

Professionalism and Clinical Autonomy in the Practice of Medicine

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Abstract

Professionalism in medicine requires a reasonable measure of freedom for physicians to determine patients' needs based on their own judgment. However, because virtually every medical decision is also a spending decision, third-party payers concerned about rising health care costs have introduced cost-containment tactics that significantly limit physicians' accustomed autonomy. In response, groups of physicians have filed class-action lawsuits against managed care plans, alleging causes of action such as fraud, breach of contract, extortion, and violations of federal RICO (Racketeer-Influenced and Corrupt Organizations) law. Such litigation may have merits, but it also faces significant obstacles, in part because the contracts involved may not actually have promised the broad measure of clinical autonomy that the physicians allege was promised, then denied. As physicians seek to restore and retain their professional autonomy, it will be important for them to be increasingly proactive in structuring or modifying the contracts under whose terms they practice — as some physicians have successfully done.

Key Words: Professionalism, law, RICO/racketeering, clinical autonomy, cost containment, managed care.

Introduction

AS THE OTHER ARTICLES in this issue indicate, professions are defined by many characteristics — specific features such as an esoteric body of expert knowledge, and certain values and obligations such as a fiduciary duty to place the patient's interests above the professional's own interests. This article will focus on one fairly narrow aspect of medicine as a profession, namely, the need for clinical autonomy and independence of judgment.

This autonomy is not to be understood as some sort of petulant freedom to do or demand whatever one wants, or as a freedom to ignore the rules of law or the needs and interests of other people. Rather, it stems from a recognition that professions concern matters of enor-

mous complexity for which simplistic formulae are inappropriate and impracticable. Science and standard routines will of course guide much of clinical care. Yet it cannot be certain whether a given patient will fit the norm until a knowledgeable, experienced physician actually examines that person. The patient may have an atypical presentation of a common illness or a typical presentation of a very uncommon condition; he might have anomalous anatomy defying standardized surgical techniques; he may exhibit unusual side-effects to medications that suit most people well; or he could have personal preferences that require revisions in the usual course of treatment.

This pivotal need for judgment that attunes general precepts to individual variations characterizes all professions, not just medicine. No "cookbook" can tell an attorney precisely how to litigate a particular criminal indictment or civil suit, because so much depends on the specific facts being alleged; existing precedents (or lack thereof) in that jurisdiction; the predilections of various personnel, including that case's jurors, judge, and opposing attorneys; and the preferences of the client.

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In medicine, however, a special challenge arises from the fact that health care is often very costly, and from the fact that third parties generally cover those costs. The latter is not ordinarily the case in other professional relationships. The attorney, architect, and engineer typically bill clients directly for their services, and clients can take costs into account however they wish as they decide what sort of services they want to purchase. But in medicine, the decisions that would otherwise be made by physicians in consultation with patients are now heavily constrained by payers' decisions about whether a proposed treatment is "medically necessary" and appropriately cost-effective. This intrusion of payers into the health care decision-making process has significantly curtailed physicians' accustomed professional independence.

This article briefly reviews the history of this challenge and then explores a special twist currently posed by class-action litigation that has been brought against several health plans. Finally, the article will make some suggestions on how physicians might exercise personal involvement and responsibility, to preserve a measure of professional independence even in the face of broad and conflicting financial demands.

History

Prior to the proliferation of health insurance during and after World War II, patients paid for medical care out of pocket — it was not usually an overwhelming burden, since medicine had relatively little to offer. Technologies and improvements in hospital care began to emerge during the post-war years, but with insurance steadily becoming a standard workplace benefit, physicians and patients still felt few financial constraints on their decision making. This pattern was solidly entrenched with the passage of Medicare and Medicaid legislation in 1965. These government programs, and soon thereafter private insurers, generally paid providers according to their "usual, customary, and reasonable" fees, rarely challenging what physicians chose to order for the care of their patients. Physicians, after all, had the professional expertise, and it ill behooved insurers to challenge their medical judgments (1–4). Such policies created an "artesian well of money" (5) in which physicians, for the most part, could care for their patients however they wished, and patients could accept whatever was offered, secure in the knowledge that all would be paid

for. Even uninsured patients could receive virtually the same level of care as everyone else, once they were accepted into the system, through a cost-shifting in which providers charged more to those who could pay in order to cover those who could not.

By the early 1970s it was obvious that such a system was highly inflationary, as costs were beginning to escalate out of control (6, 7). Numerous attempts at cost containment — ranging from President Nixon's wage- and price-controls, to President Carter's quasi-voluntary hospital price limits, to Medicare's Diagnostic-Related-Group payment system, to corporations' mandates for second opinions to justify high-cost care — failed to stem soaring costs (2). Finally, in the late 1980s and early 1990s, business firms, watching their international competitive position erode because of their inability to control the huge cost of employee benefits, finally demanded change. "Managed care" became a major force, and in 1993, for the first time in several decades, annual increases in per capita health care expenditures were less than two percent (8).

This "taming" of health care costs came about through wide-ranging and often vexing changes in the ways health care has been financed and delivered. Tools have ranged from intensive and sometimes intrusive utilization management and gatekeeping arrangements, to denials of payment, to financial incentives such as withholding pools, bonuses, penalties, and capitation arrangements. Physicians "game" their way around the rules (9–12), while health plans game their way around the physicians and reinvent the rules (13–18). If the consequences were not so distressing, the scene would be a comedy of herding cats.

Still, cost-containment tactics in one form or another are surely inevitable. Virtually every medical decision is also a spending decision. So long as third parties incur the financial consequences of physicians' medical/spending decisions, they must and will attempt to limit their economic liability. They can do so either by controlling the spending directly, in which case they effectively control or at least circumscribe the medical decisions (as in utilization management) or by transferring the financial consequences of the decisions (as in risk-shifting arrangements) (19). Either way, the clinical autonomy to which physicians had become so comfortably accustomed as their right of professional independence is now significantly limited.

Managed Care Litigation

Physicians have not accepted these changes passively or altogether peaceably. Some of the more forceful responses are found in lawsuits filed by providers, paralleling similar suits filed by patients, challenging health plans' strategies for containing the costs of health care. A plethora of provider-filed suits has now been consolidated into a single class-action suit (the "provider-track") (20); similarly, a number of patient suits have been consolidated into a parallel class-action suit (the "subscriber-track") (21). Although this article does not offer an extensive discussion of these suits, it will be useful to summarize two key elements in the providers' consolidated complaint.

Alongside fraud, breach of contract, extortion, mail and wire fraud, and assorted other causes of action, the suit alleges violations of the Racketeer-Influenced and Corrupt Organizations Act (RICO, the federal anti-racketeering law, 18 U.S.C., 1961–1968). That is, the complaint alleges that health plans across the United States have engaged in a pattern of racketeering activity, "defined as behavior that violates certain other laws" (22, p. 1079) such as extortion, fraud, mail fraud, and wire fraud. Among other concerns, the suit argues that the health plans made, and broke, two major promises.

First, the plans allegedly promised that physicians would be able to exercise independent judgment, free from improper interference and control. Second, they promised to provide physicians with adequate compensation for their services. In reality, the complaint says, health plans have failed to disclose important policies and practices that resulted in delays, denials, and decreases of payment; they paid unconscionably low rates, whether in a fee-for-service or in a capitated setting; and in risk-sharing situations such as those involving pharmaceutical benefits, they transferred unacceptable levels of risk to physicians. Moreover, the defendant health plans systematically interfered with physicians' medical judgment, thereby impeding physicians' ability to fulfill their professional obligation to provide appropriate care and interfering with the trusting relationship between physicians and their patients.

In essence, the complaint portrays a "catch-22" situation. On the one hand, physicians who provide care within the constraints of the health plans' payment policies risk loss of trust, reputation, and profession, and in the process in-

crease their exposure to legal liability. Conversely, if the physicians' care comports with the accepted medical standard of care, the plans punish them with nonpayment, inadequate payment, delayed payment or other coercive tactics. All this, the complaint notes, is done to increase the defendant health plans' profits.

Accordingly, the suit asks for declaratory and injunctive relief to require plans to cease such tactics; for attorney fees and the costs incurred in bringing the suit; and for whatever other relief the court deems appropriate. The latter could include financial damages that, under RICO, would be trebled.

Although it is difficult to predict whether the litigation will succeed or fail, two recent court decisions address related issues and, in the process, speak to broader questions about physicians' autonomy and professionalism.

Related Cases

The Supreme Court's decision in *Pegram v Herdrich* (23) addresses the question of whether it is legitimate for for-profit health plans to engage in cost-containment practices such as incentive schemes. In the context of complex issues concerning the federal Employee Retirement Income Security Act (ERISA) law of 1974, that governs workplace benefits, the Court opined that such financial constraints were not inherently illegitimate, even though they may increase the risks of some kinds of undesired outcome. "Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others (ruptured appendixes are more likely; unnecessary appendectomies are less so), any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk" (23, p. 2150). If cost-containment measures such as incentive schemes are to be restricted, it is the legislature, not the courts, that must do so. Moreover, neither is it the Court's place to outlaw health plans that operate on a for-profit basis. After all, since "the provision for profit is what makes the HMO a proprietary organization, [Herdrich's] remedy in effect would be nothing less than elimination of the for-profit HMO. . . . [T]he Judiciary has no warrant to precipitate the upheaval that would follow. . . ." (23, p. 2156).

Accordingly, if the current anti-managed-care litigation proposes that courts should force

health plans to refrain from providing incentives to physicians to constrain care or from making profits, the Supreme Court would seem to disapprove. If incentive systems pose undue hazards to physicians' clinical autonomy and thereby to the content of patients' care, then it is for the legislature, not the courts, to rule them out. Thus far, no legislature has chosen to do so.

A second recent decision comes from the federal Third Circuit Court of Appeals in *Maio v Aetna* (24). Analogous to the providers' class-action suit described above, *Maio* featured a class-action RICO suit brought by patients against Aetna US HealthCare. Patient-plaintiffs alleged a substantial gap between what the plan promised and what it delivered, largely because the plan's cost-containment policies allegedly discouraged physicians from providing appropriate health care. That gap, they argued, added up to fraud and other assorted offenses, thereby representing a pattern of racketeering violations.

The Third Circuit rejected plaintiffs' claims on several grounds, one of which is particularly pertinent here. The court took note of the actual contractual language by which the health plan made its promises to enrollees. That contract does not promise what plaintiffs claim, the court observed. Aetna never promised to permit (or pay for) physicians to order whatever services they wished. In contrast to plaintiffs' claims, "Aetna promised to provide its members with a different contractual benefit — namely the right to receive covered health care benefits in the form of medically necessary supplies, health care services and treatment through Aetna's participating providers" (24, p. 491). Moreover, the contract explicitly reserved the right for the plan, not the physicians or enrollees, to determine which services are medically necessary. Thus, the so-called gap between what was promised and what was provided fades considerably once one looks more closely at the actual contractual promises. As a consequence, the allegations of fraud and racketeering likewise failed to stand up.

This emphasis on contract is highly relevant to broader issues about physician professionalism and autonomy in the face of medicine's economic overhaul. The complaint in the provider-track of the current class-action suit seems to imply that the defendant health plans promised physicians essentially the same sort of independence and clinical autonomy that physicians exercised during the days of the "artesian well" — the freedom to provide virtu-

ally whatever care they wanted and to charge virtually whatever they saw fit, with almost unquestioned assurance of being paid in full. As noted above, those days are gone. While the actual contracts featured in this particular litigation are not available for review by the readers or the author of this article, it is reasonable to be at least somewhat skeptical that those contracts actually promised "artesian" freedom. Perhaps the independence they promised was instead the sort that health plans commonly promise today: physicians are free to provide care however they wish, but health plans are also free to refuse to pay for it, in accordance with the coverage terms of the contract. As in the *Maio* case, the plans may have retained the right to make their own decisions about which care is medically necessary and thereby covered.

If indeed the various contracts made limited rather than "artesian" promises, then the racketeering allegations may fail, for the same reasons as in the *Maio* decision. There is no fraud or extortion, nor any pattern of it, if the promises match what is delivered — even if some observers might argue that those promises are considerably more modest than they should be. Accordingly, at this point it seems appropriate to discuss some deeper issues concerning, first, the importance of clinical autonomy in the practice of medicine, and second, the role that physicians should take in ensuring that they practice with an adequate measure of autonomy.

Deeper Issues

The Scope and Focus of Clinical Autonomy

The first issue — inquiring just how much clinical independence physicians really ought to have in order to provide good care — is as complex as it is important, and will not be the focus of extensive discussion here. Readers are referred elsewhere for a detailed consideration of the question (25), but a brief summary would nevertheless be useful.

Although a measure of independent judgment is very important in any profession, for the reasons outlined above, the extraordinary independence physicians exercised during the days of the "artesian well" was not always in patients' best interests. Partly because physicians were so free to do whatever they saw fit, and partly because scientific research focused mainly on the development and approval of costly new technologies rather than on the more mundane modes of clinical care, physicians'

clinical practices came to vary quite widely. As noted by Wennberg (26–29), among a host of other observers, medical practice variations came to reflect, not always the medical differences among patients, but such ancillary factors as availability of beds and facilities, and local fashions and customs (30–32). In addition, physicians too often failed to implement even ordinary forms of care that were known to be effective and cost-effective, such as prescribing aspirin and beta-blockers for patients surviving myocardial infarction, or ACE inhibitors for patients with congestive heart failure (33–37).

The introduction of evidence-based guidelines can serve as an important antidote to unfounded variations in care. Such guidelines can help physicians to remember a host of factors that are otherwise difficult to keep in mind, such as who needs which preventive care and when. They can also incorporate the latest information for a faster dissemination of improvements in clinical care, and they can help to reduce rates of error (38–42).

Still, it is obvious that guidelines cannot replace the clinical observation, judgment and experience of a physician. Physicians need to retain substantial clinical autonomy for at least two major purposes. First, they need freedom to render appropriate care when a particular patient does not fit the applicable guidelines. No guideline can adequately anticipate the patient who does not respond as expected to a given medication, whose presentation of illness is atypical, or whose preferences create adherence challenges. In these cases physicians cannot deliver adequate care without adequate freedom to deviate from guidelines. This does not mean that health plans must finance unlimited freedom for physicians to deviate whenever they please, because that would represent a return to the “artesian” financing that has become fiscally unsustainable. However, it does require appropriate procedures whereby physicians can make and implement their own judgments without undue impediment. This is particularly the case for the ordinary ailments seen in the great majority of clinical encounters. A relatively small number of patients consume the vast majority of resources (43), and it is in this area that health plans should ideally focus their greatest attention, not by endlessly diddling in the daily details (44).

Second, physicians need an avenue by which they can help to reshape guidelines that are clinically or scientifically ill-founded or outdated. In some cases the guidelines by

which health plans make decisions about care and coverage are the product, not of science, but of actuarial data or of a short-sighted focus on costs without adequate attention to evidence or to consequences (25). Where that is the case, physicians should have a strong voice in modifying the guidelines by which their care is guided, evaluated, and paid for.

Physicians’ Obligations in Protecting Clinical Autonomy

One of the most complex, yet relatively undiscussed, aspects of the class action lawsuit concerns the question of how these physicians came to be contractually bound by such allegedly onerous conditions. The payment rates are unconscionably low, the complaint says, and physicians are effectively forced to provide inadequate care.

On the one hand, physicians in at least some areas of the country face a difficult predicament. Where a small number of very large, powerful managed care organizations provide health care coverage for a great majority of the people in a particular geographic area, the average physician may have limited alternatives to contracting with those plans, if he or she wishes to remain in that locale. For instance, “five HMOs control nearly 90 percent of California’s HMO market. A total of 300 physician groups operate in the same market, giving enormous bargaining power to the HMOs” (45, p. 1067). The challenge is compounded by the fact that, if otherwise-independent physicians conspire together to insist on a better fee schedule or to boycott the health plans with whose terms they are dissatisfied, they can be guilty of antitrust violations — including so-called *per se* violations that carry treble damages (46).

And there is yet another side. Ostensibly, these physicians signed their respective contracts voluntarily. No one held a gun to anyone’s head. If physicians agreed to ethically dubious terms, they must accept a measure of responsibility.

In the end, the answers will surely be as complex as the problems. On the one hand, health plans have an obligation to negotiate honestly and to fulfill their agreements in good faith. Courts have agreed. In one case, for instance, a dental HMO consistently failed to provide its provider-dentists with accurate lists of enrollees. The plan was capitulated, and providers needed that information in order to know whom they were obligated to serve, and

to manage their budgets appropriately. Because the dentists had no alternate means of verifying which of their patients were enrolled, the dentist group “could not determine who to treat or how much capitation it was owed. More important, without accurate eligibility data, the dental HMO would not even realize if it were being underpaid” (47, p. 194). The group was entirely dependent on information provided by the plan, and the plan knew that to be the case, yet did not provide the correct information. Accordingly, a Texas appellate court found that the health plan had violated a special duty of good faith and fair dealing (47).

Indeed, physicians’ lack of negotiating power is perceived to be so significant in certain regions that some physicians have joined together in union-like associations to bargain collectively (48–50), although a recent Supreme Court decision casts significant doubt on whether physicians can successfully unionize (51). Other physicians have used litigation, or the threat of it, to work out special arrangements with health plans, as physicians and others did regarding Aetna in Texas (52, 53). More broadly, some commentators support legislation to provide physicians with some relief from antitrust constraints, in hopes of permitting more evenly matched negotiating (54, 55). The question of whether and to what extent physicians need to increase their bargaining leverage depends at least partly on empirical analyses of each side’s market power and negotiating strength — analyses that have not yet been undertaken in any systematic way.

On the other hand, physicians themselves must shoulder some major responsibilities if they are to preserve a measure of the clinical independence needed for serving their patients well. Perhaps at the top of the list, they must now learn to scrutinize prospective contracts — or more realistically, to hire knowledgeable people to do it on their behalf — and refuse to sign on to arrangements that they find ethically, financially, or medically intolerable.

This is not a task to which many physicians are accustomed. As noted by one commentator (56, p. 191):

Too often, doctors sign managed care agreements without reading them; other times, doctors don’t keep copies, so they can’t verify whether the terms are being met. Sometimes, doctors don’t even tell their office manager which contracts they’ve signed. Physicians also fail to seek advice from

readily available sources, such as their state medical associations.

Though they may find the task distasteful, physicians have little alternative. In many cases, physicians can exercise considerably more bargaining power than they realize. In one case, for example, the health plan covering employees for a very large corporation insisted that its fee schedule and contract terms were not negotiable. The physician group providing care for these employees found those terms to be unacceptable and directly informed the employer. After a nine-month standoff, the plan offered a significantly improved contract (56). With the help of advocates skilled in such negotiations, physicians have been able to: improve the fees a health plan pays, particularly for higher-volume interventions; remove the “hold harmless” clauses that can potentially leave physicians exclusively liable for treatment decisions, including denials of care, that lead to adverse outcomes; limit the array of services physicians are required to provide under a capitation arrangement; obtain a health plan commitment to pay claims within specified time-limits, such as thirty days; and secure disclosure of (and thereby place appropriate limits on) the formulae for bonuses and withholds (56–63).

Conclusion

Physicians across the nation are understandably bewildered by the dramatic changes that have substantially constricted their ability to make decisions with the independence to which they had been accustomed. Some of that loss is regrettable, yet the situation is not hopeless, even if it requires physicians to take greater responsibility for the conditions of their own practice.

One major task for the profession as a whole is to create more coherent, evidence-based patterns of care. If physicians are to expect patients and payers to “trust me, I’m a doctor,” they must make good on the profession’s promise to provide a scientifically well-founded approach to care that can documentably produce the best outcomes for patients.

In the same spirit, physicians must also take a more active role in the conditions of their work. If physicians are to regain and retain an acceptable level of professional autonomy, they cannot expect others to do that task for them. Other players in this fast-changing scene have their own responsibilities, including patients as

well as payers and employers. As fiduciaries of their patients, physicians have a professional obligation to make sure that the conditions under which they agree to practice do not place them under untenable restrictions or conflicts of interest. Accordingly, physicians must take a much more active role in studying, understanding, and appropriately modifying the contractual terms under which they practice. It is not acceptable to point to others and say "they made me do it," if the physician has not read the contracts that, per his agreement, will define or restrict his practice as well as his income.

In the end, the current situation, while challenging, presents an important opportunity to bring a new rationality and coherence to the structure of health care. And it provides an opportunity for physicians and health plans alike to consider more carefully the ways in which physicians need clinical independence and professional autonomy as prerequisites to providing good care, and the ways in which that autonomy can best be secured.

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