosure of errors that may have caused a patient harm. According to Emory University bioethicist, John Banja, Ph.D., author of *Medical Errors and Medical Narcissism*, "realization that an error has seriously harmed a patient is one of the most psychologically painful experiences a health professional can have." Unfortunately, given malpractice concerns, disclosing such errors to patients may often be as painful as the error itself. Nonetheless, such disclosure is vital to maintain the trust required for supporting the patient through such an experience.

Recent federal regulations have heightened awareness of errors and adverse occurrences through changes in Medicare that now prohibit reimbursements to health care facilities for extended stays and additional treatments directly related to serious, preventable incidents or occurrences, dubbed "never events." Among more than two dozen identified events are wrong-

site surgery, blood incompatibility, medication errors, decubitus ulcers, air emboli, and many more. The economic consequences of these restrictions could prove to be significant.

Confidentiality

Whether it is an employer interested in the results of an employee's health screening; an insurer attempting to learn more about an enrollee's prior health history; the media in search of a story; or health planners examining the potential value of national health databases, the confidential nature of the traditional doctor-patient relationship may be compromised through demands for clinical information by parties other than the patient and treating caregivers. In addition, without clear safeguards the growth in use of electronic medical records may put personal health information at risk of tampering or unauthorized access. Clearly, employers and insurers are interested in the status of an individual's health and ability to work; but does this desire to know, combined with their role as payers for health care, constitute a right to know? The patient's right to privacy remains a volatile and unresolved issue.

Counter to this concern is the recognition that electronic records may dramatically improve communications by offering greater accessibility of information to clinicians in the hospital or office potentially reducing medical errors through elimination of handwritten notes, increased use of built in prompts and clinically-derived triggers for orders and treatments, and development of pathways for optimal treatments based on clinically valid and tested best practices.

Cultural Sensitivity

While America has often been called a "nation of immigrants," it has never been more

true than today. Consequently, the challenge for physicians and other health care providers, in both large cities and small communities, is meeting the health care needs of increasingly diverse and multi-cultural populations who speak different languages and have social norms, traditions, and values that may substantially differ from their own. Problems arise when clinicians expect, even demand, that patients and their families discard their cultural foundations and adhere to the health care provider's view of the care and decision-making process.

Instead, the health care team should be more aware of and sensitive to the values and beliefs of patients who come from other cultures; working within to assure that the patient's individual rights are supported and wishes honored to the fullest extent possible. In her award-winning book, *The Spirit Catches You and You Fall Down*, Ann Fadiman chronicled this tragic clash of two cultures in medical care for a child of the traditional Hmong people of Laos, transplanted to California after the Vietnam War. In the book, Fadiman recounts a conversation with Professor Arthur Kleinman of Harvard University, a highly regarded expert in multicultural relations and conflict, who noted that "If you cannot see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else's culture?"

Former U.S. Surgeon General David Satcher, M.D., Ph.D., now Director of the Satcher Health Leadership Institute at Morehouse College of Medicine in Atlanta, Georgia, helped develop a special curriculum designed to foster greater cultural competence among physicians and health care providers. Called the "CRASH Course," the program emphasizes:

- Cultural Awareness.** Acknowledging the diversity and legitimacy of the many cultures that make up the fabric of American Society;
- Respect.** Valuing other cultural norms, even if they differ or conflict with your own;

•**Assess and affirm.** Understanding the points of both congruence and difference among cultural approaches to decision-making; learning how to achieve the best outcomes within the cultural framework of the patient and family unit;

•**Sensitivity and self awareness.** Being secure in your own values; while willing to be flexible in working through cultural differences with others;

•**Humility.** Recognizing that every culture has legitimacy and that no one is an expert in what is best for others; being willing to subordinate your values for those of another to achieve the goals of treatment.

There is little doubt that multi-cultural sensitivity will continue to grow as an increasingly integral component of medical education and health care practice.

CASE MODEL:

An elderly Asian-born patient is diagnosed with fast-growing cancer requiring immediate surgery. The patient is alert and competent. The physician approaches the patient regarding her diagnosis and to seek consent for the operation. In the family's culture, patients are protected from bad news and such health care decisions are delegated to a spouse or adult child. The eldest son intercedes with the doctor and indicates that he speaks for the patient. The physician counters that "this is the United States" and the patient has a right to make her own decisions, and demands to talk directly to the patient. As another member of the health care team witnessing this episode, what should you do?

Access to Care

In his book *Back to Reform*, author Charles Dougherty wrote that “cost containment is the goal for the healthy. Access is the goal for the sick.” Consequently, the concerns described above are almost meaningless for millions of Americans because they are, for the most part, outside the current structure of the health care insurance system. Employers are downsizing staff or cutting out health insurance benefits in an effort to either survive in the economic downturn or to compete in a global economy. At the same time, demands for greater government accountability for the expenditure of tax dollars have brought about increasingly more stringent eligibility requirements for safety-net programs like Medicaid and State Children’s Health Insurance Programs (SCHIP). As employer-provided or individually-purchased insurance becomes more expensive, and government programs undergo budget cuts, people are being excised from the insurance system with little or no safety net. A direct consequence has been a dramatic increase in personal bankruptcies driven by crushing medical expenses; something virtually unknown in other industrialized countries.

At the same time, new competitive demands have fostered unprecedented consolidations, mergers, and closures of healthcare facilities. This shake-out may have served to reduce overcapacity that once plagued the system, but it has been done with greater emphasis on cutting costs than on fostering efficiency and effectiveness in creating a true system of care delivery.

Those who view health care as little different from other commodities available through the free market see the present access concerns as simply a byproduct of inevitable restructuring of the system. While they argue that we must adhere to market solutions to solve our health care access problems, others demand a different approach calling for government sponsored or mandated universal health insurance, or some form of subsidized care, providing at least a basic level of treatment for all citizens. While Americans continue to proudly tout that we do not

explicitly ration care as do some other countries, we tacitly accept a health care system that implicitly excludes citizens who are unable to overcome financial barriers to access.

Access to care represents the most visible issue at the very foundation of the ethical principle of justice. In their text *Principles of Biomedical Ethics*, authors Thomas Beauchamp, Ph.D. and James F. Childress, Ph.D. point out that justice is subject to interpretation and may even be invoked to support the positions of parties in direct opposition. For example, those who support the predominant principle of *distributive* justice – the fair allocation of resources based on laws or cultural rules – still must decide on what basis these resources will be used. *Utilitarians* argue for resource distribution based on achieving the “greatest good for the greatest number;” *Libertarians* believe that recipients of resources should be those who have made the greatest contributions to the production of those resources – a free market approach to distribution; while *egalitarians* support the distribution of resources based on whom is in greatest need, irrespective of contribution or other considerations. Consequently, developing a system of access based on “justice” will always be fraught with enormous difficulty as advocates for health reform call on the principle of justice as the foundation for diametrically opposite positions supporting universal access (egalitarian) or individual responsibility (libertarian).

In the current health care environment, access to medical care is approaching crisis levels as increasing malpractice insurance premiums are driving physicians from high risk specialties such as obstetrics, emergency medicine, and surgery in record numbers. The impact is most dramatic in rural and under-served areas of the country where solo practitioners and small group practices are discontinuing services, leaving local citizens with no choice but to forego care or travel greater distances to regional medical centers to find necessary treatment. At the same time, the recent economic crisis facing the country has led to significant budget cuts at both the

federal and state levels seriously eroded funding for Medicaid, leaving this especially vulnerable, and growing, segment of the population with even fewer options than before.

Two other areas of the care access dilemma are rapidly moving to the forefront. The first is in emergency medicine. A study by the Federal Centers for Disease Control and Prevention, cited statistics showing that in the decade from 1996 to 2006, emergency room visits increased by 32 per cent, while the number of emergency departments shrank by 15 per cent. Increasingly, hospitals have closed emergency departments due to increasing costs, staffing shortages, and declining payments for services. This crisis comes at a time when post 9/11 fears of terrorism, concerns over pandemic influenza, and a rapidly increasing number of Americans who find themselves without insurance, have placed an even greater burden on the delivery of emergency services. A second area is the rapid growth in the numbers of undocumented individuals in the United States. Many of these individuals work in a “shadow” cash economy, or for employers who do not offer health insurance; and their status often makes them ineligible for publicly funded insurance programs. Consequently, when they do seek health care for urgent or chronic conditions, providers may be faced with severe financial consequences associated with the uncompensated care the patients require.

These issues and many more were at the forefront of a vocal, and at times rancorous, debate over President Barack Obama’s health reform proposals during the 2009 congressional session. Arguments over such issues as publicly financed health care for those who do not have access to private insurance (the ‘public option’); utilization of effectiveness models for ‘best practices’ to make health care delivery more efficient and consistent; and prohibiting insurance provider practices of denying coverage for preexisting conditions have so far yielded more heat than light as arguments have fallen along ideological or party lines. Nevertheless, despite the

partisan nature of the debate, a modification of healthcare reform become law on March 21, 2010 achieving a goal elusive to Presidents Truman, Kennedy and Clinton, each of whom sought to restructure America's system to offer some form of universal health care.

CASE MODEL

A large, urban public medical center announces the closure of its outpatient dialysis clinic due to massive funding shortfalls. A significant number of the patients receiving dialysis in the clinic are undocumented individuals who do not have resources to pay for the care and are not eligible for public assistance (Medicaid) due to their status. Without access to regular dialysis, many of these patients will likely die. As a clinician at this facility, how might you respond to this issue? Should this problem be addressed by the institution's ethics committee?

Professional Autonomy

Not so long ago, a physician's clinical judgment was virtually unquestioned. Now with the advent of algorithm-based clinical pathways and case management protocols, many aspects of treatment allow allied health professionals to carry out care plans with only minimal direct input from a physician. Much about this change has been good. Physicians have been freed from much tedious routine and are better able to watch more closely for unexpected effects to treatments and then utilize their knowledge to chart an appropriate response.

What is of special concern, though, is the restrictive nature of protocols in some care plans that may unduly limit a physician's clinical prerogatives to address a patient's specific needs. Such plans may prove to be the ultimate bad examples of "cook book" medicine. While some may find health care and the practice of medicine an increasingly stressful and

unrewarding field, others are continuing to search for ways to assure that caring, compassionate, and ethically rewarding medicine remain at the heart of our health care system.

Another facet of professional autonomy that has come under increasing scrutiny is the clinician's right of conscience to accept or reject patients, perform certain procedures or treatments, or carry out certain orders or prescriptions. While it has been long accepted that physicians or surgeons could not be compelled to perform a procedure, such as an abortion, to which they objected on clinical or moral grounds; professional autonomy has now extended beyond the medical profession to other allied health fields, most notable among them to pharmacists who may refuse on moral grounds to fill lawfully completed prescriptions for contraceptives or other birth-control medications. Typically, such conscientious objections are acceptable if another clinician may be found who will carry out the order or procedure; however, this becomes problematic when no other health professional is available to honor the patient's lawful request.

CASE MODEL

After an office visit with her obstetrician-gynecologist in a rural community, an unmarried, female patient attempts to have her prescription for contraceptives filled at the town's only pharmacy. The pharmacist refused to fill the prescription, citing moral objections. The patient calls her physician asking for help. How should the physician respond?

Fostering Ethically Sound Medicine for Unsettling Times

While the patient-physician relationship has undergone significant erosion, it still remains somewhat tenuously at the center of the medical care universe. There is much that physicians

may do within the framework of managed care or other evolving models to both restore their role as patient advocates and compassionate care providers.

In order to do this successfully, it is important to recognize that irrevocable changes have occurred, but the future evolution of the delivery and financing of care is not yet established. It is much like a pendulum that has swung from one extreme (unregulated, fee-for-service medicine) and is now on an arc toward another, as yet, undetermined destination. Will it be a government controlled national health care system? A market driven service bought and sold like any other commodity; or something in-between? Physicians and other healthcare providers have the power to influence the answer.

Whether the ultimate system contains the characteristics of managed care, consumer-driven care, or some form of universal care, the expectation is that it must be a highly functional and effective system committed to providing cost efficient and clinically effective care. Renowned physician-ethicist Edmund Pellegrino, M.D. of the Kennedy Center for Ethics at Georgetown University noted that “what our health policies do to the individual patient serves as a reality check to what values we hold most dear and the ethical foundation of the policies we develop and impose.” So those who truly believe that we can still have a caring and compassionate system of care for all patients must actively work within the system to bring it about.

No matter what model evolves, physicians must not abdicate to others their central role in patient care, but must work within the care framework to foster its development as a means of delivering care that is effective, efficient, and clinically justified. Care should be provided in a setting that respects the values of individual patients and, at the same time recognizes the finiteness of society’s resources. The following represent some steps in this process.

Being a Patient Educator, Facilitator and Mentor

It is no longer enough for physicians to be healers, intervening when a patient appears at their door with an acute or chronic illness. They must be proactive educators, providing patients with the information needed to change poor health habits like smoking, drinking, and obesity; and encouraging the adoption of healthier lifestyles. Unfortunately, this task is more difficult than it appears. Historically, Americans have refused to accept the consequences of their poor health habits, preferring to seek medicine's help in repairing the damage after it has been done. Results from the Gallup-Healthways Well Being Index (WBI) Poll released in February 2009 showed only marginal improvements in the overall health of Americans, with the most gain among those 65 years of age and older, and those with higher incomes. Nonetheless, the report showed that only 46% of Americans consistently follow good health habits. The report's summary concluded that "it is clear that millions of Americans are in need of continued education and encouragement around critical healthy behaviors."

One aspect of this educational process that has both advocates and opponents is direct-to-consumer (D2C) advertising, notably by pharmaceutical firms. In the past, information on medications was provided to physicians who then made a decision regarding appropriateness for their patients. Today, consumers are bombarded by almost never-ending radio, television, and print advertisements for products to treat almost everything from high blood pressure and intestinal discomfort to erectile dysfunction. These ads, combined with nearly inexhaustible sources of information – some good some bad – on the internet, have changed the dynamics of the patient-physician discussions of treatments choices and preferences. On balance, the greater access to information may be of great value to patients and their physicians, but only if it leads to

more informed and coherent medical decision making.

Even when confronted with the time constraints and discontinuity inherent in frequently changing health insurance plans, it is clear that physicians must be diligent in assessing their patients' health habits and helping them articulate their health goals; assuring that patients understand the terms, limitations, and costs associated with their health plan, and serving as mentors and partners to provide them with the knowledge and self-motivation to change for better long term health.

Instead of being "gatekeepers" charged with limiting access to the system, physicians should view their roles as that of "facilitators" - guiding patients through an increasingly confusing maze of treatment alternatives, and leading them in the direction of informed choices and optimal outcomes. In today's health care environment, the principle of beneficence is inextricably woven into the premise that physicians must do more to help patients help themselves.

Becoming Quality Driven

Whether care should be "managed" is no longer a legitimate question. The fundamental question now is for what purpose is care to be managed, and by whom? The moral vulnerability of managed care rested with its apparent overriding concern with cost reduction through limitations on access and service; possibly at the expense of clinical appropriateness, quality, and the health needs of the individual patient.

A disconcerting component of the health care reform debate in 2010 was the opposition by many to research into and use of "evidence-based" practices as a means to reduce the cost of care while improving its effectiveness. Numerous studies have shown wide variability in

treatment methodologies and associated costs, often on a regional basis, and have called on adoption of those practices that have shown to have positive outcomes at lower costs. Opponents have condemned such proposals as “cookbook medicine” that strips away professional judgment and discretion; while supporters argue that physicians should be advocates for widespread application of such “best practices” when proven to provide more effective outcomes. This debate will continue so long as organized medicine fails to acknowledge that widespread variation in treatments increases the cost of care without contributing to optimal outcomes.

If physicians are to be credible advocates for their patients, they must unwaveringly stand for quality and against arbitrary and unjustifiable restrictions on access to clinically justified and appropriate care. This does not imply a return to unregulated, fee-for-service medicine, but rather a demand that providers and payers be held accountable for *both* cost effectiveness *and* quality. To date, unfortunately, this has not taken place in a coordinated fashion with any clear goal of establishing a cohesive, seamless healthcare system. Consequently, we have a fragmented, patchwork system, described by Marcia Angell, M.D. as a “hodgepodge of temporary alignments, existing independently, often working at cross purposes...” that leaves many patients and providers with inadequate tools and information to make truly informed health care choices.

Physicians, other care providers, payors, and regulators should work in concert to develop a system of care that is integrated and coordinated, epidemiologic-data dependent, consumer-focused, sensitive to privacy and confidentiality concerns, and clearly responsive to the legitimate health care needs of individuals and the general population.

We as a nation can have a health care system that embraces compassionate, clinically appropriate, cost-effective care, with universal access to basic services, if we are willing to make

difficult, but publicly informed and debated, choices regarding our health care priorities. Physicians must be proactive and central to this process.

Demanding High Professional Moral Standards of Self and Financing Organizations

It has been argued that physicians have abdicated the “moral high ground” in health care by their interest in seeking protection for their high incomes, their highly publicized self-referral arrangements, and their historical opposition toward reform efforts that jeopardized their clinical autonomy. In his book *Medicine at the Crossroads*, Emory University professor Melvin Konnor, M.D., noted that “throughout its history, organized medicine has represented, first and foremost, the pecuniary interests of doctors.” He goes on to lay significant blame for the present problems in health care at the doorstep of both insurers and doctors, stating that “the system’s ills are pervasive and all its participants are responsible.” In order to reclaim their once esteemed moral position, physicians must actively reaffirm their commitment to the highest standards of the medical profession and call on other participants in the health care delivery system also to elevate their values and standards to the highest level.

In the evolutionary shifts in models for care, physicians have been asked to embrace business values of efficiency and cost effectiveness, sometimes at the expense of their professional judgment and personal values. While some of these changes have been inevitable as our society sought to rein in out-of-control costs, it is not unreasonable for physicians to call on payers, regulators and other parties to the health care delivery system to raise their ethical bar. Harvard University physician-ethicist Linda Emmanuel noted that “health professionals are now accountable to business values (such as efficiency and cost effectiveness), so business persons should be accountable to professional values including kindness and compassion.” Within the

framework of ethical principles, John La Puma, M.D., wrote in Managed Care Ethics, that “business’s ethical obligations are integrity and honesty. Medicine’s are those plus altruism, beneficence, nonmaleficence, respect, and fairness.”

Incumbent in these activities is the expectation that the forces that control our health care delivery system, the payers, the regulators, and the providers will reach out to the larger community, working to eliminate the inequities that have left so many Americans with limited access to even basic health care. Charles Dougherty clarified this obligation in *Back to Reform*, when he noted that “behind the daunting social reality stands a simple moral value that motivates the entire enterprise. Health care is grounded in caring. It arises from a sympathetic response to the suffering of others.”

DEVELOPING SKILLS NEEDED FOR THE NEW HEALTHCARE 2.0

Medical practice today is vastly different from a generation ago, and physicians need new skills to be successful. In order to balance their obligations to both individual patients and to larger groups, physicians now must become more than competent clinicians. Traditionally, the physician was viewed as the “captain of the ship,” in charge of nearly all the medical decisions, but this changed with the dynamics of managed care. As noted previously, the physician’s role may be more akin to the ship’s navigator, utilizing his or her clinical skills and knowledge of the health care environment to chart the patient’s course through a confusing morass of insurance requirements, care choices, and regulations to achieve the best attainable outcome. Some of these new skills include:

- Negotiation* - working to optimize the patient’s access to appropriate services and facilities;
- Being a team player* - working in concert with other care givers, from generalist and specialist

physicians, to nurses and therapists, to coordinate care delivery within a clinically appropriate and cost-effective framework;

- *Working within the limits of professional competence* - avoiding the pitfalls of payer arrangements that may restrict access to specialty physicians and facilities, by clearly acknowledging when the symptoms or manifestations of a patient's illness require this higher degree of service; then working on behalf of the patient to seek access to them;

- *Respecting different cultures and values* - inherent in the support of the Principle of Autonomy is acceptance of values that may differ from one's own. As the United States becomes a more culturally heterogeneous nation, health care providers are called upon to work within and respect the socio-cultural and/or spiritual framework of patients and their families;

- *Seeking clarity on what constitutes marginal care* - within a system of finite resources, physicians will be called upon to carefully and openly communicate with patients regarding access to marginal and/or futile treatments. Addressing the many needs of patients and families at the end of life will be an increasingly important challenge in both communications and delivery of appropriate, yet compassionate care;

- *Supporting evidence-based practice* – physicians should utilize outcomes data to reduce variation in treatments and achieve higher efficiencies and effectiveness of care delivery;

- *Fostering transparency and openness in communications* – physicians should be willing and prepared to discuss all aspects of care and treatment, especially when disclosing problems or issues that may arise;

- *Exercising decision-making flexibility* - treatment algorithms and clinical pathways are extremely useful tools when used within their scope, but physicians must follow the case managed patient closely and have the authority to adjust the plan if clinical circumstances

warrant;

- Fostering “patient and family centered care* – whenever possible, medical treatments should be undertaken in a way that respects the patient’s values and preferences, and recognizes the important role to be played by family in supporting the patient’s care and well-being. For details on engaging families in this process, visit the website for the Institute for Family-Centered Care at www.familycenteredcare.org;

- Becoming skilled in the art of listening and interpreting* -- In her ground-breaking book, *Narrative Ethics: Honoring the Stories of Illness*, Rita Charon, M.D., Ph.D., a professor of Clinical Medicine at Columbia University’s College of Physicians and Surgeons, writes of the extraordinary value of utilizing the patient’s narrative, or personal story, in the care and treatment process. She notes that, “medicine practiced with narrative competence will more ably recognize patients and diseases, convey knowledge and regard, join humbly with colleagues, and accompany patients and their families through ordeals of illness.” In many ways, attention to narrative returns medicine full circle to the compassionate and caring foundations of the patient-physician relationship.

These represent only a handful of examples to illustrate the myriad of new skills that today’s and tomorrow’s physicians must master in order to meet their timeless professional obligation of compassionate patient care.

ASSESSMENT

From 2001 to 2004, the Institute of Medicine (IOM) issued six reports on the critical issue of health reform in the United States. Their studies showed, without equivocation that

America must find the social and political will to achieve health insurance coverage and access to care for all citizens, or face severe, long-term consequences. The 2004 report, *Insuring America's Health*, noted that the “clinical literature overwhelmingly shows that uninsured people, children as well as adults, suffer worse health and die sooner than those with insurance’ and that ‘The economic viability of the nation is limited by productivity lost as a result of the poorer health and premature death or disability of uninsured workers.’”

The Impending Crisis

In February 2009, the IOM released a follow-up report, *America's Uninsured Crisis: Consequences for Health and Healthcare* that the problems identified in the 2004 report have gotten much worse in the intervening five years. Most notably:

The percentage of nonelderly Americans with employer-sponsored insurance has continued a steady decline from 66% in 2000 to 59.8% in 2008; and has been further eroded due to the severe impacts of the deep recession that began in 2008. Studies have shown that employees with access to insurance through an employer have seen significant increases in premiums, co-pays and deductibles; and limitations on services covered; and that a growing number of employees are declining insurance due to unaffordability.

- From 2001 to 2006, per-capita spending on health care increased by 47%, while the nation's Gross National Product increased by only 34%.
- 45.7 million Americans, 17.2% of the population, lacked health insurance in 2007 and this number has risen since then,
- Nonelderly Americans without employer-sponsored insurance are finding nongroup health insurance to be increasingly unaffordable.

In a discussion with the chairs of institutional ethics committees, held at the Center for Ethics at Emory University in November 2009, Arthur Kellerman, M.D., an IOM Fellow, past president of the American College of Emergency Physicians, and Associate Dean for Health Policy at the Emory University School of Medicine, noted that without serious reform of our health care system, the growth in the cost of care will become increasingly unsustainable. He pointed out that meaningful reform will require serious steps to reduce costs but such steps have been opposed by formidable special interests – notably organized medicine, hospital associations, and the pharmaceutical industry, each of whom supports reform – so long as it does not have negative impacts on their constituencies. The direct result has been intense lobbying pressure on Congress to craft bills that may not ultimately achieve the reforms needed.

Kellerman closed his remarks by calling on physicians, ethicists, and other health professionals to educate their colleagues and communities on the critical need for health care reform and the consequences of failure, noting that “the status quo is everyone’s second choice” but that maintaining the current system will ultimately be ruinous to our nation’s health, both physically and economically.

Fostering a Socially Responsible Health Care System

Fostering this ethical corporate culture is the objective of the National Department of Veterans Affairs Integrated Ethics initiative. Through the program, VA health care facilities across the nation are examining the ethical dimensions of both patient care and organizational decision-making, acknowledging the importance of ethics at all levels. While this initiative focuses on a large system, the fundamental goals of integrating ethics into all aspects of

operations applies to any organization, from a large medical center to a physician's office practice. To learn more about this program, visit the website for the VA's National Center for Ethics in Healthcare at www.ethics.va.gov.

In an article published in the *Journal of the American Medical Association*, authors Ezekiel Emanuel, M.D. and Nancy Dubler, L.L.B. cited what they call the "Six C's" of the ideal physician-patient relationship: Choice, Competence, Communications, Compassion, Continuity, and [no] Conflict of interest. Physicians who accept a seventh "C" - the Challenge, and are imbued with the moral sensitivity embodied in their solemn oath, have an obligation to serve as the conscience of this new system dedicated toward caring for all Americans.

Writer and ethicist Emily Friedman said it best when she wrote, "There are many communities in health care. But three to which I hope we all belong are the communities devoted to improving the health of all around us, to achieving access to care for all, and to providing our services at a price that society can afford. These interests are, of course, expressions of the deeper community of values that states that healing, justice, and equality must guide what we believe and do."

CONCLUSION

The erosion of trust expressed by the public for the health care industry may only be reversed if those charged with working within or managing the system place patient and community interests ahead of their own. We must foster an ethical corporate culture within health care that rewards leaders with integrity and vision; leaders who encourage and expect ethical excellence from themselves and others; and who recognize that ethics establishes the moral framework for all organizational decision making.

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THE END

