5-1-1997

The changing role of the physician as a consequence of the "gag clause" in managed health care contracts

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The Changing Role of the Physician as a Consequence of the "Gag Clause" in Managed Health Care Contracts

by
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A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree in the Graduate Division
of Rowan University
May 7, 1997

Approved by _____
Professor

Date Approved 5/1/97

ABSTRACT

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In November 1995, at a meeting of the Managed Health Care Congress, Harvard Medical School professor and physician, Dr. David Himmelstein, delivered a presentation that included a slide of what he called the "gag clause" in his U.S. Healthcare contract. Dr. Himmelstein explained that he was being restricted in what he could say to his patients – three days later, U.S. Healthcare terminated his contract.

This event, coupled with Dr. Himmelstein's appearance two weeks later on the Donahue Show, sparked a flood of media attention and, in turn, a public outcry. Managed health care, designed to regulate and curtail growing health care costs, had restricted physician-patient communications and ultimately threatened the physicians' role.

This study provides an historical report of the gag clause including (1) a description of its public unveiling and critical evaluation, (2) a review of related literature, and (3) a detailed report of the state and federal gag clause legislation.

MINI-ABSTRACT

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In November 1995, at a meeting of the Managed Health Care Congress, Harvard Medical School professor and physician, Dr. David Himmelstein, showed a slide of what he called the "gag clause" in his U.S. Healthcare contract. The gag clause, a stipulation in many managed health care contracts limiting patient-physician communications, became a hot media topic that stirred a public outcry.

This study provides an historical report of the gag clause including (1) a description of its public unveiling and critical evaluation, (2) a review of related literature, and (3) a detailed report of the state and federal gag clause legislation.

Chapter One
Background

In November 1995, at a meeting of the Managed Health Care Congress, Dr. David Himmelstein delivered a presentation during which he showed slides of what he called the "gag clause" in his U.S. Healthcare contract. Two weeks later, he took his complaints to the Donahue show and said, "One of the HMOs I practice in tells me I can't tell my patients if there's something wrong with what the HMO insists I do" (Cole & Mattos, 1996, p. 50).

Three days later, U.S. Healthcare told Himmelstein his contract was being terminated. Himmelstein, an associate professor at the Harvard Medical School, became a persistent critic of for-profit HMOs, charging that they "offer doctors steep financial incentives — what I consider bribes — to minimize care" (Cole & Mattos, 1996, p. 50).

In another instance, a Los Angeles doctor worked for three years as a neurologist for CIGNA HealthCare, another large HMO. When she advised the mother of a brain-damaged boy that a muscle biopsy might help diagnose the extent of his condition, she was chided by her bosses for suggesting the test. "I was told it was a mistake to tell the patient about a procedure before checking to see whether it was covered," she said. "It was as if I was a store vendor and was only supposed to advertise the products we offered" (Cole & Mattos, 1996, p. 50).

Another physician in Tulsa, Okla., prescribed a sophisticated magnetic-resonance exam to determine the cause of a young woman's acute headaches. When her HMO refused to pay, opting for a less expensive but riskier test, the doctor urged her to protest the decision. Shortly thereafter he received a letter from the health plan's medical director. "Pitting the HMO against its member," it warned, "may place your relationship with this plan in jeopardy" (Meyer, 1997, p. 45).

The Physicians' Ethical Code

"... I will prescribe regimen for the good of my patients according to my ability and my judgment ..." (Stanton, Angelo, & Luthin, 1996, p. 117). These words, from the sacred Oath of Hippocrates (400 B.C.), are recited on graduation day at the country's top medical schools. Young physicians, anxious to practice their craft, recite these words written in an older, simpler time. They swear to this oath before taking their place in society as the new healers and protectors of human life.

The American Medical Association's (AMA) Code of Medical Ethics, which lays out the guiding principles for the entire medical profession (McAffee, 1996), is a modern set of medical guidelines that expands beyond the Hippocratic Oath. It reads:

> The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. (McAfee, 1996, p. 1)

But recently, as a result of the increasing trend in the U.S. toward managed health care, the AMA's Council on Ethical and Judicial Affairs found it necessary to add:

> The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan . . . Patients cannot be subject to making decisions with inadequate information. (McAfee, 1996, p.1)

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) evolved in the mid-1970s as pre-paid programs featuring preventative-care coverage. They offered a way to control costs and a means to encourage wellness. HMOs were an answer to the nation's plea for affordable health care, curtailing sky-rocketing costs with reasonable co-pays and structured services. Most Americans with health insurance are enrolled in some form of managed-care plan, and according to the AMA, 83% of U.S. physicians hold some form of managed-care contract, up from 61% just 5 years ago (Lancet staff, 1996). So, simply put, Americans are joining HMOs and paying less for health care; doctors are signing contracts to work in the HMO network and care for its growing membership.

But is it that simple? HMOs are for-profit organizations — businesses. And doctors are what they've always been — healers. But now the doctor has taken on a

second role, that of the businessperson and employee to his patron, the HMO. They are signing contracts and pledging their allegiance to the HMO. However, the physicians' HMO contract may create a conflict with their first obligations — the words of the Hippocratic Oath and the AMA's Code of Medical Ethics. So, affordable, regulated health care may be more costly than mere dollars; it may threaten a patient's ability to trust his or her physician. And the physician's employer, the HMO, may be no more than a for-profit business whose primary concern is its bottom line. So where does the doctor/patient relationship come in? And how is this, too, regulated by the HMO?

The Gag Clause

"Physician shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in (the HMO) or the quality of (the HMO) coverage" (Lancet staff, 1996, p. 903).

This statement, taken from one HMO/physician contract, is an example of what is commonly referred to as a "gag clause." The gag clause can be found in many forms in an HMO contract and is designed to limit the communication between contracted doctors and their patients in one or more of the following:

1. discussing treatment options with a patient unless the plan has authorized payment for the treatment;

2. making critical comments about the plan, its policies, or quality standards to enrollees or other physicians;

3. communicating with plan patients in the event the physician is deselected (raising concerns of continuity of patient care);

4. discussing plan financial incentives to reduce care, including capitation and utilization review protocols; and

5. referring patients to other specialists or facilities not participating in the plan. (McAfee, 1996)

These provisions in managed care contracts are a source of conflict for many physicians. In December 1995, the AMA's House of Delegates ruled that such restrictions "... are not in the best interests of patients and physicians," and began a series of steps to remove such clauses from managed-care contracts (Cole & Mattos, 1996, p. 50). The AMA called on managed-care providers to remove the gag clauses and instructed the medical community to continue to abide by their duty to provide patients with all treatment alternatives. The AMA pledged to stand behind any physician who felt unable to fulfill his or her ethical duties because of a gag clause or similar policy (Segal, 1996). Also, the AMA called upon health plans to submit their managed-care contracts for review to determine if they interfered with the physician-patient relationship.

The largest health-maintenance organization accreditation group, the National Committee for Quality Assurance, decreed that its members should not "prohibit restrictions on the clinical dialogue between practitioner and patient" (Lancet staff, 1996, p. 903). Some HMOs have done away with gag clauses, including the one stated on page four that was dropped by U.S. Healthcare after the outcry from physicians and consumer groups. However, in the eyes of the AMA, much remains to be done to restore the right of a physician's freedom of speech, of a patient's freedom of information, and of the freedom from the fear of "deselection" for physicians.

Managed Care Glossary

Adverse Selection — Attracting members as enrollees into a health plan who are sicker than the general population (specifically, members who are sicker than was anticipated when the budget for medical costs was developed).

Capitation — A method of payment to providers that is common in most managed-care arenas. Unlike the older fee-for-service arrangement in which the provider is paid per procedure, capitation involves a pre-paid amount per month to the provider per covered member. The provider is then responsible for administering all contracted services required by members of that group during that month for the fixed fee, regardless of the amount of charges incurred.

Deselection — When an HMO rejects a physician's application to practice in their network.

Fee-for-Service — A traditional means of billing by health providers for each service performed, with payment in specific amounts for specific services rendered (as opposed to retainer, salary, or other contract arrangements).

HMO — Health Maintenance Organization. A pre-paid organization that provides health care to voluntarily enrolled members in return for a pre-set amount of money on a PMPM (per member, per month) basis.

Managed Health Care — A system that uses financial incentives and management controls to direct patients to providers who are responsible for giving appropriate care in cost-effective treatment settings. Such systems are created to control the cost of health care.

Oath of Hippocrates — Written in 400 B.C., the oath is said to be authored by Hippocrates, the "father of medicine."

MLR — Medical Loss Ratio. The amount of revenue from health insurance premiums that is spent to pay for the medical services covered by the plan.

Network — In this instance, a network is a group of physicians that participate in a certain HMO by signing a contract and agreeing to their coverage terms.

PMPM — Per member, per month. Specifically applies to a revenue to or cost by a provider for each enrolled member each month.

Utilization

(1) The extent to which a given group uses specified services in a specified period, expressed as the number of services used per year per 1,000 or per 1,000 persons eligible for the services. Utilization rates may be expressed in other types of ratios, e.g., per eligible persons covered.

(2) The extent to which the members of a covered group use specified services over a specific period, in the aggregate. Usually expressed as the number of services used per year. Utilization rates are established to help in comprehensive health planning, budget review, and cost containment. (DelPizzo, 1996)

Chapter Two
Statement and Methodology

Statement

An historical study of the "gag clause" in managed health care contracts.

Methodology

This study outlines the history of the so-called "gag clause" in managed health care contracts. This term is used to refer to any clause in a managed health care contract that restricts physician/patient communication.

A search of the relevant literature on this topic found that no similar studies have been conducted, as gag clause legislation did not reach Congress before July 1996. Gag clauses did not receive extensive media attention prior to a speech given by Dr. David Himmelstein in November 1995, where he presented the gag clause in his U.S. Healthcare contract to the Managed Health Care Congress. Therefore, the majority of the media coverage, public attention, and legislative activity surrounding the gag clause occurred in recent months.

In order to research the gag clause's history, the following methodology will be followed:

SECONDARY RESEARCH

A search of literature to uncover any articles written on the gag clause, authored by HMO executives, physicians, reporters, or others. A search of the Congressional Record to determine the course of action to date on the patient/physician communication bills facing federal legislature. An online search via the Internet to provide background on the gag clause, the organizations either in support of or opposed to these clauses, and possible communication between the government supporters of the relevant legislation. The Internet proved to be a useful medium to contact the physicians who uncovered the gag clause and also the HMOs in support of such clauses, to determine the facts behind these opposing views.

Chapter Three
Data

By September 1996, more than 1,000 pieces of legislation relating to consumer protections under managed care were introduced in state and federal legislature (Miller, 1996). During the first half of that same year, 33 states enacted new laws pertaining to managed care, while 15 states already prohibited the use of gag clauses.

Today, nearly 30 states have banned, or are considering banning, gag clauses (Lancet staff, 1996). Although the AMA supports state legislation, they feel that a federal anti-gag clause law is necessary to reach all health plans that may not be touched by state regulations. Therefore, the AMA pledged its support of the bill before the House of Representatives, the **Patient Right to Know Act**, and the Senate version, the **Patient Communications Protection Act**.

The Patient Right to Know Act of 1996 (HR 2976)

On February 27, 1996, Representatives Greg Ganske (R-IA) and Edward Markey (D-MA) presented the Patient Right to Know Act before the House of Representatives. Mr. Markey introduced the bill, designed to render managed care contract "gag clauses" null and void, by stating,

> When I was a boy, my mother told me, "if you don't have anything nice to say, don't say anything at all." Now, when my mother said that, she was not talking about protecting the feelings of health plans. She was talking about people, who sometimes, unfortunately, become patients. So she would be quite surprised to see this dangerous twist on her advice in some of the contracts between doctors and health plans we see today. Today, to protect the feelings of health plans, doctors are being asked to restrict what they say to their patients. This is wrong, just plain wrong. No doctor can practice good medicine in a muzzle. (Markey, 1996)

In addition to declaring all gag clauses illegal, the bill also prohibits plans from contractually interfering with "medical communications" between physicians and their patients and from taking "adverse actions" against physicians (Ganske, 1996). Penalties for managed care plans that violate the law would be a fine up to $25,000. States would be allowed to establish stricter standards. Mr. Markey closed his argument by summarizing,

> Hippocrates said, "Health is the greatest of human blessings." Surely, it is the most precious although many of us do not realize this until we ourselves or someone we love becomes seriously ill. Then, we would give away anything we have — all of our worldly treasures — to make them well again. At that moment, our greatest ally is our doctor, and our most valuable asset is the information he can give us. That is why passing the **Patient Right to Know Act** is so important. (Markey, 1996, p. 1)

Patient Communications Protection Act of 1996 (S. 2005)

The Patient Communications Protection Act of 1996, sponsored by Senator Ron Wyden (D-Ore), was first introduced in the Senate July 31, 1996 (Kassebaum, 1996). In September 1996, Senators Wyden and Kennedy proposed a series of amendments in an effort to pass the basic premise of the bill — to bar health insurers from restricting patient-physician discussions. However, the bill sparked opposition from the Catholic Health Association, the lobbying arm for Catholic hospitals, represented by Senator Don Nickles (R-Okla). The group feared that the proposal – which would have allowed doctors to discuss all available treatment options with their patients – would encourage its physicians to discuss abortion and birth control, which are prohibited by church doctrine. During the budget talks over the last weekend in September, White House and congressional negotiators scrapped the proposal after the issue threatened to embroil Congress in a debate that would delay the passing of the budget. In a last-minute plea, Senator Wyden appealed to his peers, stating,

> Mr. President, gag rules have no place in American medicine. Americans deserve straight talk from their physicians. Physicians deserve protection against insurance companies that abuse their economic power and compel doctors to pay more attention to the health of the company's bottom line than to the health of their patients. (Wyden, 1996, p. 1)

Patient Right to Know Act of 1997 (H.R. 586)

On February 5, 1997, legislation was introduced in the House by Representatives Ganske and Markey to eliminate gag clauses and so-called gag practices in all health care plans. The purpose of the new bill is the same as the previous year's – to establish a federal standard that protects medical communications between health care providers and patients. However, H.R. 586 includes a new section entitled the 'Protection of Religious or Moral Expression' that reiterates the right of any health plan to advise both physicians and plan participants of "the plan's limitations on providing particular medical services or referrals for care outside the plan based on the religious or moral convictions of the health plan" (Ganske, 1997, p. 3). The bill, sponsored by 157 House members, is currently working its way through the necessary review Committees.

Abstracts

Corporate Managed Care vs. Single Payer, Dr. Steffie Woolhandler (1996)

Dr. Steffie Woolhandler, Associate Professor of Medicine at Harvard Medical School, presented *Corporate Managed Care vs. Single Payer* before the PNHP (Physicians for a National Health Program) in February 1996. Her emphasis was on the growing "corporatization of American health care," as she explained that although the

number of health administrators grew 2000% from 1970-1994, the number of uninsured Americans nearly doubled during that same period. Her description of the managed health care industry in upcoming years was summarized by one theme – survival of the financed. Dr. Woolhandler stressed that capital is the key to this new medical marketplace, and doctors cannot afford to compete with the large HMOs. Dr. Woolhandler offered the following example of one HMO's payment policy:

> A physician contracted with U.S. Healthcare has an income based on utilization of hospital days, specialist referrals, emergency room visits, and quality and loyalty measures. If a doctor earns all her incentives, she can make a good living – over $256,000 in gross income for caring for 1,500 patients. But if she doesn't make any of the incentives, if she 'flunks' by letting her patients use too many hospital days or referrals, she would have a net income of $0. Utilization incentives in U.S. Healthcare contracts are not just a little bit of sweetener on the top; they entirely determine physicians' income. (Woolhandler, 1996, p. 3)

Dr. Woolhandler suggests that a single-payer system of national health insurance (e.g., a Canadian-style system) is the only viable alternative to corporate medicine.

Managed Care – Bound and Gagged; Michael Meyer, Newsweek (March 1997)

"Any workplace drone knows that fighting with the boss isn't the best way to keep a job. But what if you're a doctor who believes your boss is messing up your patient" (Meyer, 1997, p. 45).

Michael Meyers opened his article by posing this question, then proceeded to discuss the concept of "gag rules." Mr. Meyer suggests that although gag regulations are becoming increasingly popular, the idea of Congress redressing every managed-care problem could undermine the purpose of health care reform – quality care at a lower cost.

"Legislating the practice of medicine can be very dangerous," says Dr. Ted Lewers of the AMA. "Rather than creating a patchwork of quick fixes," he adds, "legislators should force all parties – HMOs, doctors, hospitals, and consumer groups – to agree on national standards and procedures for cost-effective medical treatment" (Meyer, 1997, p. 45).

The article supports a ban on gag clauses, but warns that too much government intervention will only create laws that are unable to cover every medical scenario, while raising costs and ultimately diminishing care.

Gagging the Doctors; Wendy Cole and Jenifer Mattos, Time (January 1996)

The article begins with a description of the HMO "gag clause" uncovering by Dr. David Himmelstein, Harvard Medical School, in November 1995. After Dr. Himmelstein's presentation to the National Managed Health Care Congress where he showed slides of what he termed the "gag clause" in his U.S. Healthcare contract, his contract was terminated by the billion-dollar HMO. David Simon, U.S. Healthcare's senior vice president, denied that Dr. Himmelstein was fired because of what he said, but instead because he expressed a "lack of comfort" with U.S. Healthcare. Simon said the company assumed he would welcome the notice.

Dr. Himmelstein described the HMOs' "dirty little secret" of capitation – where a physician's pay may increase if they limit the treatments they provide or recommend.

The article outlines the following U.S. Healthcare incentive system, based on a physician treating 925 patients:

> Hospital Stay: If the patients collectively average fewer than 178 days in the hospital per year, the doctor receives a bonus of $2,063 per month. If the patients together spend more than 363 days, the doctor receives nothing extra.
>
> Emergency Room Use: If emergency-room costs average less than $.84 per patient in any given month, the doctor receives a $453 bonus for that month. If the patients average more than $1.64, their doctor receives nothing extra.

Specialist Referral: If specialist costs per patient average less than $14.49 per month, the doctor gets a bonus of $1,323 for the month. But if the costs rise above $30.49, the doctor receives nothing extra.

Manipulated Care: Gagging Doctors, Blinding Patients; editorial, The Lancet (1996)

This editorial is in support of the current legislation for unrestricted physician-patient communication. The writer feels that these bills "... represent America's characteristic (and curious) confidence that enormous, for-profit insurance companies beholden to investors and stockholders are primarily concerned with care of patients, and that market forces and competition will, in the end, solve the problem of a health-care system that excludes almost one in six of its own citizens" (Lancet staff, 1996, p.903).

Although restoration of the right of freedom of speech to doctors and the freedom of information for patients is important, the banning of gag clauses will not restore another right – the freedom for doctors from fear of "deselection."

Most Americans with health insurance are enrolled in some form of managed-care plan. This means that to practice and survive financially, doctors must also sign up. This gives nearly omnipotent managed-care plans the power to bully individual doctors, who scurry to be included on insurers' lists.

Americans must realize that if their care is to be determined by the marketplace, their health may be in jeopardy.

Chapter Four
Conclusions

"Everyone wants straight answers – especially from the doctor. Nothing – certainly not a few bucks or bureaucratic rigmarole – should come between doctor and patient" (Stop Gagging Doctors, 1996, p. 1).

"The fact is that when you're a patient, what you don't know *can* hurt you" - Rep. Edward Markey (Hookman, 1996, p. 1).

"Instead of being seen as a public service, health care is being seen as a field for profit making, and is increasingly controlled by Wall Street" (Woolhandler, 1996, p. 6).

"The entire phenomenon of managed care needs an airing. The windows need to be opened and the spotlight shone all around" (Hidden Agenda, 1996, p. 1).

The uncovering of the gag clause by Dr. David Himmelstein was perhaps the unlocking of the managed-care window, while the following media coverage certainly helped to open it a crack. However, the increasing visibility of the gag clause, capitation, and other incentive programs for HMO physicians is causing more than an eye-opening for the millions of managed-care participants. As our attitude toward the HMO evolves, so does our perception of the HMO's key employee – our doctor.

Not long ago, the HMO was seen as the cure for skyrocketing health-care costs. However, public opinion of the managed care system has steadily, if not dramatically, decreased in recent years. A 1995 AMA nationwide poll uncovered an astonishing 77% of Americans willing and eager to pay more for health care if personal physicians could be freely chosen (Message to Managed Care, 1996). The same poll identified the doctors' preference for patient choice as well: 92% felt the increase in managed care had a negative impact on their clinical independence, 71% saw a decrease in quality of care, and 84% saw an immediate threat to the physician-patient relationship. Dr. Daniel H. Johnson Jr., president of the AMA, commented on the survey results by saying, "Isn't it ironic that we require patients to make decisions which affect life and limb, but we don't think patients are capable of making wise decisions about how to finance their health care or which doctor to see?" (Message to Managed Care, 1996. p. 1)

While doctors are being generously rewarded by their managed-care employers for attracting "healthy" patients (or patients who don't utilize medical services), managed-care participants are paying premiums that they expect to be used toward care. In actuality, a large portion of the premium dollar goes a different route altogether — straight to the HMOs' bottom line:

> In for-profit HMOs, a tremendous share of each health care dollar goes to overhead and profits. U.S. Healthcare HMO (now part of Aetna) spends

> 27.1 percent of premium dollars on overheads and profits. Leonard Abramson, the U.S. Healthcare CEO, had an annual compensation in one year of $21.2 million dollars. At the time he personally held $784 million in stock in the company. (Woolhandler, 1996, p. 2)

How is the public expected to respond to this distribution of funds? The messages are mixed and loyalties confused. Are family physicians reciting the Hippocratic Oath and perusing their AMA Code of Medical Ethics to make decisions, or are those decisions clouded by financial incentives and HMO handbooks?

For the average patient, HMOs are perceived as untouchable entities, too large to be harmed or reckoned with. Although powerless against such a monstrous corporation, we can still relate to our family doctor — the one who gives just the right medicine for our wintertime flu, and returns our frantic, late night calls when the baby's fever rages.

But even that story is changing. Our trusted family physician may not participate in our company's chosen health plan, so we need to make a choice. Our 'primary-care physician' may simply be the only doctor who practices in our town, or the one who keeps the most convenient office hours. Then where do our loyalties lie? If we can't even trust our long-time family doctor to choose our best interests over the HMO's rules and payment plans, how does 'participating-physician Dr. Smith' stand a chance?

HMO policies, and more specifically gag clauses, are undeniably detrimental to the valuable physician-patient relationship. If the simple pledge of the Hippocratic Oath – to practice for the good of my patients – was not being threatened by the snowballing trend toward managed health care, the AMA would not have felt the need to adjust its ethical code. And, if gag clauses were not dangerous to the well-being of the American public, legislation banning their use would not be raging in the 105th Congress. And, most importantly, HMOs would not be removing these clauses from their physician contracts and openly admitting to their public that they indeed changed their policies. For example, Prudential Healthcare, a leader in managed care, recently released a new series of member rights to their New Jersey participants that included the following:

(1) The right to have no "gag rules" apply. Doctors are free to discuss all medical treatment options with members, even if the options are not covered services.

(2) The right to know the payment method for participating providers, allowing members to know if there are financial incentives or disincentives tied to medical decisions and to be provided with a telephone number and address to obtain additional information about compensation methods if desired. (Prudential Healthcare, letter, April 1, 1997)

Although these member communications are important to keep HMO participants informed, the damage to the patient-physician relationship has been done. Pending legislation and the public's increasing awareness of gag clauses will help to protect both doctor and patient rights, but the more we learn about HMO practices, the more skeptical we become. A doctor's role is changing from that of the trusted advisor to the 'HMO-participating physician' practicing at the will and hand of his employer. The history of the gag clause, from its unveiling in November 1995, to its inevitable demise in the 105th Congress, is little more than an account of the deteriorating patient-physician relationship.

Benjamin Franklin once said, "Well done is better than well said." In something as delicate and important as our health, we can't afford to sacrifice either.

Chapter Five
Suggestions for Further Study

The study of the gag clause in managed health care contracts reveals a number of interesting topics for further research.

A study should be conducted after the gag clause legislation is passed to determine whether attitudes have changed toward managed care companies. A comparison of the existing opinion polls and a new research study would determine this.

A study should be done comparing public attitudes toward physicians. A cross-generational study would determine if patients view their doctors differently today, in the wake of managed health care, than they did years ago.

A study of physicians should be conducted to determine their view of managed care – a comparison of the existing information and the new data would determine if the removal of gag clauses changed the physicians' opinion of their managed-care employer.

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