

11.2.2 Conflicts of Interest in Patient Care

The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients.

Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. Physicians should not provide wasteful and unnecessary treatment that may cause needless expense solely for the physician's financial benefit or for the benefit of a hospital or other health care organization with which the physician is affiliated.

Where the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority.

AMA Principles of Medical Ethics: II

Opinion 11.2.2 Conflicts of Interest in Patient Care reorganizes guidance from multiple sources as follows:

CEJA Report 3-A-07 Referral of Patients: Disclosure of Limitations, *Amendment*
CEJA Report 8-A-02 Referral of Patients: Disclosure of Limitations, *Amendment*
CEJA Report B-A-90 Financial incentives to limit care: ethical implications for HMOs & IPAs

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-07

Subject: Opinion E-8.132, “Referral of Patients: Disclosure of Limitations,” *Amendment*

Presented by: Robert M. Sade, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Richert E. Quinn, Jr., MD, Chair)

1 INTRODUCTION

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3 At the 2006 Annual Meeting of the AMA House of Delegates, Board of Trustee Report 38,
4 “Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral
5 Expectations” was adopted. The report requested “that our AMA ask the Council on Ethical and
6 Judicial Affairs to consider revising E-8.132 to address all health care delivery settings.”

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8 BACKGROUND

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10 Opinion E-8.132, “Referral of Patients: Disclosure of Limitations,” (AMA Policy Database) was
11 originally written in response to provisions in managed care plans, specifically HMOs and PPOs,
12 that could limit access to care by expressly restricting patient referrals or providing financial
13 incentives to control referrals.

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15 In 2002, the Opinion was amended to expand its applicability beyond these entities to all health
16 care plans, not just managed care plans. The CEJA report from the 2002 Annual Meeting,
17 “Referral of Patients: Disclosure of Limitations, *Amendment*,” specifically stated this intent: “CEJA
18 proposes that...other Opinions on managed care in the *Code of Medical Ethics* be extended in
19 scope to cover health care plans in general rather than managed care organizations only...” While
20 the amendment to the Opinion was meant to expand its application beyond a limited number of
21 managed care entities, it did not clearly express an expansion to all methods of health care delivery.

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23 Board of Trustees Report 38 asks CEJA to consider expanding the Opinion E-8.132 because of a
24 concern that the terminology it uses does not include all possible types of health care delivery
25 mechanisms. Arguably, “health care plan” includes only insurance plans, and not integrated
26 hospital systems or similar organizations that may have an influence on how health care is
27 delivered. Furthermore, transformation in our health care system will continue to occur, and a

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 broader application of this Opinion is appropriate to address current as well as future
2 circumstances.

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4 CONCLUSION

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6 Opinion E-8.132 uses the term “health care plans,” without defining it. Therefore, the Council
7 proposes amending the Opinion to require disclosures of limitations on referrals, irrespective of the
8 financing and delivery mechanisms or contractual arrangements.

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10 RECOMMENDATION

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12 The Council recommends that Opinion E-8.132, “Referral of Patients: Disclosure of Limitations,”
13 be amended as follows and the remainder of the Report be filed.

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15 E-8.132 Referral of Patients: Disclosure of Limitations

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17 Physicians should always make referral decisions based on the best interests of their
18 patients, regardless of the financing and delivery mechanisms or contractual agreements
19 between patients, health care practitioners and institutions, and third party payers. When a
20 physicians agrees to provide treatment, ~~they~~ ~~he or she~~ ~~thereby enters into a contractual~~
21 relationship and assumes an ethical obligation to treat ~~their~~ ~~the~~ ~~patients~~ to the best of his or
22 her~~their~~ ability. ~~Some health care plans contracts generally restrict the participating~~
23 physician’s scope of referral to medical specialists, diagnostic laboratories, and hospitals
24 that have contractual arrangements with the health plan. Some plans also restrict the
25 circumstances under which referrals may be made to contracting medical specialists. If the
26 a physician knows that a patient’s health care plan or other agreement does not cover
27 referral to a non-contracting medical specialist or to a ~~diagnostic or treatment facility~~ when
28 that the physician believes ~~that the~~ ~~to be in the patient’s best interest~~ ~~patient’s condition~~
29 requires such services, the physician should so inform the patient so ~~that~~ ~~to permit~~
30 the patient ~~may to~~ decide whether to accept the outside referral, ~~at his or her own expense or~~
31 confine herself or himself to services available within the health care plan. In determining
32 whether treatment or diagnosis requires referral to outside specialty services, the physician
33 should be guided by standards of good medical practice.

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35 Physicians must not deny their patients access to appropriate medical services based upon
36 the promise of personal financial reward, or the avoidance of financial penalties. Because
37 patients must have the necessary information to make informed decisions about their care,
38 physicians have an obligation to ~~assure the disclosure of~~ disclose medically appropriate
39 treatment alternatives, ~~regardless of cost.~~ Physicians should also promote an effective
40 program to monitor and improve the quality of the patient care services within their
41 practice settings.

42
43 Physicians must ~~assure~~ ensure disclosure of any financial ~~inducements~~ incentives that may
44 ~~tend to limit the~~ appropriate diagnostic and therapeutic alternatives that are offered to

1 patients or that may ~~tend to~~ limit patients' overall access to care. ~~Physicians may~~ This
2 obligation may be satisfied ~~satisfy this obligation by if assuring that the health care plan or~~
3 other agreement makes adequate disclosure to enrolled patients. ~~Physicians should also~~
4 ~~promote an effective program of peer review to monitor and evaluate the quality of the~~
5 ~~patient care services within their practice setting.~~ (II, IV)
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7 Issued June 1986; Updated June 1994 based on the report "Financial Incentives to Limit Care:
8 Ethical Implications for HMOs and IPAs," adopted June 1990; updated June 2002.
9 (Modify HOD/CEJA Policy)

Fiscal Note: Staff cost estimated at less than \$500 to implement.

APPENDIX- PROPOSED OPINION AMENDMENTS (CLEAN)

E-8.132 Referral of Patients: Disclosure of Limitations

Physicians should always make referral decisions based on the best interests of their patients, regardless of the financing and delivery mechanisms or contractual agreements between patients, health care practitioners and institutions, and third party payers. When physicians agree to provide treatment, they assume an ethical obligation to treat their patients to the best of their ability. If a physician knows that a patient's health care plan or other agreement does not cover referral to a non-contracting medical specialist or to a facility that the physician believes to be in the patient's best interest, the physician should so inform the patient to permit the patient to decide whether to accept the outside referral.

Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to disclose medically appropriate treatment alternatives. Physicians should also promote an effective program to monitor and improve the quality of the patient care services within their practice settings.

Physicians must ensure disclosure of any financial incentives that may limit appropriate diagnostic and therapeutic alternatives that are offered to patients or that may limit patients' overall access to care. This obligation may be satisfied if the health care plan or other agreement makes adequate disclosure to enrolled patients. (II, IV)

Issued June 1986; Updated June 1994 based on the report "Financial Incentives to Limit Care: Ethical Implications for HMOs and IPAs," adopted June 1990; updated June 2002.

4. ~~Patients have an individual responsibility to~~ Physicians should encourage both that patients be aware of the benefits and limitations of their health care coverage. ~~Patients should and that they~~ exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs. (I, II, III, V)

Issued June 1996 based on the report "Ethical Issues in Managed Care," adopted June 1994 (*JAMA*. 1995;273: 330-335); updated June 2002.

8. REFERRAL OF PATIENTS: DISCLOSURE OF LIMITATIONS, *AMENDMENT*

HOUSE ACTION: FILED

At the 2001 Annual Meeting, the American Medical Association House of Delegates adopted Resolution 3, "Restrictive Drug Policies in Public Programs such as Medicaid," in response to which the Council on Ethical and Judicial Affairs is amending Opinion 8.135, "Managed Care Cost Containment Involving Prescription Drugs." For the sake of consistency, CEJA proposes that, like Opinion 8.135, other Opinions on managed care in the *Code of Medical Ethics* be extended in scope to cover health care plans in general rather than managed care organizations only and be edited to direct their recommendations to physicians only. Accordingly, CEJA proposes the following amendments to Opinion 8.132, "Referral of Patients: Disclosure of Limitations." The revised Opinion will appear in the next edition of the *Code of Medical Ethics*.

8.132 Referral of Patients: Disclosure of Limitations

When a physician agrees to provide treatment, he or she thereby enters into a contractual relationship and assumes an ethical obligation to treat the patient to the best of his or her ability. ~~Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO)~~ Some health care plans contracts generally restrict the participating physician's scope of referral to medical specialists, diagnostic laboratories, and hospitals that have contractual arrangements with the ~~PPO and HMO~~ health care plan. Some plans also restrict the circumstances under which referrals may be made to contracting medical specialists. If the ~~PPO or HMO~~ health care plan does not permit referral to a non-contracting medical specialist or to a diagnostic or treatment facility when the physician believes that the patient's condition requires such services, the physician should so inform the patient so that the patient may decide whether to accept the outside referral at his or her own expense or confine herself or himself to services available within the ~~PPO or HMO~~ health care plan. In determining whether treatment or diagnosis requires referral to outside specialty services, the physician should be guided by standards of good medical practice.

Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost.

Physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care. Physicians may satisfy this obligation by assuring that the ~~managed health care plan~~ makes adequate disclosure to enrolled patients ~~enrolled in the plan~~. Physicians should also promote an effective program of peer review to monitor and evaluate the quality of the patient care services within their practice setting. (II, IV)

Issued June 1986; Updated June 1994 based on the report "Financial Incentives to Limit Care: Ethical Implications for HMOs and IPAs," adopted June 1990; updated June 2002.

6. The patient should have the right to essential health care and physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care.

**B. FINANCIAL INCENTIVES TO LIMIT CARE: ETHICAL
IMPLICATIONS FOR HMOs AND IPAs
(RESOLUTION 28, I-88)**

HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTION 28 (I-88)

Resolution 28 (I-88), which was referred to the Board of Trustees, requests a study “to provide an updated description of standards for the receiving of fees for services from all payors . . . in the context of health maintenance organizations (HMOs), independent practice associations (IPAs) and joint ventures.”

The Council on Ethical and Judicial Affairs recommends the adoption of the following report in lieu of Resolution 28 (I-88).

OVERVIEW

The physician-patient relationship is built on a foundation of mutual trust. It is the confidence inspired by this relationship that enables patients to place their health and well-being in the hands of physicians. At least since the time of Hippocrates, physicians have cultivated the trust of their patients by professing to place patient welfare before all other concerns. This tradition of placing primary emphasis on the interests of the patient has endured through the ages as the guiding tenet of medical practice.

In recent years, however, pressures to contain spiraling health care costs have tended to create a potential for conflict between the interests of patients and physicians. Patients in America have come to expect access to the best available care, regardless of its cost. They trust their physicians to do all that is possible to enhance their health and well-being. Physicians, however, increasingly have conflicting obligations to their patients and to those who finance medical services. Not only are physicians expected to serve as advocates for their patients in obtaining appropriate diagnostic and therapeutic services, but they also are expected, in their relationships with third party payors, to contain health care expenditures. This conflict is evident, for example, when the remuneration received by physicians is tied, through the use of financial inducements, to the degree of cost containment achieved in the provision of medical services.

CONFLICTS OF INTEREST IN HEALTH CARE DELIVERY SYSTEMS

Potential economic conflicts of interest are inherent to the practice of medicine. Health care services traditionally have been rendered on a fee-for-service basis, whereby physicians receive compensation for each diagnostic or therapeutic service provided to a patient. In such a setting, an incentive exists to increase the number of services rendered. These potential conflicts of interest, which are beyond the scope of this report, have been addressed in a more comprehensive manner in a separate Board of Trustees report currently before the House of Delegates.

Alternative practice settings also are characterized by potential conflicts between the interests of physicians and patients. Managed care plans that include, for example, HMOs and IPAs may provide physicians with economic incentives to limit the medical services provided to patients. Increasingly, these include direct financial rewards for physicians who help the organization to achieve their cost-containment

objectives. The nature of these rewards may vary with the organizational structure and compensation practices of the managed health care plan.

THE ORGANIZATIONAL STRUCTURE OF HMOs AND IPAs

The organizational structure of HMOs differs from that of fee-for-service systems in the methods used to compensate physicians and in the general degree of emphasis on cost containment. HMOs typically agree to provide all necessary medical services to an enrolled population in return for a fixed premium, paid on a monthly or yearly basis. In theory, HMOs are able to reduce health care expenditures in at least two important respects.

First, HMOs promote cost savings by encouraging early, office-based treatment. The presumption here is that routine, preventive care is cost-efficient, whereas treatment of acute conditions, that because of financial concerns have been left unattended, ultimately may require more costly intervention or hospitalization.

Second, some HMOs limit their costs by placing institutional controls on patient access to costly services, such as hospitalization or referrals to medical specialists. For example, patients often must obtain prior authorization from an HMO primary care physician before consulting a medical specialist. Failure to do so may result in the HMO's refusal to provide reimbursement for the unauthorized care. Medical referrals may be further restricted to a particular physician, group or facility that is responsive to the cost containment objectives of the HMO. These restrictions customarily are conveyed to potential members of the HMO prior to enrollment, and therefore represent voluntary conditions of participation.

With increasing frequency, some HMOs attempt to achieve additional savings by providing participating physicians with a variety of financial incentives to contain the overall costs of the medical services provided to their patients. The structure and effectiveness of these inducements tend to vary with the organizational characteristics of the HMO and with the methods used by the organization to compensate participating physicians.

Four organizational models of HMOs have been described: (1) the staff model, in which health care services are delivered to an enrolled population through employed physicians responsible directly to the health maintenance organization; (2) the group model, in which the HMO contracts with an independent group of physicians to provide medical services to qualified enrollees; (3) the network model, in which the HMO contracts with two or more group practices; and (4) the independent practice association (IPA) model, in which independent physicians contract with the HMO to provide comprehensive medical services to an assigned patient population.

HMOs also use variable structures to compensate physicians. The three arrangements commonly used for primary care physicians are: (1) salaries, (2) fee-for-service, and (3) capitation arrangements. Under fee-for-service compensation arrangements, HMOs base their payments to physicians on the actual charges incurred in the provision of particular services, the customary and prevailing charges in the physician's geographic area of practice, or a predetermined fee schedule. Capitation fees, on the other hand, provide participating physicians with a fixed monthly or yearly payment per HMO enrollee. The physician then is obligated to provide certain types of medical services (e. g., primary care) to the enrolled population during the benefit period, regardless of cost. Capitation arrangements represent a form of financial risk sharing, whereby physicians profit only if the total costs of the medical services provided to enrollees is less than the sum of the capitation fees collected by the physician. If all clinically indicated care cannot be provided to the enrolled population for an amount that is less than or equal to the sum of the capitation fees, the physician may suffer a financial loss unless the HMO has sufficient reserves to cover the loss or some appropriate care is withheld.

Compensation arrangements in HMOs also may involve a variety of withholding schemes designed to shift a portion of the organization's financial risk to individual physicians. Typically, the premiums paid by enrollees are divided into a number of distinct accounts. The funds in each account are earmarked for specific types of expenses, such as administrative costs, primary care, referrals to specialists, hospitalization and outpatient diagnostic tests.

A percentage of the revenue that is allocated to primary care accounts frequently is withheld from participating physicians until the end of the year to assure that adequate funds are available for referrals and other outside services. If, at the end of the year, an overall surplus exists in an account that is earmarked for a specific type of service, the withheld portion may be returned to the HMO's physicians. Surplus amounts above and beyond the initial withholding also may be distributed to participating physicians, either individually or as a group, as a bonus or reward for effective cost containment.

Similarly, the HMO may penalize physicians for year-end deficits in particular accounts by requiring them to forfeit the amounts withheld, or occasionally, by imposing additional financial penalties. The HMO may or may not place an upper limit on the extent of a physician's personal financial risk.

In the event of either a surplus or a deficit in the HMO's accounts, the corresponding bonus or penalty for physicians may be calculated individually, based on the total care provided by individual practitioners, or as a group, with the total financial benefit or risk equally distributed among all physicians.

POTENTIAL EFFECTS OF FINANCIAL INCENTIVES

The use of financial incentives to promote cost awareness among HMO physicians has created some concern that such inducements could result in inappropriate reductions in the services made available to HMO patients. As noted in a recent General Accounting Office study:

A primary purpose of HMO physician incentive plans is to get the physician to consider the cost implications of alternative courses for diagnosing or treating patients. The goal of such plans should be to encourage physicians to select the least expensive course of care that meets the patient's needs and results in adequate care. However, incentive plans may offer such strong financial incentives to physicians to reduce utilization that quality of care could be adversely affected through the withholding of needed services.

This same study identified four characteristics of financial incentive plans that seem to have the greatest potential to adversely affect the quality of the medical services provided to HMO patients. The characteristics identified were: (1) the amount of financial risk that is shifted from the HMO to individual physicians, (2) the number of physicians whose performance is used to calculate monetary distributions, (3) whether the incentive payments are based on a percentage of individual provider savings or profits, and (4) the length of time over which the cost performance of physicians is measured. It was found, for example, that when performance is measured over a short period of time (e. g., one month) such that incentive payments are closely linked to individual treatment decisions, financial inducements exert a greater influence on physician behavior.

THE IMPACT OF FINANCIAL INCENTIVE PLANS ON QUALITY OF CARE

It is difficult to measure the impact of financial incentive programs on the quality and appropriateness of the care that is rendered to HMO participants.

Several studies have attempted to determine how HMOs achieve their cost savings. The results from these studies are not conclusive, nor are they consistent.

One study presented comparative data for eight discretionary procedures (e. g., hysterectomies). The findings revealed that HMOs do not differentially reduce discretionary procedures in order to achieve cost savings. In other words, according to this study, HMOs appear to contain medical costs by eliminating both discretionary and nondiscretionary inpatient procedures. Other studies also have found that fewer hospital admissions among HMO patients do not appear to result exclusively from reductions in those procedures that are viewed as discretionary. However, a study of diagnostic testing practices among physicians did suggest that fewer discretionary outpatient tests are ordered for HMO enrollees than fee-for-service patients.

ETHICAL CONSIDERATIONS INVOLVING FINANCIAL INCENTIVES PLANS

The primary responsibility of the medical profession is to benefit patients. Physicians have an ethical obligation to place the health and well-being of their patients before all other concerns. If a conflict develops between a physician's personal financial interests and his obligations to a patient, the physician must not permit the patient's health and well-being to be compromised.

Financial inducements must not be permitted to taint a physician's judgment of appropriate therapeutic alternatives. Such alternatives should be disclosed to the patient, who then is at liberty to make an informed decision about his or her medical treatment, based upon the information provided. It would be unethical for a physician to deny his or her patients access to appropriate medical services based upon the promise of personal financial reward.

If the treatment alternatives available to a patient are limited by contractual agreement, such limitations should be fully disclosed, as noted in Section 8.13 of "Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, 1989":

REFERRAL OF PATIENTS — DISCLOSURE OF LIMITATIONS. When a physician agrees to provide treatment, he thereby enters into a contractual relationship and assumes an ethical obligation to treat the patient to the best of his ability. PPO and HMO contracts generally restrict the participating physician's scope of referral to medical specialists, diagnostic laboratories and hospitals that have contractual arrangements with the PPO or HMO. Some plans also restrict the circumstances under which referrals may be made to contracting medical specialists. If the PPO or HMO does not permit referral to a noncontracting medical specialist or to a diagnostic or treatment facility when the physician believes that the patient's condition requires such services, the physician should so inform the patient so that the patient may decide whether to accept the outside referral at his own expense or confine himself to services available within the PPO or HMO. In determining whether treatment or diagnosis requires referral to outside specialty services, the physician should be guided by standards of good medical practice.

As suggested by tradition, patient welfare must be the primary concern of physicians. The Council on Ethical and Judicial Affairs therefore recommends adoption of the following statement to address the potentially adverse effects of financial inducements on the quality and appropriateness of patient care:

- Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties.
- Patients must have the necessary information to make informed decisions about their care. Physicians therefore have an ethical obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost.
- Physicians must assure that their contractual agreements restricting referral or treatment options are disclosed to patients.

- Physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care.
- Physicians may satisfy their disclosure obligations by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan.
- Physicians should promote an effective program of peer review to monitor and evaluate the quality and appropriateness of the patient care services provided within their practice setting.

The Council recommends the adoption of this report in lieu of Resolution 28 (I-88).

(References pertaining to Report B of the Council on Ethical and Judicial Affairs are available from the Office of the General Counsel.)

C. GUIDELINES FOR THE APPROPRIATE USE OF DO-NOT-RESUSCITATE ORDERS

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES FOR REPORT TO THE HOUSE OF DELEGATES AT THE 1990 INTERIM MEETING

OVERVIEW

Cardiopulmonary resuscitation (CPR) is routinely performed on hospitalized patients who suffer cardiac or respiratory arrest. Consent to CPR is presumed since the patient is incapable at the moment of arrest of communicating his or her treatment preference and failure to act immediately is certain to result in the patient's death. Two exceptions to the presumption favoring CPR have been recognized, however. First, a patient may express in advance his or her preference that CPR be withheld. If the patient is incapable of expressing a preference, the decision to forgo resuscitation may be made by the patient's family or other surrogate decision maker. Second, CPR may be withheld if, in the judgment of the treating physician, an attempt to resuscitate the patient would be futile.

In December 1987, the AMA Council on Ethical and Judicial Affairs issued a series of guidelines to assist hospital medical staffs in formulating appropriate resuscitation policies. The Council's position on the appropriate use of CPR and do-not-resuscitate (DNR) orders is updated in this report.

BACKGROUND

Closed-chest cardiac massage was first described in 1960 as a means of restoring circulation in victims of cardiac arrest. Kouwenhoven and his colleagues successfully used external chest compressions, both alone and in conjunction with artificial ventilation, to resuscitate 20 patients in whom cardiac arrest had occurred. In the years immediately following the development of this life-sustaining technique, CPR was administered primarily to otherwise healthy individuals who experienced cardiac or respiratory arrest during surgery or as a result of near-drowning. Today, however, it is widely recognized that CPR can be attempted on any individual who experiences a cessation of cardiac or respiratory function. Since such events are inevitable as part of the dying process, CPR potentially can be used on every individual prior to death.

In health care settings, CPR is viewed as an emergency procedure that is routinely administered to patients who experience cardiopulmonary arrest. More health care institutions employ specialized teams of