10. Protection Against "Gag Rules:" Safeguarding Provider-Patient Relationships

Charge

The imposition of managed care principles and techniques can cause deviations and irregularities in standards of practice within the VHA health care system, for example, distortions of clinician-patient relationships, outcomes and costs of care. One example of a managed care practice is the "gag rule" appearing in provider contracts. What are the ethical considerations of "gag rules" for clinicians, and what ethical considerations should guide VHA regarding this organizational practice? The purpose of this report is to focus on this one specific pressure or challenge to professional standards of practice as it may affect VHA practitioners, and to examine the current status of "gag rules" and the associated ethical considerations.

Background

Health care has existed historically in an environment that has offered virtually any potential benefit or prolonged life to health care recipients able to pay for the services under the assumption of unlimited resources. That assumption is increasingly being called into question. Managed care is one expression of that challenge which has profoundly altered the delivery of health care.[1]

The traditional fee-for-service system has not been without its ethical challenges. Over-utilization of some services and rationing on the basis of financial means have occurred. The concept of managed

care is morally neutral and may be used to convey the positive concept of managing the care of a patient in an ethical manner, with the most appropriate treatment to achieve the most beneficial outcome. However, the morality of the concept depends on its intent and the effect on the beneficiaries. The term managed care has increasingly become associated with economics as the ascendant intentional motivation, introducing "the plan" as a decision-making agent and stakeholder. This resulting shift of focus, in some instances, places the provider in a conflict-of-interest situation. Having posed the moral neutrality of the term managed care, the focus of this paper will be on that use of it which places economics ahead of ethical imperatives inherent in treatment situations.

One purpose of a managed care approach is keeping treatment costs down. Cost reduction is potentially beneficial to each individual patient and the group or the plan membership. These benefits include appropriate, quality care for the individual and resulting cost-savings, which will provide additional benefits for a larger group of people (the entire plan membership).

These relatively recent and dramatic changes in health care delivery in response to economic pressure have contributed to major changes in the relationship between the health care provider and the patient. The professional obligation has been focused traditionally on the individual patient and his or her welfare or particular interests. The physician-patient relationship has expanded to include a wide variety of technicians, specialty health care providers, administrators, and payers who comprise collectively "the plan." Many of those who represent the plan are not directly part of the physician-patient relationship. Payers are assuming a larger role in the management and actual delivery of health care[2] and have become part of the decision-making process that affects the care patients receive. Many of these players act without having any technical or medical knowledge and without knowing either the patient or the provider. To the extent that these other factors represent an expanded universe within which health care is delivered and for which we accept the notion of finite resources, the necessity to balance competing interests is not *per se* reprehensible or extraordinary.

This conservation in the allocation of resources, however, requires the imposition of limits and inevitably leads to conflict. The resolution of these conflicts requires consideration of the interests of all who are stakeholders. Balancing these competing interests rationally and fairly of necessity involves ethical considerations.

Under pressure to keep costs down, managed care plans use a variety of techniques, including pre-authorization requirements, utilization review, and financial incentive payments to limit the services that are provided to patients. The new reality is that physicians are under economic pressure to include consideration of cost in making treatment decisions.

Some health plans and institutions have introduced cost containment financial incentives for providers and some have incorporated contractual restrictions on providers with respect to the information that may be provided to the patient. (The word providers will be used to include not only physicians, but all other professional personnel who are involved, and who will be involved, in the delivery of patient care.) These specific restrictions may be incorporated into a physician contract with a Health Maintenance Organization (HMO) or health care plan and are referred to as "gag rules" or clauses. Some health plans that do not have written "gag rules" have unwritten policies that have been orally communicated.[3] Many providers have become concerned about these restrictions, which are used to inhibit physicians from full explanation of particular treatment options and from saying whether or not the plan covers these treatments. Clinicians believe that these "gag rules" are unethical.

It is not known how many managed care contracts contain "gag rule" clauses. However, some of the nation's largest health insurance companies, such as Aetna, CIGNA, and ChoiceCare, have included statements in their contracts with physicians that seek to limit discussion of treatment options with patients.[4]

Some representative clauses from managed care plan contracts with providers state:

"Do NOT discuss proposed treatment with … (health plan) members prior to receiving authorization. Do NOT discuss the (utilization oversight) process with members. Do NOT give out (plan's oversight) phone number to members."

"Physician agrees not to disparage plan or its processes, programs or policies to any persons, including members or other participating providers."

"Any dissatisfaction with the specialist program should be communicated directly to plan rather than patients or other physicians. Specialist physician who engages in a pattern of derogatory remarks to patients or otherwise damages plan's business reputation may be suspended or terminated."

Under pressure from the medical community, the large managed care organization U.S. Healthcare recently changed its policy to encourage open discussion between physicians and patients about treatment options.[5]

The managed care industry argues that "gag clauses" are intended to prevent medical practitioners from disclosing proprietary information and from criticizing their plans. Nevertheless, considerable anecdotal evidence suggests that some managed care plans have been using "gag rules" to prevent physicians from telling patients about alternative and often more expensive treatments that the plan does not cover or would not like to provide because of their extra costs.

While VHA does not, and likely will never, tolerate an explicit "gag rule," the potential for unwritten, implicit "gag rules" in individual VHA medical facilities exists (see case scenarios in Appendix A). In fact, VHA operates in a climate very similar to the environment that brought about "gag rules" in some private sector health care organizations. VHA is under increasing pressure to compete with other health care delivery systems, to operate under a tight budget, and to deliver cost-effective care. The fact that health care organizations have imposed "gag rules" on clinicians, and that state and Federal governments and regulatory bodies are moving to eliminate the practice should serve as a red flag for VHA.

Developing Societal Consensus

"Gag rules" in effect at many new HMO-style health care plans are not the first examples of censorship over physicians' ability to prescribe or discuss medically appropriate treatment options for their patients. In 1988, the Department of Health and Human Services issued regulations barring all discussion of abortion in federally funded family planning clinics. The regulations were challenged in the case of *Rust v. Sullivan*, argued before the U.S. Supreme Court. Opponents alleged that the regulations would force practitioners in the federally-funded family planning clinics to violate their professional ethics and the law of informed consent, which obligates physicians to render care in a manner respecting of the patient's right to make an informed decision. They argued that the physician plays a central role in a patient's decision-making process by providing the patient with crucial medical facts relevant to medical decisions. They also argued that the rules would prevent the practitioners from exercising their best medical judgment and would expose them to liability for malpractice.[6]

The Court upheld the regulations in a 5-4 vote, ruling that when government pays for a service it can dictate what is said in the course of that service. In the majority opinion, Chief Justice Rehnquist implied that the patient should assume that her doctor might withhold information relevant to her medical condition.

In his dissenting opinion, Justice Blackmun expressed a different view of the doctor-patient relationship. He wrote that the patient "has every reason to expect, as do we all, that her physician will not withhold relevant information regarding the very purpose of her visit." President Clinton rescinded the regulations in 1992.

Since *Rust v. Sullivan*, "gag rules" have become more prevalent in the health care landscape, as cost containment under managed care has emerged to become the predominant health care delivery principle. As these restrictions proliferate, consumers, providers, and policymakers have begun to believe that some cost-cutting measures designed to limit how a physician might prescribe, refer, or otherwise provide

treatment for a patient have been taken too far. Private organizations and consumer advocates have mobilized to push both state and Federal legislative and regulatory measures to protect consumers in the managed care environment. Among those measures are prohibitions on clauses in provider contracts that restrict communication between clinicians and patients. In addition, numerous legislative initiatives seek to limit incentive payments to physicians.

State Legislation

States only recently began to address the issue of "gag clauses" in managed care contracts. Nevertheless, since 1995, 17 states[7] have enacted some form of anti-"gag rule" legislation and many other states have attempted to address the issue.[8] State anti-"gag clause" provisions outlaw managed care contracts that limit in any way or penalize providers for disclosing to patients information about the medical conditions or treatment options, for advocating on behalf of patients, and/or for providing information about HMO policies, including financial incentives or arrangements. Examples of state anti-"gag rule" legislative provisions appear in Appendix B.

Federal Legislation/Regulatory Action/Private Sector Initiatives

Several Federal anti-"gag rule" measures were introduced in the 104th Congress,[9] including the Patient Right to Know Act (HR 2976), which was approved June 27, 1996, by the House Commerce Subcommittee on Health and the Environment.

On November 25, 1996, the Health Care Financing Administration (HCFA) issued a letter to all HMOs that serve Medicare patients informing them that enrollees are entitled to "advice and counsel from their physician on medically necessary treatment options that may be appropriate for their condition or disease." The agency further stated that physicians may not be limited by the HMO in counseling or advising patients. On March 27, 1996, HCFA also published rules restricting inappropriate financial incentives that plans contracting with Medicare and Medicaid often impose on their providers.

Many private organizations recently have adopted policy positions against "gag rules" in managed care plans. Such organizations include: The National Committee for Quality Assurance (NCQA), The American Medical Association's Council on Ethical and Judicial Affairs, American Academy of Family Physicians, The National Association of Insurance Commissioners (NAIC), and the Institute of Medicine. (Additional details appear in Appendix B.)

Ethical Issues

Medical ethics in the United States is often introduced by raising four basic ethical principles:

1. **Autonomy**: the right of the patient with decision-making capacity to control his or her own life by making decisions, according to personal values, being one's own person without constraints either by the actions of another or by physical or psychological limitations.
2. **Beneficence**: doing "good" for the patient; keeping the patient's welfare and best interests foremost.
3. **Nonmaleficence**: avoiding evil or harm to the patient; preventing evil or harm; removing sources of evil or harm.
4. **Justice**: treating all patients fairly and equitably; fair and equitable access to care; burdens and benefits to be distributed fairly; fair allocation of scarce and limited resources.

Included within these four are **veracity** (truth-telling), which implies a full and complete disclosure of all relevant facts and deems it "better" for the patient to know than not to know. Also included are **promise-keeping** and **confidentiality**. All of these concepts recognize and support the unique worth and dignity of the individual and the respect due each patient as an individual.

Fidelity, as contemplated in the physician-patient relationship, is defined as the patient's right to expect continuing service aimed toward the advancement of his or her own interests and the rejection by the

physician of possible conflicting interests. The requirement of fidelity is based on the patient's vulnerability, both physical and psychological, due to illness, impairment, ignorance, and an imbalance of power in the physician-patient relationship. The physician acts as a fiduciary, blunting his or her own self-interest in favor of responsibility for those patients in his or her charge.

The concept of **professional integrity** extends to all providers who are involved with care of patients. All have professional responsibilities, and should make personal commitments, to fulfill the above-noted patient-centered virtues and values.

Often associated with all of these concepts is **advocacy**, or acting in the patient's best interests: pleading; interceding; or speaking for, or in behalf of, the patient.

With the growth of managed care, the emphasis in health care delivery has expanded beyond the individual patient and his or her best interests to inclusion of the group of patients and economic issues of access. Physicians in this setting recognize and account for additional responsibilities beyond those to their own patients, as discussed above. Physicians must be aware of the importance of proper resource utilization in the care of their own patients, while still recognizing responsibility to all other patients who may have equal need and/or claim to the resources in question. This balancing is called stewardship. The ethical principle of justice demands as much.

"Gag clauses" and "disparagement clauses" (to prohibit critical comments about the institution or health care plan) imposed upon physicians, other providers, and employees raise troubling questions about the level of candor or completeness encouraged or tolerated in dealing with patients.

Any employed physician may have additional duties and responsibilities to the "managed care" institution:

a. Observing the institution's bottom line, since it cannot continue operation if there is significant fiscal irresponsibility and the

institution's resources are not husbanded carefully;

b. Containing costs;

c. Participating thoughtfully in technology assessment, resource utilization, outcome evaluation, and good faith peer review.

VHA's Institutional Responsibility to Its Patients

VHA has institutional ethical responsibilities to its beneficiaries: obligations of justice—fair and equitable distribution of scarce and/or limited resources—as well as veracity, beneficence, and fidelity.

Further, the relationship of VHA to its patient beneficiaries is unique, without parallel in modern American medicine. It is based upon the recognition and acknowledgment of a moral responsibility "to care for him who shall have borne the battle, and for his widow and his orphan." Legislation originally establishing the VA was enacted in recognition of this moral claim. Some would argue that this claim is stronger than that which exists between an HMO and its enrollees, where the commitment is based on a contractual relationship in return for premiums paid or as a fringe benefit of employment. The claim will come under review and modification with the new focus on eligibility reform and enrollment.

VHA's Responsibility to Its Physician-Employees

It is well-recognized that institutions have an ethical life of their own.[10] There is an expectation that the responsible organization will not only permit, but actively support, the development of professional ethics and integrity of its employees by such means as providing educational programs and addressing moral and ethical issues that arise in the course of doing business. Such training should encompass those economic issues involved in the appropriate planning of resource allocation and utilization. VHA must be committed to keeping "rationing" decisions and/or economic decision-making out of the dyadic provider-patient situation (or away from the bedside) and addressing such issues at the corporate and institutional level. This relates in a special way to physicians and to patients/enrollees. This

responsibility also encompasses providing physicians and all other professional employees with a well-maintained environment conducive to the delivery of high-quality medical care and with adequate personnel, technological, and fiscal support. It also envisions that those providers will care for their patients in a manner consistent with the ethical dictates of their professions and with the support of the institution in the fulfillment of those ethical dictates. These are obligations of mutual trust and fidelity between patient and physician, between patient and institution, and between physician and institution.

Current Pressures in VHA

The question posed is whether the management methods designed to streamline and improve the delivery of care in VHA will, in practice, impose additional or new ethical burdens and restraints on the ability of individual practitioners to discuss appropriate treatment options with patients. Unknown also are the effects of budget pressures and the drive to "bottom-line medicine" (such as contracting out or eliminating expensive outlier care) upon the relationship between the provider and the patient. Yet to be determined is whether explicit or implicit pressures, or other subtle inducements, will be placed on VHA clinicians to restrain discussing limitations or options of care based on cost considerations or performance incentives, or otherwise to refrain from advocating for their patients.

Some specific developments that parallel initiatives in the community, posing potential opportunities for risk within VHA, are the proposed physician pay incentives and the performance agreements negotiated contractually with VISN directors and at other organizational levels. Although nothing in these formal agreements currently appears to restrict full disclosure to veterans, the conditions exist for such to occur. As VHA evolves in this managed care environment, managers must be cognizant of the potential inherent risks. They must keep ethical issues in the forefront of the thinking process to assure that "Putting Budgets First" does not supplant the ethical and moral obligation of "Putting Veterans First."

VHA practitioners will come under increasing pressure to provide services to more veterans at lower cost during a time of shrinking resources. Realizing this fact, it is also clear that VHA will not always be able to provide all services available in the complete medical repertoire in the health care marketplace to all veterans presenting themselves for treatment. However, honesty and forthrightness in the physician-patient relationship as well as informed consent common law require that providers inform patients of those treatment options that are medically appropriate to their condition and which courses of treatment are available through VHA. They must also be exquisitely clear and straightforward as to what options are not provided by VHA and why, but could be sought by the patient elsewhere or obtained in a more timely manner from another source.

Such ethical considerations are not new to most physicians working in modern American medicine, including VHA practitioners. In the future, their impact on the physician-patient relationship will become increasingly complex. VHA must directly address these ethical challenges as they occur in order to maintain fidelity in its relationships with its patients, its managers, and the veteran community at large.

Recourses Available to Health Care Professionals

There are both formal and informal recourses available to VHA health care providers who feel unduly restrained from providing complete and comprehensive information to patients about their health care choices due to organizational policy or administrative decisions. Currently, physician pay is not contingent on meeting certain budget or productivity goals. However, it is possible in this environment for an individual provider, whose cost profile shows unique variations, to come under pressure to alter practice patterns based primarily on cost considerations.

Formal recourses available to health care professionals who feel constrained or ethically challenged include the following:

a. Internal quality assurance monitors could be designed to document outcome and discussion of treatment alternatives with patients.

b. Presentation of ethical concerns resulting from "gag rules" may be made at clinical practice committee meetings.

c. Consults may be requested of legal counsel and resolved locally or forwarded to general counsel for analysis and opinion. Consultation with Headquarters regarding a discrepancy between local policy or practice and official VHA policy should also occur.

d. The Office of the VHA Medical Inspector is available for consultation by the practitioner who feels that local avenues have been exhausted and needs another level of consultation still within VHA.

e. Physicians can call the Inspector General Hotline if they feel that all other avenues have been exhausted and that implicit or explicit "gag rules" prevent an appropriate informed consent discussion with patients about treatment alternatives.

f. Should an adverse action be taken against a physician, appellate processes are available. The physician's appeal would be reviewed either by a Board of Peers, if the action was determined to be one of professional competence or conduct, or through the regular grievance process if the action was determined to be of an administrative nature. This latter procedure would be adjudicated by a hearing officer who in all probability would be a peer, although a peer is not a requirement. Human Resources Management Service in the medical facility would facilitate the hearing arrangements.

g. Federal "whistle blowing" legislation might be invoked to protect a local care giver if one were to experience reprisal as a result of speaking out about "gag rule" use to restrict information regarding treatment for veterans.

Conclusions and Recommendations

Anything less than open, honest, and forthright discussion with patients regarding their treatment options is unethical and unacceptable. A distinction must be made between *discussion/disclosure* of treatment options in the medical repertoire and *availability*

of any given option within the VHA system. The issue here is that both options and availability must be freely discussed with patients. These discussions should include information about budgetary issues and issues related to justice as appropriate. No provider should be compromised in any way by a management or supervisory influence or direction that would force him or her to violate the informed consent requirements for disclosure and for full discussion of treatment options. There must be no subtle implicit or explicit attempts to impose a "gag rule" on professional staff within VHA. Nor should individual providers allow their loyalty to the system or corporate VHA or intimidation by subtle pressures from colleagues or from supervisors influence or restrict their freedom to speak openly and honestly with patients about their treatment options.

The Under Secretary for Health should formally communicate the position that VHA will not tolerate formal or informal "gag rules," and initiate ongoing procedures to inform administrators, health care providers, consumers, and stakeholders in the veteran community that anything but a free, open, and complete exchange of medical information between patients and health care practitioners will not be tolerated.

Some specific actions might include, but not necessarily be limited to: a) an Information Letter (IL) to raise the level of awareness regarding the Informed Consent regulations and policy that require that patients be informed of all reasonable treatment alternatives, including a clear statement that no "gag rules" will be tolerated in the VHA; b) QA monitors and/or questions on the patient-satisfaction survey designed to address the issue of full disclosure and free discussion of treatment alternatives with patients; and c) emphasis on open and honest disclosure and discussion of physician pay incentives, where those incentives are tied to allocation of resources or cost containment actions.

Appendix A: Hypothetical Scenarios

While these cases may appear to be stating the obvious to many health care providers, they are real examples that have been sanitized. These examples were selected to show how compliance with an unspoken part of the organizational culture can evolve, even when it is not highlighted as a "gag rule" *per se*.

1. Veteran X, a veteran of the Airborne troops during the Korean War, was 80% service-connected for bilateral hip injuries. In 1991, he had a left hip replacement followed by 21 days of daily inpatient rehabilitation and 2.5 months of outpatient rehabilitation treatment, three times a week at the ABC VA hospital. He did well until 1995, when the right hip began to cause increasing pain and lack of mobility. He returned to the ABC VA hospital and sought similar surgical and rehabilitation treatment for the new problem.

   In the meantime, because of budget limitations, the Rehabilitation Medicine Service at the ABC VA hospital had been forced to down-size its physical therapy technician staff from nine to four. As a result, patient rehabilitation treatments have been severely limited.

   The veteran was readmitted and underwent right hip replacement on August 14, 1996. Inpatient rehabilitation was provided twice weekly for two weeks, at which time he was discharged. Outpatient rehabilitation was scheduled for 10 visits, two each week for five weeks. The physiotherapy staff had previously been advised not to discuss the difference in rehabilitation schedules with any "new patients."

2. The STU VA Clinic was a free-standing rural facility. It had an active cardiac clinic, with a staff of four EKG technicians. Because of budgetary limitations, the EKG tech staff was cut to one, Linda Hoskins. Three weeks after the cut, Ms. Hoskins was injured in an auto accident in which both her legs were broken. No EKG tech staff are now available. The physicians and nurses in the cardiac clinic have been instructed not to discuss the lack of availability of EKGs with patients, families, or other clinic employees.

3. A high level manager in Network 65 knows that he is being considered for a sizable year-end bonus. To make his administration "look good," he suggested to all facility directors in his service area to "keep everything on an even keel," minimize appeals for expensive drugs, avoid requests for transplant surgery, etc. Dr. H, a nephrologist at XYZ VA facility, submitted a request for a kidney transplant for one of his End Stage Renal Disease (ESRD) patients. His request was denied, and he was reminded of the limitation of funds that might require some reduction of employees or possible program cut backs that could affect his service.
4. A physician in the outpatient clinic recommends a specialty consult to the patient. This particular specialty has a 4-month waiting time for an appointment. Although the physician knows that the patient could be seen in the community within approximately a week, he does not inform the patient that a prompt appointment within a week would be possible if the patient is willing to see a private physician and use his Medicare benefits and/or pay privately. The full range of options is not disclosed to the patient, thereby preventing a fully informed choice and prompt treatment for a potentially serious problem.

In each of these cases, the full range of treatment options was not clearly explained to the patient, and staff ability to act or respond to patient need was compromised by an apparent pressure to withhold information.

Appendix B: Notes on Developing Societal Consensus

State Initiatives

Examples of state anti-"gag-rule" legislative provisions:

A health maintenance organization shall not refuse to contract with or compensate for covered services of an otherwise eligible provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients. (Massachusetts)

No health care provider may be penalized for discussing medically necessary or appropriate care with or on behalf of his or her patient. (Georgia)

The carrier shall not terminate the contract with a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person; or because the provider assists the covered person to seek reconsideration of the carrier's decision; or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternative, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients. (Colorado)

Congressional Initiatives

The Patient Right to Know Act (HR 2976) was approved by House Commerce Subcommittee on Health and the Environment on June 27, 1996. The language contained in the legislation was a scaled-back version of the original bill, which included broad language banning limits placed on physician-patient communications in managed care plan contracts. The new version would only ban plans from writing contract clauses that limit what physicians can say about treatment options. It would allow contract clauses that prohibit providers from criticizing plans or disclosing financial incentives and how decisions to authorize or deny care are made. Provisions limiting action plans can take against providers also were stripped from the bill.

In the final days of the 104th Congress, "gag rule" legislation (S 20005) was proposed as an amendment to the Treasury Department–U.S. Post Office spending bill; the amendment failed. In February 1997, President Clinton declared his support for anti-"gag rule" legislation.

Federal Regulatory Initiatives

Not only have the Federal and state legislatures begun to take action to protect consumers, Federal regulators have recently taken steps to address the issue. Recognizing the pressure financial incentives can place on physicians to limit or deny care, on March 27, 1996, the Health Care Financing Administration (HCFA) issued regulations governing financial incentives that managed care plans serving Medicare and Medicaid often impose on their providers. These regulations became effective January 1, 1997.[11]

The rules will require health plans with Medicare and Medicaid contracts to disclose the nature of physician incentive plans to HCFA or to state Medicaid agencies and to provide a summary of such arrangements to beneficiaries when requested. Information of this nature would help patients determine whether their doctor's interests are concordant with their own. Under the regulations, plans will be prohibited from making specific payment to doctors to limit or reduce necessary medical services. The rules also outline several requirements health plans must comply with to ensure that they do not place undue financial risk upon their physicians.[12]

Private Sector Initiatives:

The National Committee for Quality Assurance (NCQA), the largest accrediting entity for managed care organizations in the United States, recognized the importance of ethics by adopting a standard related to members' rights and related grievance procedures. Recently, NCQA issued a clarification of its standard for Members' Rights and Responsibilities, which states that "at a minimum, the organization has a written policy that recognizes the following rights of members to participate in decision making regarding their health care and prohibits restrictions on the clinical dialogue between practitioner and patient."[13]

In January 1996, the American Medical Association's Council on Ethical and Judicial Affairs released the following statement on "gag clauses:"

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. That would be an absolute violation of the informed consent requirements. If these [gag] clauses are carried out and the physicians are subject to sanction, a reduction of patient quality of care will result.[14]

The American Academy of Family Physicians issued the following policy statement on family physicians' interaction with managed care plans:

Physicians must be able to discuss any information, clinical or financial, necessary for their patients to make informed decisions regarding their medical care.[15]

The National Association of Insurance Commissioners (NAIC), an association of insurance regulators from all 50 states, the District of Columbia, and the four U.S. territories, has developed model state laws in the area of managed care. Many states base their laws on NAIC models. The Managed Care Plan Network Adequacy Model Act contains a provision that would prohibit health carriers from preventing providers from discussing treatment options with covered persons without regard for the health carrier's position on the treatment options, or from advocating on behalf of a covered person within the plan's utilization review and grievance processes.[16]

An Institute of Medicine (IOM) report, published in August 1996, stated that managed care plans with gag rules should be barred from participating in Medicare. The IOM-convened committee expressed its concern about potential restrictions on the physician's traditional patient advocacy role and said that it favors the abolition of payment incentives or other practices that may motivate providers to evade their ethical responsibility to provide complete information to their patients about their illness, treatment options and plan coverages.

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Writers

Mary E. Bozeman, M.S.W. - Chairperson
Richard J. Dunne, M.A.
Julia S. Hysom, M.A., M.H.A.
David H. Law, M.D.
Ruth-Ann Phelps, Ph.D.
Diane Prescott, M.S.P.H.
Dorothy Rasinski-Gregory, M.D., J.D.