SURGICAL ETHICS CHALLENGES

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Ethics of administrative guidance: How much is too much?

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A younger vascular surgeon has been recruited to start a new program at a suburban hospital outside of a large city hosting a world-class medical center. The new program will provide state-of-the-art equipment, including robotics, free office space, and a generous salary guarantee. Dr Ready obtained a license in the state where he is relocating and is preparing to move. He is an excellent technical surgeon but is uncomfortable with complex aneurysm surgery. This morning he went to sign a contract with the hospital and found that a clause that prevents him from referring patients to physicians outside the hospital in strong legalese is included. How should he proceed?

A. Do not sign.
B. Sign but plan to make appropriate referrals.
C. Consult his attorney.
D. Consult the hospital’s ethics committee.
E. Sign.

“Money doesn’t talk, it swears.”
—Bob Dylan (It’s Alright Ma (I’m Only Bleeding))

It is past time for physicians to confront the reality that medicine is a business, not charitable endeavor, and therefore must be organized and led in a fiscally sound manner. Medicine as the most complex business model is facing serious threats to its professional, fiduciary commitment. Politicians, regulators, and administrators are becoming more intrusive into medical affairs and ever more powerful. An emerging professional concern should be that, as physician control in medical practice decreases, quality of care is at risk for being adversely affected.

American medicine is going to have to cope with an aging population that has adopted the unhealthiest lifestyle on the planet as an incubator for chronic disease. Medical professional dedication and the profit motive have made enhanced and costlier therapies available. Sade1 identified the economic problem: Consumers of health care do not perceive they are spending their own money. “It is viewed as a service that has already been prepaid.” And the Affordable Care Act is set to provide more unfunded medical care. “Unsustainable” is a seemingly overused term to describe American medical costs—unfortunately, it is true.

Recognition of the need to control the steadily accelerating cost of medical care has been around for more than three decades, as evidenced by the beginning of managed care in the early 1980s. Managed care’s objectives were to reduce cost and ostensibly improve quality; it has a poor record of accomplishment on both counts.

Engelhardt2 warned more than a decade ago that medicine was losing status as “a self-governing guild with its own moral vision.” He decried that “the good of the patient has now been qualified in terms of concerns for patient autonomy and financial constraints.”

American medicine’s professionalism is ill prepared to deal with these financial problems; it broadly considers finances not to be a central factor in medical care decisions. Generally, as it should be, patient safety is paramount, followed closely by the patient’s wishes. Cost has insidiously grown more important since managed care permeated medicine, and steadily rising cost is likely to impose future restrictions that are inconceivable today. This case identifies how macroeconomic pressures on medical managers from insurers, who are in turn pressured by government, will seek to regulate medical decisions of physicians at the organizational level.

Whether or not restrictions of medical practice are ethically permissible depend on whether they will prevent the standard of care to be provided to every patient. Not all clinical pathways are unnecessary intrusions; some promote quality medicine by standardization and limiting possible omissions. If such supportive clinical pathways result in decreased growth in the cost of medical care, physicians should not object, they should applaud, because professional responsibility and fiscal responsibility will become aligned.
Organized medicine has reams of political interaction but little to do with policy; it seems to focus on reimbursement. The American Medical Association’s Political Action Web site is entirely devoted to financial data. Their paper, “Advocating for improvement to the Affordable Care Act,” lists nine provisions that need to be refined, and seven are concerned with reimbursement. Leading from behind is a common leadership criticism because it is not leading at all; it is capitulation.

Just as medicine considers patient safety foremost in every individual patient’s therapy, it should remain so in societal policy decisions. Cost is a necessary consideration and the impetus but should be focused on reducing the cost of quality medicine. When the national medical care budget is sustainable, nonmedical pressures to control medical practice will abate; necessity is their stimulus.

There is a broad solution. Simply put:

America cannot afford the accelerating cost of medical technology to make unhealthy lifestyles less dangerous. Thus, it is essential that medical leadership, health advocates, and government establish national programs of health education and incentives to foster healthy lifestyles. Health is a personal moral responsibility, and unless Americans take health-promoting lifestyles seriously, we could become a pauper nation populated with invalids.

The euphemistic “guidance” in this case is actually a demand. Few in procedural specialties are master artisans in all procedures, especially newly minted ones. Clinical integrity demands referring patients to others when it clearly is in the patient’s best interest. This is necessary as soon as the patient’s clinical needs exceed one’s skills set. If Dr. Ready has such colleagues in his hospital, there is no problem with the contractual restriction to which he has been asked to agree. In a suburban hospital, however, this is unlikely to be true for all of Dr. Ready’s patients.

Economic restrictions are not all bad. Opining that there are no budgetary restrictions is absurd; it ignores the law of diminishing returns. The prime example of over utilization is at end of life. The survival of patients with unresectable pancreatic cancer is measured in months regardless of medical therapy. There are aggressive oncologists who administer therapy costing 100% more than those less aggressive, and despite the increased cost and morbidity, survival is the same. Oncologists did that study.

Economic restrictions on medical practice, however, that remove access to indicated therapeutic tools or repress valid evidence-based decisions are ethically unacceptable. Signing on as a double agent (option B) speaks of a defective moral character and will likely result in future work problems. Option E undermines professional integrity and is therefore ruled out. Consulting an attorney on a matter of ethics speaks of a confused or, worse, weak mind. C is absurd. An ethics committee in most circumstances has the least political power in medicine. Consulting them speaks of poor judgment.

Option A is ethically required for Dr Ready to protect his professional integrity. Dr Ready should start with the chief medical officer and explain that this clause in the contract is ethically impermissible and should be removed for all of the physicians at the hospital. The chief medical officer’s professional integrity is now being tested. If he or she fails the test, he or she will tell Dr Ready that the contract is take-it-or-leave-it. Dr Ready will then learn something very important: the hospital’s culture is corrupt. He should run, not walk, to the nearest exit. If the chief medical officer is committed to the protection of the professional integrity of medical staff members, he or she will take this matter to the chief executive officer of the hospital and demand that physicians employed by the hospital be able to practice freely without possible quality restrictions.

When physicians worthy of being called “professional” detect that money is swearing at professional integrity, which is just what this contract is doing, they should promptly swear back and be prepared to dissociate themselves from corrupt organizational cultures.

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REFERENCES