REPORT 5 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-13)
Professionalism in Health Care Systems
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

As payment and delivery models in health care have evolved over the last two decades the Council on Ethical and Judicial Affairs (CEJA) has analyzed emerging ethical challenges and offered guidance for physicians. Thus the *Code of Medical Ethics* now contains multiple opinions on closely related topics involving managed care and the use of various incentives and tools to help contain health care costs and promote safety and quality. CEJA recently reviewed these opinions and determined that they are informed by a common analysis and the same enduring ethical values:

- the overriding importance of preserving trust in patient-physician relationships,
- the imperative to minimize the effects of financial conflicts of interest and competing responsibilities, and
- the need to sustain physicians' commitment to use their best professional judgment in the service of their patients and to preserve opportunities for physicians to advocate meaningfully on behalf of their patients.

CEJA also found that the guidance in these opinions is often quite narrow, relevant only to very specific mechanisms, structures for care delivery, or payment models and thus is difficult to interpret and apply as health care continues to evolve rapidly. To ensure that guidance remains timely and readily accessible, CEJA has developed updated guidance to address these issues of professionalism in the context of health care systems. Physician leaders have a responsibility to ensure that practices for financing and delivering health care are transparent; reflect input from both physicians and patients; recognize that over-reliance on financial incentives may undermine physician professionalism; make use of well-designed, ethically acceptable, thoughtfully implemented incentives; support physicians to respond to the unique needs of individual patients and meaningfully advocate on behalf of their patients; and monitor practices for both unintended adverse consequences and positive outcomes. All physicians have a responsibility to hold physician-leaders accountable for meeting conditions of professionalism in health care systems and to advocate for changes in payment and delivery models to promote access to high quality care for all patients.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5-I-13

Subject: Professionalism in Health Care Systems

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Referred to: Reference Committee on Amendments to Constitution and Bylaws (Larry E. Reaves, MD, Chair)

The past 20 years and more have seen significant change in health care in the United States. Over this period, new organizations for delivering health care (such as health maintenance organizations [HMOs], preferred provider organizations [PPOs], and more recently, accountable care organizations [ACOs]) have combined with new payment systems (notably capitation) and third-party payers' adoption of new roles to influence treatment recommendations and decisions, to change the landscape of health care for both patients and physicians. At the same time, the goal of controlling the cost of health care has been joined by enhanced emphasis on improving patient safety and quality of care and new visions for "learning health care organizations" that create a dynamic, rapidly changing environment.

Over this period, the Council on Ethical and Judicial Affairs (CEJA) analyzed ethical challenges that emerged with the changes in health care, including challenges to physician professionalism posed by "gag clauses" in contracts with managed care organizations and the use of formularies, financial incentives, and other tools to help contain costs and promote safety and quality. As a result, the *Code of Medical Ethics* now contains several opinions that address various aspects of professionalism in physicians' relationships with health care organizations and payers:

- E-8.051 Conflicts of Interest under Capitation (1997, updated 2002)
- E-8.054 Financial Incentives and the Practice of Medicine (1998, updated 2002)
- E-8.056 Physician Pay-for-Performance Programs (2006)
- E-8.13 Managed Care (1996, updated 2002)
- E-8.135 Cost Containment Involving Prescription Drugs in Health Care Plans (1996, updated 2002)

CEJA recently reviewed these opinions and found that each is informed by a common core analysis and the same enduring ethical values:

- the overriding importance of preserving trust in patient-physician relationships,
- the imperative to minimize the effects of financial conflicts of interest and competing responsibilities, and

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- the need to sustain physicians' commitment to use their best professional judgment in the service of their patients and to preserve opportunities for physicians to advocate meaningfully on behalf of their patients.

However, CEJA also found that the ethical guidance these opinions offer is often closely tied to details of specific cost-containment mechanisms, structures for delivery of health care, or payment models. Such narrowly focused guidance can be difficult to apply, and thus of limited value, in a health care system that continues to evolve rapidly.

CEJA concluded that it could best ensure that guidance in this area remains timely and readily accessible by combining and updating guidance from these earlier opinions into a new opinion addressing core ethical considerations for physician professionalism in the context of efforts to contain costs and improve quality in health care systems. To develop updated guidance, CEJA has based its analysis on its review of current opinions and on a review of ethics literature published in the years since existing opinions were issued. The following report summarizes the Council's deliberations and updates ethical guidance.

PHYSICIAN ACCOUNTABILITY: FROM COST CONTAINMENT TO QUALITY & VALUE

Existing opinions in the *Code* addressing professionalism in health care systems were formulated largely in response to mechanisms introduced by managed care in the 1990s that sought to control health care costs, especially by holding physicians accountable in new ways.[1–3] While many of these mechanisms, in the right environments, offered the possibility of controlling overall costs, supporting cost-effective care, and improving quality of care, they could also pose ethical conflicts for physicians.[4–6]

Models for delivery and payment of health care focus increasingly on questions of value in health care, defined by a leading proponent as "the health outcomes achieved per dollar spent,"[7,8] and toward models that share accountability among health care professionals differently than managed care.[7,9] Emerging models, such as accountable care organizations (ACOs) and medical homes, take advantage of lessons learned, a stronger evidence base, ongoing refinement of quality measures, a more collaborative approach to care, and greater physician control in health care organizations than did their managed care predecessors.[9]

ETHICAL CHALLENGES TO PROFESSIONALISM IN HEALTH CARE SYSTEMS

Models for financing and organizing the delivery of health care, whether fee for service, managed care, or ACOs and other emerging models can create financial conflicts of interest, set competing responsibilities for physicians, undermine trust and the integrity of patient-physician relationships, and have unintended consequences in relation to patients' access to care and physicians' professional satisfaction.[10–15]

Conflicts of Interest & Competing Responsibilities

As CEJA noted in its report on ethical issues in managed care, "financial conflicts are inherent in the practice of medicine, regardless of the system of delivery" or method of payment.[1] The intensity and immediacy of incentives, as well as how broadly or narrowly incentives are targeted shape how deeply particular incentives raise conflicts of interest.[1,6,16–17] Physician-leaders in health care organizations have a responsibility to minimize the intensity and immediacy of incentives and to use incentives targeted to specific interventions only when there is evidence of

overuse of the intervention and there are scientifically sound guidelines for appropriate use.[1,6,17]

Efforts to contain costs can also create conflicting loyalties and competing responsibilities for physicians in asking them to serve both the interests of individual patients and the interests of populations of patients or of health care organizations.[1,11,18] At the same time, physicians are uniquely positioned to recognize the effects of uneven or unfair distribution of health care resources, and they do have a responsibility to be wise stewards of health care resources. To fulfill that responsibility, physicians must be able to rely on health care organizations to minimize the possible effects of competing responsibilities and to support appeals and meaningful advocacy on behalf of individual patients.[1,19]

Trust

A defining obligation of physicians as members of the medical profession is to put patients' interests ahead of physicians' personal financial interests.[1,4,16,17,19–21] Conflicts of interest and competing responsibilities created by models for financing and organizing the delivery of health care have the potential to undermine trust.[4,22] Yet trust is a complex phenomenon and multiple factors can influence how strongly payment mechanisms or incentives affect patient trust in their individual physicians and the medical profession.[22–26] Payment models and incentives should minimize conflicts of interest and care delivery systems should support robust patient-physician communication, enable physicians to advocate effectively for individual patients, and make available resources physicians need to provide high value, cost-conscious health care.[1,17]

UNINTENDED CONSEQUENCES

Mechanisms intended to influence what care is available to patients and how or by whom care is provided can have unintended consequences for patients, physicians, and health care systems. For example, formulary restrictions may help contain medication costs for a majority of a health care organization's patient population, but provide lesser benefit or poorer outcomes for a subset of the population, possibly offsetting cost savings.[4] Inadequate capitation rates may result in pitting the needs of one patient against the needs of others in a physician's practice, undermining trust.[4] Among the issues of greatest concern are the possible adverse effects of payment and delivery models on health care disparities and physician professionalism.

Exacerbating Health Care Disparities

Incentives also carry the potential to exacerbate inequities in health care. For example, pay-for-performance programs can adversely affect care for vulnerable populations of patients if they incentivize physicians to avoid patients for whom performance targets would be difficult to achieve.[10,12–14,27] To minimize the risk that pay-for-performance or other incentives will "accentuate inequity in health care," incentives must be appropriately adjusted for case mix, practice structure, availability of resources, etc.[1] Adjustment methods must be carefully considered, however. Hong and colleagues note that "to the extent that health systems reward physicians for higher measured quality of care, lack of adjustment for patient panel characteristics may penalize physicians for taking care of more vulnerable patients, incentivize physicians to select patients to improve their quality scores, and result in the misallocation of resources away from physicians taking care of more vulnerable populations. Conversely, adjustment for patient panel characteristics may remove the incentive to improve care or may inappropriately reward lower-quality physicians caring for more vulnerable patients."[13]

Physician Professionalism & Satisfaction

Experience with managed care has also led to questions about other ways in which payment models, delivery structures, and incentives built into health care can have unintended consequences for physicians as well, especially for physician professionalism. Pressures to contain costs "may encourage some physicians to try to manage cases longer than they should," especially under a capitated system of payment.[1] Incentives may perversely encourage physicians to "treat to the measure, rather than the patient's presenting complaint,"[28] or to "game" the system in various ways to improve performance ratings.[27] Similarly, incentives in one practice area may shift physicians' attention away from other, unmeasured areas,[27] including "communication, compassion, and trust."[11] Research has also indicated that incentives can undermine physician satisfaction—for example, studies showing reduced satisfaction among physicians in pay-for-performance programs.[14]

FLAWED ASSUMPTIONS & UNCERTAIN UTILITY

The use of incentives rests on the assumption that a given incentive will motivate a specific desired behavior—in health care, that incentives will motivate physicians to act in specific ways so as to help lower health care costs and improve quality of care. But whether the use of incentives in health care is an effective way to influence the behavior of professionals is open to question. Moreover, there is growing evidence that incentives, particularly financial incentives, are not effective in controlling costs or improving quality.

Incentives as Motivators

Financial incentives presume that money is an important motivator for physicians. As Glasziou and colleagues note, financial incentives "assume that paying more for a service will lead to better quality."[27] However, financial rewards are only one among several extrinsic motivators, which can include lifestyle considerations, recognition, and patient appreciation.[27,29] For physicians, intrinsic motivators, including "feelings of accomplishment associated with completing difficult tasks; satisfaction in delivering positive clinical outcomes; and experiencing autonomy, respect and collegial relationships" may play a stronger role than financial rewards (or penalties) in shaping behavior.[29] Further, incentives to reach specific performance targets fail to reward skills that are central for physicians, such as managing complexity or solving problems,[29] or creating rapport with patients.

Perversely, incentives may have the opposite of their intended effect, undermining motivation instead of enhancing performance.[29,30] Rewards can "worsen performance on complex cognitive tasks, especially when motivation is high to begin with" and "undermine the intrinsic motivation crucial to maintaining quality when nobody is looking."[30]

Biller-Andorno and Lee argue that the most appropriate incentives for physicians are those that are based in a sense of shared purpose and protect and promote physicians' sense of moral responsibility and enable physicians to "take ownership" of the incentive.[15] With shared purpose incentives "instead of being passively graded or rewarded, physicians engage in the development, ongoing evaluation, and critical review" of an incentive scheme. Physicians should also have opportunity to report "any negative effects on quality, efficiency, and equity of patient care" that result from an incentive scheme.

Weaknesses in Design & Implementation; Uncertain Utility

Criticism has also been voiced about the design of incentives. In its report on ethical issues in managed care, CEJA noted that flawed incentives based on too large or too small a sample of patients (or physicians), or on too long or short a time interval of measurement can have the effect of penalizing physicians whose panel includes patients with difficult to treat medical conditions [1; cf. 17]. If not carefully designed, performance measures can hold physicians accountable for aspects of quality over which they have no control, including limitations in the delivery system itself or social factors external to health care that affect patient outcomes.[11]

Measures may also be based on a problematic understanding of quality that "equates quality with the achievement of non-individualized, pre-determined health goals for broad populations." [11] Measures also have tended to focus on processes rather than clinical outcomes or other endpoints of value to patient.[7,14]

Evidence to date also suggests that incentives are not necessarily effective in controlling health care costs or improving health care quality. Glasziou and colleagues note that "evidence on the effectiveness of financial incentives is modest and inconsistent."[27] The absence of robust evidence for the effectiveness of pay-for-performance programs led the Society for General Internal Medicine to criticize pay-for-performance from an ethical perspective "because of significant potential for unintended consequences but scant data regarding its impact."[28] The Society further noted that pay-for-performance programs "generally lack key safeguards as well as monitoring" and may be unable to identify adverse events to which they give rise.[28]

PRESERVING PROFESSIONALISM

Models for financing and organizing the delivery of health care undoubtedly will, and should, continue to evolve. However, efforts to refine payment mechanisms or to reorganize where and by whom care is provided in the interests of promoting high value, cost conscious care and better outcomes for patients must be sensitive to the ethical risks such efforts can pose. They must be designed and implemented with an eye toward preserving the core values of medicine and sustaining physicians' professionalism and patients trust.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that Opinions E-8.051, Conflicts of Interest under Capitation; E-8.054, Financial Incentives and the Practice of Medicine; E-8.056, Physician Pay-for-Performance Programs; E-8.13, Managed Care; and E-8.135, Cost Containment Involving Prescription Drugs in Health Care Plans, be amended by substitution as follows and the remainder of this report be filed:

> Containing costs, promoting high quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
>
> Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage under treatment and over treatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations have an ethical responsibility to ensure that practices for financing and organizing the delivery of care:

a) Are transparent.

b) Reflect input from key stakeholders, including physicians and patients.

c) Recognize that over reliance on financial incentives may undermine physician professionalism.

d) Ensure ethically acceptable incentives that:

    i) Are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data, and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethical guidelines.

    ii) Are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities.

    iii) Are implemented in conjunction with the infrastructure and resources needed to support high value care and physician professionalism.

    iv) Mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

e) Encourage, rather than discourage, physicians (and others) to:

    i) Provide care for patients with difficult to manage medical conditions;

    ii) Practice at their full capacity, but not beyond.

f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

g) Are routinely monitored to

i) identify and address adverse consequences;

ii) identify and encourage dissemination of positive outcomes.

All physicians have an ethical responsibility to:

h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

i) Advocate for changes in health care payment and delivery models to promote access to high quality care for all patients.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500 to implement.

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