

Dividing Loyalties: Caring for Individuals and Populations

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Are health maintenance organization (HMO) physicians obligated to act exclusively in the interest of the individual patient? Does the mere existence of financial incentives to limit patient care violate this obligation? To what extent are doctors responsible for the population of patients served by a health plan, or for promoting a fair distribution of health care among society as a whole?

These questions come to the fore in the recent U.S. Supreme Court case, *Pegram v. Herdrich*.¹ In *Pegram*, Herdrich claimed that the terms of the Carle HMO organization, rewarding its physician owners for limiting medical care, entailed an inherent or anticipatory breach of the physician's fiduciary duty under ERISA. Specifically, the terms of the HMO created "an incentive to make decisions in the physician's self-interest, rather than the exclusive interests of plan participants."² Her claim rested on showing first, that treatment decisions made by the HMO, acting through its physician employees, were fiduciary acts under ERISA. Second, her claim required showing that the terms of the HMO violated fiduciary obligations under ERISA to act "solely in the interest of" plan participants and beneficiaries when providing benefits and defraying the reasonable expenses of administering the plan.³

It is important to underscore that the breach of duty Herdrich alleges is neither the decision to delay care, nor the harm resulting from this decision. Thus, "Herdrich does not point to a particular act by any Carle physician owner as a breach. She does not complain about Pegram's actions, and . . . the ERISA count could have been brought, and would have been no different, if Herdrich had never had a sick day in her life."⁴ The alleged breach of fiduciary duty consists instead in the HMO's scheme of awarding physicians a year-end distribution consisting of the profit derived from the spread between subscription income and expenses of care and administration. In short, Herdrich alleges that it was wrong for Carle physicians to care for patients under the influence of incentives that

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enabled them to profit financially from their own choices to minimize the medical services they provide. She claimed this practice was legally, if not ethically, wrong because it violated an obligation to act solely for the patient's interest.

The Supreme Court did not deny that there is a fiduciary duty to act exclusively for the interest of plan beneficiaries. Instead, it held that Congress did not intend Carle, or any other HMO, to be treated as a fiduciary to the extent that it makes "mixed" eligibility decisions acting through its physicians. Although "pure" treatment decisions are fiduciary in nature, both "pure" eligibility decisions and "mixed" eligibility and treatment decisions are not fiduciary in nature. In the case of Herdrich, Pegram's decision about treating her was inextricably mixed with the eligibility decision about whether Carle would cover immediate care. Pegram's treatment decision that Herdrich's condition did not warrant immediate action implied an eligibility decision that Carle would not cover immediate care, which it would have covered if the treatment decision had been otherwise. The Court held that these decisions made by an HMO, acting through its physician employees, are not fiduciary acts within the meaning of ERISA.

Did the presence of financial incentives to reduce care violate Pegram's professional obligation to serve the patient? It is often assumed that traditional ethics of medicine require physicians to act single mindedly to promote the interests of the individual patient under their care. Scholars cite the Hippocratic Oath, which requires physicians to swear allegiance to patient welfare by "follow[ing] that method of treatment which, according to my ability and judgment I consider for the benefit of my patients."⁵ Adherents to this approach claim that "...physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations."⁶ They lament the loss of a historical "golden age" prior to the advent of managed care, when "it was generally agreed that the doctor's sole obligation was to take care of each patient...to act only in the patient's interest."⁷ Since the advent of managed care, physicians have been dubbed "double agents,"⁸ responsible not only to advocate for their own patients, but also to advocate for the entire population of patients served by a health plan. Proponents of unrestricted patient advocacy assert that if health care rationing must occur, it is health care organizations and the broader society, not physicians at the bedside, who should take the initiative in designing rationing policies. Not only does rationing conflict with the physician's duty to serve as the patient's advocate, it also risks pitting the physician's personal financial interests against the patient's medical needs.⁹

Yet in response it has been argued that the professional duty to advocate on behalf of individual patients is limited, and must be placed in the broader context of other ethical duties of the physician.¹⁰ These include the duty to promote the welfare of society as a whole, or, at a minimum, to promote the welfare of the population of patients served by a health plan. Challengers to “traditional ethics” note that this response finds roots not only in contemporary debates about the “new ethics” of managed care, but also in the historical traditions of ethics in medicine. The Hippocratic corpus itself makes reference to the physician’s social responsibility, citing for example a duty to care for indigent and vulnerable patients: “Sometimes give your services for nothing. . . . And if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man, there is also love of the art.”¹¹ During the modern era, the newly formed American Medical Association held in 1847 in its very first Code of Ethics, “As good citizens, it is the duty of health professionals to be ever vigilant for the welfare of the community.”¹²

Managed care itself has a long history in medicine, with the very first prepaid medical care programs in the United States organized in 1787 by fraternal societies and mutual benefit associations. Although the dominant method of physician reimbursement during the late nineteenth and early twentieth centuries was fee-for-service, physicians also provided care on credit, offered unlimited services for a fixed-fee per annum, and worked as “company doctors” for industries such as railroads, mining, and lumber.¹³ Under these arrangements, care was managed and methods of physician reimbursement created incentives for physicians to limit costly care.

Yet the crux of the argument against unrestricted patient advocacy is not the historical traditions of ethics and medicine. For even if single-minded advocacy historically occurred and was defensible, the context of modern medical practice makes this approach untenable. As Jonsen and Hellegers note, the professional practice of medicine today occurs within a social context: modern medicine is “an institution that incorporates a profession.”¹⁴ The institutional setting of medicine arises as a modern necessity because the solo physician diagnosing and treating a single patient has “gradually been surrounded by the indispensable cooperation of other people, by accessory producers, by physical environments, by customary and legal prescriptions.”¹⁵ Medicine comprises a social institution responsible not only for the care of individual sick people, but also for distributing the benefits and burdens of social life. Professional accountability is not exclusive to the patient, but to the society that the institution of medicine serves. As a consequence, the ethics of the medical

profession cannot be adequately understood in a vacuum; it requires a doctrine of the common good and social justice. While fidelity to one's patients and to the bond between patient and physician is an important value, it is not an ethical absolute. Instead, fidelity must be considered in tandem with other important values, such as social justice.¹⁶

Moreover, the view of the solo physician as devoid of social and economic constraints does not accurately portray physicians' own perceptions of their professional role.¹⁷ Sulmasy and colleagues reported that 80.8% of physicians randomly selected from seventy-five U.S. metropolitan areas believed that changes in the health care system in the past decade have diminished physicians' commitment to an ethic of undivided loyalty to patients.¹⁸ Although physicians worry that financial incentives to limit care diminish patient trust in them,¹⁹ research shows that the vast majority of patients trust their physicians.²⁰ Although fee-for-service indemnity patients have higher levels of trust than salary, capitated, or fee-for-service managed care patients, the overwhelming majority of patients in all groups trust their physicians.²¹

In response, opponents of managed care might argue that even if trust remains high, it has declined and will continue to do so. Yet those who regard managed care as necessary and beneficial can argue that whether trust has declined is an empirical question that has yet to be answered. Moreover, even assuming trust has declined since the advent of managed care, this change may be only temporary. Ultimately, patients (and physicians) will adapt to and accept managed care practice.

As noted already, contemporary physicians recognize limits to an ethic of undivided loyalty to patients. These limits may spring from social responsibilities to use scarce resources in a fair and consistent fashion. Or they may result from specific obligations to a population of patients served by a health plan. In addition, society recognizes, even mandates, societal duties of physicians. For example, in the case of patients with communicable diseases, such as tuberculosis, society mandates disease reporting to protect the public's health despite the strong ethic of confidentiality in the individual physician-patient relationship.²² In the case of tuberculosis, the safety of a group of people supercedes the privacy rights of an individual patient when it comes to a highly communicable and potentially deadly disease.

Generally speaking, the physician's duty to protect the health and welfare of the society is owing in part to the fact that physicians are recipients of numerous benefits from society. Massive amounts of money are regularly spent to fund medical education, the research on which medical practice rests, the institutions in which most medical activity

occurs, and the demand for medical services. Accepting such societal benefits places physicians under an obligation to practice medicine in a manner that benefits, or at least avoids harming, the society granting them.²³

If the above reasoning is sound, there are ethical limits to patient advocacy. The question remains however, whether financial incentives in general, and the specific financial incentives under which Pegram operated, are ethically defensible. Research points to the fact that physicians who operate under personal financial incentives to reduce services find these arrangements more ethically troubling than their colleagues who do not practice under such circumstances.²⁴ Moreover, incentive structures that align personal financial gain for physicians with reduced services for patients, may create unique professional challenges.

For many physicians, the professional commitment to serve the patient's interests includes an obligation to accept personal sacrifice.²⁵ This sacrifice may require exposing oneself to medical risks, such as risking infection when this is necessary to care for the patient. Or personal sacrifice may entail assuming financial risks, such as risking financial losses to care for an indigent patient. Physicians who perceive self-sacrifice on behalf of patients as integral to professional identity may experience personal financial incentives to reduce care as a threat to their self-understanding as professionals.²⁶ Rather than putting the patient first, physicians are invited to put themselves first. Rather than sacrificing themselves for the patient, physicians are invited to sacrifice the patient for themselves.

In response, it can be argued that this conception of the physician's professional role takes for granted that the chief client of the medical profession is, and should be, the individual patient. But the alternative conception we have been considering regards the physician's chief clients to include not only the individual patient, but also the population of patients served by a health plan, and even the society as a whole. Rather than regarding the interests of doctor and patient as necessarily conflicting, we might instead say that the physician's financial interests are aligned with the interests of the population the physician serves. In other words, the balance is tipped in favor of one client (the population) rather than another (the patient) by aligning the physician's financial interests accordingly. More broadly understood, the entire population of patients served by a health plan benefits when resources are distributed more fairly among subscribers. Provided the financial incentives imposed on physicians improve fairness, the burden of saying no to individual patients will be eased, although it will remain difficult.

Consider a somewhat analogous case. The chief client of a lawyer initially seems to be the party whose case the lawyer represents or to whom the lawyer gives advice. However,

Lawyers are told and they announce in their self-descriptions and codes of conduct that they have obligations to the whole justice system; therefore, there are things that they as professionals may not ethically do, even if doing them would advance the situation of the party they represent or advise. So it appears that the answer to the question about the chief client of the legal profession is complex, involving not only the persons lawyers represent or advise but the whole justice system and/or perhaps the whole larger community served by that system.²⁷

Once this complexity emerges in case law, analogous cases in medicine appear more complex. Rather than viewing Pegram's dilemma exclusively as a conflict between herself and her patient, the dilemma can now be recast in a fuller form. Should the financial incentives under which the physician operates be balanced in favor of the individual patient the doctor cares for, or the wider population of patients the physician serves? The physician can ethically support putting the population first or putting the patient first in a particular case without basing either decision on putting herself first. According to this approach, personal financial gains and losses are associated with favoring one client group over another, not merely with favoring oneself over one's client.

If these arguments are compelling, the presence of financial incentives to reduce patient care can be ethically defensible. On the one hand, the requirements of social justice make the position of unrestricted patient advocacy untenable in the context of resource or fiscal scarcity. On the other hand, the existence of financial incentives to reduce individual patient care is compatible with a conception of professional identity that requires putting clients first. Ultimately, the physician must decide whether to put individuals or populations first, irrespective of personal financial reward.

If the mere existence of financial incentives to limit care does not suffice to show that Pegram violated her fiduciary duty to Herdrich, how should we judge Pegram's actions? How should we judge the particular incentives the Carle HMO established? Even if the particular financial incentives Pegram operated under were morally licit, the decision to delay Herdrich's ultrasound by requiring that it be performed at a facility more than fifty miles away may be unethical for reasons we have not considered. Pegram may have wrongly based the decision to delay care on maximizing her personal financial gain. Pegram may have advocated too zealously for

the population of patients served by the HMO. She may have medically misjudged the urgency of Herdrich's situation. Pegram may have avoided making hard choices by denying the risks associated with her decision. That is, she may have wanted and believed she could have it all: reduced costs for the HMO, personal financial rewards for herself, and quality care for the patient.

These points obviously raise more questions than they answer. Furthermore, even if it is permissible to hold physicians accountable for cost containment by creating financial incentives to limit care, it does not follow that it is permissible to hold physicians alone accountable.²⁸ HMOs are also ethically responsible for their influence on clinical decisions and treatment outcomes. HMOs should not, for example, be allowed to create unethical financial incentives to plan physicians with impunity. Although Pegram may exert an influence on Carle's financial incentives (e.g., by choosing to accept or appeal its terms), Pegram did not establish these incentives. As long as the Carle HMO itself is not held legally accountable, physicians and patients have no legal remedy for unethical financial incentives. The concern this raises is that ERISA does not regulate how HMOs create incentive structures to motivate contracting physician's compliance with cost containment measures. And the ERISA preemption makes it more difficult for states to regulate such compensation and incentive arrangements. Some commentators conclude that "[f]rom a policy perspective, ERISA has created a regulatory vacuum in which states cannot act and there is no comparable federal regulatory mechanism."²⁹

The best recourse for physicians includes collectively designing care management practices, such as those that are currently being developed under the heading of practice guidelines, protocols, critical pathways, and disease state management.³⁰ The advantage of these approaches is that they increase the value of services delivered to patients through improved outcomes and reduced costs. They also provide information for physicians and managed care plans about standards of medical practice. And they involve physicians in designing the rules to which they will be subject. To the extent that physicians work in tandem with managed care plans to establish guidelines for the care of patients, they will be better able to make individual treatment decisions in a fair and consistent manner.

In summary, I have argued that physicians are not ethically obligated to act exclusively in the interests of their individual patients. The "mixed" nature of many medical decisions reflects the fact that physicians serve multiple clients: individual patients, patient populations, and the society at large. The existence of financial incentives to limit advocacy on behalf of one client group in order to achieve a fairer balance among all groups is

consistent with standards of justice in health care. Finding the most ethical balance among the multiple clients that physicians serve is still undetermined. A fair process for making this determination should involve not only physicians and health care plans, but ultimately the entire population of patients affected by these decisions.

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