

**Woodstock Theological Center
Seminar in Business Ethics**

**ETHICAL CONSIDERATIONS IN THE BUSINESS ASPECTS
OF HEALTH CARE**

Copyright © 1995 by the Woodstock Theological Center
Printed in the United States of America
All rights reserved

Seminar in Business Ethics.

*Ethical considerations in the business aspects of health care/
Woodstock Theological Center Seminar in Business Ethics.*

p. cm.

- 1. Medical care--Cost control--Moral and ethical aspects.*
- 2. Managed care plans (Medical care)--moral and ethical aspects.*
- 3. Health care rationing--Moral and ethical aspects.*
- 4. Medical ethics--Standards. I. Woodstock Theological Center*

II. Title

RA410.5.S36 1995

174'.26--dc20

ISBN 0-87840-587-9 95-5133

For permission to reproduce in whole or part, please write the Woodstock Theological Center, Georgetown University, Washington, DC 20057-1137, or telephone (202) 687-3532, or fax (202) 687-5835.

THE WOODSTOCK THEOLOGICAL CENTER is a nonprofit research institute established by the Society of Jesus to address topics of social and political importance from a theological and ethical perspective. Interdisciplinary and ecumenical by design, the Center engages in research, conducts conferences and seminars, and publishes books and articles. Human rights, economic justice, the church as a social institution, and business ethics are some of the public policy issues that Woodstock examines.

TABLE OF CONTENTS

Participants

Foreword

Section I The Challenge

Section II Ethical Framework

1. Compassion and Respect for Human Dignity
2. Commitment to Professional Competence
3. Commitment to a Spirit of Service
4. Honesty
5. Confidentiality
6. Good Stewardship and Careful Administration

Section III Personal Decisions in Individual Cases

1. When Resources Are Inadequate to Meet All Needs
2. When Providers Own or Profit from Patient Utilization of Specific Resources
3. When Rules and Regulations Conflict with Professional Judgment
4. When Truthfulness May Be in Conflict with Patient Confidentiality
5. When Patients' Own Behavior Contributes Significantly to Their Problems
6. Where New Technologies Are Emerging Rapidly

Section IV Checkpoints

1. When Deciding Whom to Treat, and How to Allocate Scarce Resources in Short-term Crisis Situations
2. When Drawing up a Mission Statement or Otherwise Determining My Private Commitment or Institutional Commitment to Providing Uncompensated or Undercompensated Care
3. When the Needs of My Patients or My Community Exceed My Capacity to Provide Uncompensated or Undercompensated Care
4. When Confronted with Opportunities to Invest in Testing Services or Ancillary Medical Services
5. If I Decide to Invest in Ancillary Testing Facilities, or Medical Service Companies
6. In Administering Resources and Serving My Patients in a Cost-Conscious Way
7. Whenever the Rules and Regulations of Third-Party Payers Conflict with My Professional Judgment
8. In the Course of Ordinary Record-keeping and Billing
9. When Truthfulness Conflicts with Patient Confidentiality
10. When Patients' Behavior Contribute Significantly to Their Problems
11. Whenever I Am Troubled by Decisions or Actions I Am Taking

Section V Conclusion

Appendix A Request for Institutional Arrangements That Support Ethical Behavior

1. Decent Minimum Care for All
2. Restraint and Equitable Allocation of Finite Resources
3. Design of Health Care Financing Systems
4. Information about Budget Constraints
5. Information about Peer Performance
6. Coping with Demands of Multiple Roles

7. Validating Roles for a Wider Variety of Providers
8. Adequate Funding for Research
9. Attention to the Needs of "Whole Persons"

Participants

Ms. Jodie Allen
Editor
Outlook
The Washington Post

Mr. J. J. Barry
President
International Brotherhood of Electrical Workers

Virginia Betts, J.D., R.N.
President
American Nurses Association

Dr. Margaret M. Blair, rapporteur
Economic Studies Program
The Brookings Institution

Rev. William J. Byron, S.J.
Director
Center for the Advanced Study of Ethics
Georgetown University

Rev. James L. Connor, S.J.
Director
Woodstock Theological Center

Martin F. Connor, Esq.
Chairman
Stateside Associates, Inc.

Mr. John E. Curley, Jr.
President
The Catholic Health Association

Mr. John J. Curry
Executive Director
American College of Radiology

Professor Norman Daniels

Professor of Philosophy
Tufts University

Dr. Richard J. Davidson
President
American Hospital Association

Catherine DeAngelis, M.D.
Vice Dean for Academic Affairs
The Johns Hopkins School of Medicine

Mr. Horace B. Deets
Executive Director
American Association of Retired Persons

Richard P. Delaney, M.D.
Private Practice
Silver Spring, MD

Robert Dickler, M.D.
Vice President
Association of American Medical Colleges

Leah J. Dickstein, M.D.
Associate Dean
Faculty and Student Advocacy School of Medicine
University of Louisville

Dr. Thomas C. Dolan
President
American College of Healthcare Executives

Sr. Rosemary Donley, S.C.
Executive Vice President
The Catholic University of America John

M. Eisenberg, M.D.
Chairman/Physician in Chief
Medical Center

Georgetown University

Mary Jane England, M.D.
President
Washington Business Group on Health

Professor Alain C. Enthoven
*Marriner S. Eccles Professor of Public and
Private Management*
Stanford University

Charles H. Epps, M.D.
Dean
Medical School
Howard University

Rev. John D. Golenski, S.J.
President
Bioethics Consultation Corporation, Inc.

Hon. Willis Gradison, Jr.
President
Health Insurance Association of America

Professor Ronald M. Green
Director
*Institute for the Study of Applied and
Professional Ethics*
Dartmouth College

John Collins Harvey, M.D.
Senior Research Scholar
Center for Clinical Bioethics
Georgetown University

James C. Haughton, M.D.
Senior Health Services
Policy Advisor
Department of Health Services
Los Angeles County

Hon. Constance Horner
Guest Scholar
The Brookings Institution

Rev. John P. Langan, S.J.
Senior Fellow

Woodstock Theological Center
Rose Kennedy Professor of Ethics
Georgetown University

Willis C. Maddrey, M.D.
Southwestern Medical Center
University of Texas at Dallas

Professor William F. May
Cary M. Maguire
Professor of Ethics
Southern Methodist University

Gen. Edward C. Meyer
CILLUFFO Associates

Dennis S. O'Leary, M.D.
President
*Joint Commission on Accreditation of
Health Care Organizations*

Hon. Henry Owen
Consultants International Group, Inc.

Edmund D. Pellegrino, M.D.
Director
Center for Clinical Bioethics
Georgetown University

Mr. Robert P. Pfothenauer
President and CEO
Pharmacy Direct Network

Mr. Charles O. Rossotti
Chairman and CEO
*American Management
Systems, Inc.*

Mr. Carl J. Schramm
President
Time Insurance Company

Kevin A. Schulman, M.D.
Medical Director
Clinical Economic Research Unit

Medical Center, Georgetown University

Mr. Patrick J. Scollard
Executive Director and COO
St. Francis Hospital, Roslyn, N.Y.

Ralph A. Straffon, M.D.
Former President
American College of Surgeons Cleveland
Clinic Foundation

James S. Todd, M.D.

Executive Vice President
American Medical Association

Mr. Bernard R. Tresnowski
CEO and President
Blue Cross/Blue Shield Association

Dr. Joshua M. Wiener
Economic Studies Program
The Brookings Institution

Rev. Kevin W. Wildes, S.J.
Assistant Professor
Philosophy Department
Georgetown University

FOREWORD

"Ethical Considerations in the Business Aspects of Health Care" is the product of two years of study and four major conferences of members of the health care community and academia. It offers evaluations and recommendations for health care professionals in the difficult ethical issues and questions that they face in the business aspects of their practice on a daily basis.

Those whose names appear on the previous pages were participants in the process. Not every member of the group subscribes to every sentence in this report, but all support its basic contents and sentiments, deeming its distribution within the health care community and beyond to be useful. Their support does not involve any organization with which they may be affiliated. They hope their shared experience and insight may help other health care professionals who face similar ethical challenges.

The continuing Woodstock Seminar in Business Ethics was conceived in the fall of 1988, when a group of leaders in banking and finance, business and government, academia and church began discussing ethical dilemmas in the conduct of mergers and acquisitions. From those conversations came a publication, entitled *Ethical Considerations in Corporate Takeovers* (Georgetown University Press, 1990). The group, thereafter, felt that deeper, systemic issues still needed to be addressed, which led to a second two-year series of conferences, resulting in the publication, *Creating and Maintaining an Ethical Corporate Climate* (Georgetown University Press, 1990).

The decision was made by the Woodstock Seminar in the spring of 1991 to focus on the ethical issues that health care professionals face in the business aspects of their practices. So, the Woodstock Theological Center convened a diverse group of health care specialists, physicians, nurses, hospital executives, ethicists, policy makers, academic policy analysts, and religious leaders to formulate a consensus statement on "Ethical Considerations in the Business Aspects of Health Care." Although we recognize that many agents participate in the provision of health care services (insurers, research scientists, and employees of pharmaceutical companies, to name a

few), for the sake of focus and manageability, we decided to consider only the special ethical dilemmas facing individual providers, such as physicians, nurses, and therapists, and executives of institutions such as hospitals, clinics, and managed care organizations.

The seminar members began in the fall of 1992 by sharing responses to the question, "What are the most pressing and vexing ethical issues in the business aspects of health care that you face on a day-to-day basis?" Many examples of ethical issues and dilemmas were exchanged. In the spring of 1993, the second meeting analyzed these ethical dilemmas, grouped them according to type, and began developing sets of principles that could be used to resolve them. In the fall of 1993 and again in the spring of 1994, the participants pushed their analysis further to reach agreement on the core principles and norms health care practitioners should have in view as they move through deliberation and decision. What came out of these efforts is to be found here in Section II (Ethical Framework) and Section III (Personal Decisions in Individual Cases).

Section IV of this statement contains a practical checklist of questions that health care providers can pose to themselves as they face the various ethical problems that occur in the business aspects of their profession. We hope these questions will suggest a path for reflection and a set of issues that should be addressed in making ethical choices as well as in evaluating the moral appropriateness of the decisions made.

In the course of group discussions, it became clear that ethical issues arise not only out of individual conflicts, but also out of institutional arrangements that create certain conflicts. The institutional context within which health care professionals must practice influences the kinds of issues, dilemmas, pressures, temptations, and constraints they face. Indeed, social institutions and systems embody and express many of the ethical norms, expectations, and standards of society. When those institutional arrangements undergo significant change, as the health care system is doing today, old ethical dilemmas may be alleviated, and new ones may arise.

The group also came to believe that an ethic that will be helpful for health care providers in their difficult daily decisions must be a social ethic that situates individual choices within consideration of the common good. By itself, an individualistic ethic will not suffice, just as a socially directed ethic, by itself, is inadequate. What is needed is a balanced ethic that respects the individual, but takes into account the essentially social dimension of human beings and behavior. Although society comprises individuals, society is more than the sum of all of the individuals in that society. Hence, a sound social ethic must acknowledge the interdependence of every person within the larger community.

For these reasons the participants in this project concluded that they could not provide ethical guidance to individual practitioners while ignoring entirely the institutional arrangements or health care systems within which decisions must be made.

Thus, while it is not the goal of the project to recommend a health care plan for the United States, we decided that it was appropriate to address the issue of health care reform to offer some hopes and suggestions about institutional design features that the group believes would make it easier for providers to make sound ethical choices. These reflections are attached as an appendix.

We hope that this statement, then, will serve as a guide to individuals who, in their work as health care providers, are attempting to make decisions and set priorities in ways that reflect the highest personal and professional standards. What follows represents a consensus of the views of the participants in the project. The statement does not claim nor intend to claim a single unanimous moral or religious foundation or perspective. It is not a specific proposal for policies or regulations, but is rather an invitation to personal reflection and moral commitment.

For this publication we are grateful to the Seminar Steering Committee: Margaret M. Blair, William J. Byron, S.J., James L. Connor, S.J., Sister Rosemary Donley, S.C., Alain C. Enthoven, John Collins Harvey, M.D., John P. Langan, S.J., General Edward C. Meyer, Ambassador Henry Owen, Lynn Sharp Paine, Edmund D. Pellegrino, M.D., Charles O. Rossotti, Kevin A. Schulman, M.D., Patrick J. Scollard, Joshua M. Wiener, and Kevin W. Wildes, S.J. Dr. Blair also served in the role of rapporteur.

We are happy to acknowledge our gratitude to The Robert Wood Johnson Foundation for financial support for this project.

James L. Connor, S.J.
Director
Woodstock Theological Center
March 15, 1995

SECTION I: THE CHALLENGE

The health care system in the United States is undergoing a very rapid and all-encompassing transformation. While politicians and their policy advisors debate the role that state or federal governments can or should play in this process, economic and business considerations are driving a massive restructuring of the way health care services are financed and delivered. Amid all the change, in the corridors of hospitals, nursing homes, and medical centers, and in the offices of individual health care professionals, managed care organizations, and insurance companies, health care professionals must continue to take actions and make decisions daily about the business aspects of their professional service. The changes in the industry, and the choices and decisions they are forcing professionals to make, however, are raising increasingly complicated and troubling ethical questions among thoughtful and responsible health care professionals.

As with all professions, society grants the practitioners and providers of health care services special status, privileges, and power because of the specialized knowledge they must have. In exchange, health care professionals are expected to assume certain responsibilities and obligations, and to live up to certain standards of behavior. This implicit, and sometimes explicit, agreement about the mutual expectations between professionals and society forms a "covenant of trust." Codes of ethics are one of the ways that this covenant is articulated. Today, the ethical questions facing health care professionals are more difficult than they have ever been because the institutional arrangements that formed the basis of the "covenant of trust" are undergoing profound change. As the institutional context changes, new dilemmas arise that were not

contemplated in the old covenant, the guidance given by earlier professional codes of ethics seems less and less adequate, and important values seem to be in jeopardy.

As recently as fifty years ago, most patients paid for health care services in this country directly, out of their own income, if they could. Although insurance pools to which patients belonged paid for some medical services, this was the exception rather than the rule. In some instances, "charity" care was provided by the health care professional without charge, or financed by religious institutions, civic organizations, or public funds. But again, this was the exception rather than the rule.

While there have always been situations in which the capacity of hospitals or clinics was insufficient to satisfy all of the demand, in earlier days, the set of tests and therapies that could in theory be used was limited in comparison with the range of possibilities available today. Expectations about what medical intervention could accomplish were also more limited; many treatments, tests, or therapies that are now considered necessary were then regarded as elective; and litigation over negative outcomes was less likely. The codes of professional ethics that governed most practicing health care professionals were designed to respond to the ethical dilemmas and temptations that arise in this kind of environment.

For example, in this largely bygone health care world, the decisions about whether to treat a particular patient, or what tests or therapies to use, or what fees the professional would be paid for those services, were regarded as private decisions between the practitioners and their patients. Many ethical problems that arose for professionals in this environment involved the potential conflict of interest between the needs and interests of the patient and the desire of the practitioner to do research or to enhance his or her income. Hence, a key issue addressed in earlier codes of ethics for physicians and other health care professionals was the requirement that health care professionals put the interests of their patients above their own interests, and care for all who need their help "with equal concern and dedication, independent of [the patient's] ability to pay." [*"A Physician's Commitment to Promoting the Patient's Good," Pellegrino, Edmund D., and Thomasma, David C., For the Patient's Good: the Restoration of Beneficence in Health Care, New York: Oxford University Press, 1988, pp. 205-206.*]

Ethics codes also called upon health care professionals to contribute their expertise to solving community problems, such as preventing the spread of disease, administering scarce health care resources in times of war or epidemic, and making health care policy. And health care professionals have always been expected to provide some services without charge to those who could not pay, and to assist in society's provision of care to the indigent. Indeed, a significant portion of health care has been provided by persons who saw their work as a religious vocation and who regarded health care as a form of ministry. Various religious bodies in this country have established hospitals and administrative systems that have seen the care of the poor as well of the members of their faith as an essential part of their mission.

In these ways, the social covenant between health care professionals and society has always required professionals to consider the interests of their patients ahead of their own personal interests. It was understood that service to individual patients would be constrained by available resources, and set in the context of the needs of the larger community, but such factors were

external to the ordinary relationship between the patient and the professional, and were not expected to be a routine source of ethical problems for professionals.

A number of developments in the technology of health care, and in the way health care is delivered and financed, have changed and continue to change the terms of the social covenant. These developments add new demands and in some cases qualify or condition old ethical requirements:

Third-party payers

The presence of "third-party payers" in the health care system is the feature of the current health care world that most significantly affects the ethical context of business decisions by health care professionals. Whether the third-party payer is the government or a private insurance provider, this system reallocates the costs of health care and spreads the financial risks so that today both the patient and the provider are shielded from the immediate cost of most patient care. In a third-party payer system, the resources expended in treatment of one patient are drawn from pools of resources that must serve many patients. Hence, the cost of a given test or treatment must be measured not only in terms of the out-of-pocket cost to the patient receiving the services (which may be trivial), but in terms of the cost in lost resources to the whole group. But when patients pay no more than a small fraction of the full cost of their treatments, it becomes easy for them to consume more health care services than they need, and for health care providers to recommend more services than their medical judgment justifies. In such an environment, it is no longer appropriate to consider the decision to spend resources for the care of an individual patient as an exclusively private decision between that patient and the practitioner.

Managed care groups

Today, fee-for-service practice is rapidly being replaced by other practice structures including managed care organizations or group practices in which the physician or other professional is compensated by a fixed-fee salary, or by a share in the revenues or "profits" of the group, or by some other arrangement. A key feature of these alternative compensation systems is that the professional is not necessarily paid more for providing more services.

These new arrangements alter the ethical landscape in several ways. For health care institutions and professionals in group practices or managed care groups, it may no longer be a private act of charity to accept a patient who cannot pay the usual fees. Physicians and other practitioners in the group are under pressures to control costs, and often are required to abide by practice guidelines and standards of treatment designed to limit the use of resources in cases where the benefits are expected to be marginal relative to costs. These rules and standards may at times be at odds with what the patient wants, and even with what the practitioner judges to be in the patient's best interest.

Finally, whereas professionals in a fee-for-service setting have a financial incentive to provide excessive services, professionals practicing in a managed care environment often face financial incentives to cut corners or reduce the services they provide. The ethical challenge for the professional is to resist both sets of pressures, to make a constant effort to provide precisely

those services that are medically appropriate, while respecting the desires of the patient and the realities of resource constraints.

Rules, records, and reporting

The effort to ensure quality care as well as to limit costs has produced a vast and complex set of rules about the information that health care professionals must collect and disclose to the government or to other third-party payers. Reimbursement rates may depend not merely on the services the practitioner actually provides, but on the nature of the illness or condition of the patient and the diagnosis. This means that information the practitioner may have recorded only for scientific or therapeutic reasons in the past may now be used to determine reimbursements, and therefore have important financial implications for both the patient and the practitioner.

Technology and costs

The rapid advance in medical technology in the last few decades has made numerous elaborate diagnostic procedures and therapies widely available. Many of these scientific advances have significantly relieved human suffering. Others make it possible to prolong life. But they have also helped to propel a rapid increase in the cost of treatment for the sick and injured. These increased costs are not distributed evenly, either across the population or over the life of any one individual. Individuals who are relatively young and healthy still make very low claims on available health resources. But the health care problems of a few individuals make enormous claims on the common resource pool. As the upper limit on possible expenditures rises, more people have felt the need to be insured against such extraordinary expenditures. But as more people have insurance against very large outlays, the more likely each one is to feel entitled to resource-intensive and often unproven technology when and if he or she has serious health problems. As a result, demand has risen even faster than resources have expanded. The problem is exacerbated by the fact that, especially in a fee-for-service environment, the physicians and other health care providers may benefit personally from using the new technologies or providing the new therapies. Finally, the existence and use by some of such new but costly procedures encourage even those without insurance to believe they have a "right" to them as well.

Aging and costs

The very success of new health care technologies has also increased the demand for health care services indirectly by making it possible for many more people to live to much greater ages. Since the elderly tend to have more health problems, the expansion of the elderly population is driving up total health care expenditures.

Needs or choices

As health care technology has expanded, and prosperity has risen, a growing number of previously untreatable human problems have been reclassified as medical problems. Health care resources are now routinely called upon to help people cure, or deal more effectively with such problems as infertility, minor "neuroses," minor allergies, or minor weight problems, to reconstruct faces or figures, or to repair minor joint injuries so that the "patient" can continue to

engage in sports activities. Thus, the expansion of what medical intervention can accomplish has led to a corresponding expansion in what many people think medical intervention should be expected to accomplish, and a corresponding expansion in interventions that many in society regard as health care "needs." This places a severe burden on those health care professionals who, by reason of their personal convictions or their religious values, view it as their ethical obligation to care for all who "need" their help, independent of ability to pay.

Marketing practices

The expansion of health care diagnostic and treatment possibilities has also opened up significant profit opportunities to health care professionals and entrepreneurs. Professionals can choose lucrative specialties, or can target niches within their specialties, such as cosmetic plastic surgery or sports medicine, which are especially profitable because many individuals are willing to pay high prices for these services, even if they are explicitly excluded from coverage by insurance policies. As a result, the health care field is increasingly being influenced by "marketing" practices, and the line between attending to the health care needs of society and selling a consumer product has increasingly been blurred.

Large health care systems

In U.S. health care, economic pressures and opportunities are driving many providers into larger organizations, both for-profit and not-for-profit, that are sharply focused on the bottom line. This can lead to greater efficiency and lower costs, but, especially if profit becomes the overriding motivation, it can also lead to reduced service, lower quality care, and little or no concern for providing uncompensated care.

"Needs" as "rights"

Even as the definition of "needs" has been expanding, a growing number of people are deciding that, as a matter of social norms, all individuals should have some sort of "right" or "entitlement" to some basic level of health care. But our political system makes it very difficult for anyone in authority to address head on any questions about what level of care constitutes an irreducible minimum human right, or even what level should constitute a civil right that citizens and legal residents in the United States would be entitled to receive. Yet, without some such discussion, there seems to be no way to set an upper limit on how much of society's resources should be spent in this way, and expenditures on the health care entitlements that have already been promised to our citizens continue to rise. The question of where the resources should come from to pay for entitlements already promised, let alone to provide some level of basic care for all, is central to resolving the issue, but it has not been adequately addressed.

Litigation

The general rise in public expectations about what medical intervention ought to be able to accomplish has also increased the sense of disappointment and resentment when bad outcomes occur. Combined with a growing sense of entitlement throughout society and the tendency to use litigation to resolve disputes, this rise in expectations has increased the threat of malpractice

lawsuits hanging over the heads of health care professionals, contributed to a resource-intensive style of practice as a form of defensive medicine, and increased the cost of insurance coverage for clinical practitioners.

Thus, the context in which health care professionals practice is changing in many ways. Many physicians, nurses, hospital executives, and other health care professionals feel that the current health care system is an ethical mine field, which former professional codes of ethics never envisioned and therefore do not adequately address. Many feel a sense of disappointment that their earlier aspiration to a life of service to others has been obscured by the economics and the politics of health care, particularly as these are manifest in large, heavily bureaucratic institutions. Many feel a strong sense of alienation from the ethical and religious roots of their professional commitments. Today as yesterday, most health care professionals believe that their primary obligation should be to care for their patients. But they are seeking clarification and guidance about what that may mean in practice. Do these new institutional and technological innovations, especially third-party payment systems, impose limits on the primary obligation of a physician or other health care provider to serve the interests of the patient? Do providers, in fact, also have obligations to third-party payers, and if so what are they? What about obligations to the institutions within which the providers function? What about obligations to society at large?

This changing context presents new conflicts and complexities, and redefines others, in making ethical decisions with regard to the business aspects of health care. Some specific issues are discussed in detail in Section III, but before addressing those issues, we turn to what the group saw as the key principles, virtues, and dispositions required of any ethical decision maker in the field of health care.

SECTION II

ETHICAL FRAMEWORK

Health care professionals have three different but interrelated sets of responsibilities.

The first and foremost responsibility of physicians, nurses, physicians' assistants, therapists, health educators, executives of health care institutions, and other health care professionals is to attend to the health needs of the individuals in the communities they serve. Members of the Woodstock group appreciate that the socially accepted notion of "needs" may change both over time and with the advancement of technology, and that each professional may have a different idea about how to define the "communities" he or she serves. But most members agreed that a community's health care "needs" include appropriate and reasonable measures to prevent serious illness or injury in the healthy, to cure or alleviate the suffering of the sick, and to comfort the dying.

The second set of responsibilities is to administer and use wisely the physical, technological, financial, and human resources available to health care professionals for use in meeting the needs of the communities they serve.

The third set of responsibilities is for continued education, research, and scientific advancement so that the quality of care available for patients, and the efficacy and efficiency with which resources are used in that care, can be improved over time.

Most health care professionals face all of these responsibilities in different forms and at various times. And many professionals feel that they have a fourth set of responsibilities as well: to educate the public as to its health care responsibilities and work toward policies that support professionals in carrying out the first three responsibilities. Although there may be lucrative financial opportunities for some health care providers in carrying out these responsibilities, the pursuit of personal wealth for the provider must always be subsidiary to these primary responsibilities.

This section presents the attitudes and principles that project participants regard as the basis for ethical decision making by health care professionals as they undertake these responsibilities.

A. Compassion and Respect for Human Dignity

Respect for human dignity is fundamental, providing a basis for compassion, honesty, integrity, and confidentiality, each of which will be discussed separately. While there are differences, often quite sharp, within our society about how to interpret and specify this fundamental value, it is strongly affirmed within the major religious and philosophical traditions of our pluralistic society. Compassion, in turn, provides the basis for the central tenet of the social covenant between health care providers and society: that health care professionals must be committed, first and foremost, to the welfare of their patients.

Individual health care providers should do whatever they can for their patients, consistent with obligations to other patients and necessary institutional and resource constraints. It is unethical for a provider to exploit the vulnerability of the patient in order to enhance his or her own income or profits.

Institutional health care providers also have a primary obligation to serve the needs of their patients, and to support individual health care professionals by providing the appropriate facilities, equipment, supplies, support staff, administrative systems, and services, subject to the constraints of limited resources. This requires that they devote attention to the structure of funding and the needs and requirements of shareholders, creditors, donors, other investors, or third-party payers, as long as those efforts support the primary goal of patient care. Finally, it is the job of executives and trustees to develop and foster institutional cultures that are devoted to care of patients.

Whatever form the health care system takes, the Woodstock group believes that the new social covenant must affirm that patient care is the primary goal and responsibility of the system. Since respect for human dignity applies to each and every human being, regardless of race, creed, political views, or age, this is a powerful ethical consideration supporting the view that access to basic health care should be made available to all. Concrete instances in which threats are currently posed to this primary obligation will be discussed later in this document.

B. Commitment to Professional Competence

Individual practitioners, as well as executives and trustees of institutional providers, have an obligation to continue their education and familiarize themselves with the requirements of "best practice" in their fields.

Poorly trained, inexperienced, or misinformed physicians or other practitioners can do harm to patients. They may also drive costs up by ordering unnecessary or inappropriate tests, by misdiagnosing conditions, or by administering inappropriate treatments. Humility, the recognition that health care practice requires lifelong learning, and openness to accountability are needed to ensure professional competence.

Executives and trustees serve patients and their health care needs by exercising competently their responsibilities for managing hospitals and other health care facilities or organizations. Their job is to foster a climate that rewards the delivery of quality care and promotes cost-reducing innovations. To do this, they must also stay abreast of such innovations at other institutions.

"Competence" also is required in the institutional design and operation of any health care system. Ethical dilemmas often arise, and their resolution is made extremely painful, because of inadequacies in the reimbursement system, in reporting requirements, or in other institutional demands. Society's covenant with health care providers requires efficient, flexible, and realistically designed systems that promote ethical practices, rather than making them more difficult.

C. Commitment to a Spirit of Service

As professionals, health care providers have responsibilities not simply to individual patients, but also to the community at large. In the absence of universal health care coverage, there inevitably will be members of the community who cannot afford, and who could not otherwise gain access to the resources necessary to cover the health care services they need. Thus, one of the important ways that health care providers must exercise their community responsibilities is by providing uncompensated or reduced-fee service to needy patients and by working for public policies that enable poor or uninsured people to receive adequate care. Managed care, group practice, and "for-profit" institutions should make provisions for proportionate amounts of uncompensated and less compensated care by the group or institution. As members of the medical profession, for-profit medical centers should be particularly mindful of the high standards required by the social covenant. Likewise, "not-for-profit" institutions should be mindful of the fact that their not-for-profit status gives them tax benefits that they have a moral obligation to use in service to the community.

Health care professionals look to public institutions and the political process to arrange for some form of universal coverage, and, short of that, to determine standards for "fair shares" of

uncompensated or reduced-fee care, to help provide the necessary resources, and to clarify the limits of such responsibilities. Otherwise, the ethical and financial burden on health care professionals becomes nearly insupportable.

D. Honesty

Health care professionals have an ethical obligation to report truthfully all relevant information about a patient's condition, appropriate treatments, and their associated costs, to the patient or designated guardian, or appropriate family member. They also have a professional obligation to keep accurate and truthful medical records, and to provide truthful and accurate information on official forms and documents required by third-party payers. These requirements for honesty apply equally to individual practitioners and to executives of health care institutions and organizations. A further obligation falls to executives of hospitals and managed care organizations to foster a culture that encourages honesty, and to avoid rules or oversight practices that may pressure practitioners into deceitful reporting.

Intellectual honesty is essential for professional competence. Health care professionals should know what they know, and what they do not know. They should acknowledge their doubts, and seek second and third opinions from their colleagues when they are unsure of a diagnosis or proposed path of treatment. Executives of health care institutions must likewise be honest with themselves and others about the competing interests they serve. They should be open to new ideas, and should manage their organizations in such a way that they would not be embarrassed to open their books to anyone.

The health care system should not undermine the integrity and honesty of individual practitioners by introducing constraints or imposing reporting requirements that compromise the practitioner's professional judgment.

E. Confidentiality

Physicians, nurses, and other health care professionals should not divulge the intimate details of a patient's illness or condition without permission, except as required by law. Exceptions should be considered only for the most extreme justifying reasons, as, for instance, the threat of serious harm to the patient or to other individuals at risk by exposure to the patient. Decisions in such cases should be subjected to intense ethical scrutiny. Third-party payers should request only the information they need, and should tightly restrict the use of personal information about individual patients. Patients coming into the system for any reason should be alerted as to what information is recorded, how it is used, who will have access to that information, and what these rules may mean to the patient.

F. Good Stewardship and Careful Administration

Although health care professionals have a primary obligation in any given situation to work for the best interests of their patients, they must also be mindful of their responsibilities as stewards of the common resources used to care for all of the patients in the communities each professional serves. Good stewardship requires, then, that professionals think carefully about the relative

costs and benefits of alternative therapies and courses of treatment for their patients, counsel their patients about the costs and benefits, and, if necessary, work with third-party payers to encourage the use of treatments and therapies that are the most cost-effective.

Good stewardship also requires that individual health care professionals keep detailed and accurate records. They should also, where appropriate, assist public health authorities in collecting information about the spread of disease or the effectiveness of new therapies, and should provide information to executives of the health care system to help improve the functioning of the system.

Executives of health care institutions are responsible for a wide range of administrative and financial accounting, providing useful information about services, costs, and patient outcomes to physicians, patients, third-party payers, and government regulators. Such information is necessary for billing, for quality assurance programs, for negotiations with third-party payers over prices, and for external-relations activities such as advertising or fund-raising.

It is an obligation of society at large, however, to ensure that the health care system does not impose an undue burden of complex, arbitrary, and capricious record-keeping and reporting requirements on health care professionals.

SECTION III

PERSONAL DECISIONS IN INDIVIDUAL CASES

In this section, we consider five broadly defined types of dilemmas that are representative of those that health care providers face very frequently in the current health care system.

The Woodstock group, using the principles listed in the section above, did not achieve unanimity in every instance, but was generally able to reach consensus about ways these dilemmas should be resolved. That agreement is what is reported below. We hope our struggle with the issues provides guidance for other health care professionals who face similar questions, sometimes on a daily basis.

A. When Resources Are Inadequate to Meet All Needs

There are at least two ways in which this dilemma arises for health care professionals. The first is a short-term crisis situation. The second results from a continuing resource constraint on the capacity of a given practice or institution to provide uncompensated or undercompensated care.

1. Short-term Crises

Short-term crises in which resources are inadequate to meet all needs occur, for instance, in time of war or natural disaster. They also occur in the U.S. today, most often in the emergency departments of inner-city hospitals when several critically sick or injured patients arrive simultaneously and lifesaving resources are not immediately available to serve all of them.

The group was able to agree on the following guidelines for resolving dilemmas of this short-term crisis type:

1. Resources should be allocated according to the most medically urgent needs. No one who is critically ill should be refused acute care, stabilization treatment, or at least palliative treatment, if it is in any way possible to respond to his or her needs.
2. In unusually strained conditions, health care providers may use "triage" criteria for allocating resources, taking into account the likelihood of recovery for individual patients, and giving priority to those patients for whom immediate attention is most likely to be lifesaving. [In a triage approach to setting priorities, patients are assigned to three categories: those who require treatment to live; those who will most probably live even if untreated, and those who will probably die even with treatment.]
3. Demographic factors such as race, gender, or economic status (if known) should not be a factor in the treatment decision.
4. A patient's age alone should not be a factor in choosing whom to treat or what treatment to provide, except to the extent that health conditions associated with age affect the expected outcome.
5. Ability to pay should never be considered in determining who should receive emergency treatments.
6. If all other factors are equal (or in situations where it is not feasible to make more precise determinations), resources should be allocated on a first-come, first-served basis.

2. Constraints on Capacity to Provide Uncompensated or Undercompensated Care

Even outside an emergency or crisis situation, there are numerous occasions when patients would greatly benefit from treatments whose costs exceed their ability to pay. The Woodstock group was unanimous in its belief that the dignity and worth of all individuals and the sanctity of human life impose an obligation on society to provide a basic level of health care treatment to all. We also believe that the obligation is greater in a prosperous society such as the United States. The question then comes down to how health care providers can satisfy these obligations in the absence of universal health care coverage.

The Woodstock group starts its consideration of this question from a firm agreement on, and commitment to, this basic principle: All health care professionals and institutions have an obligation to provide some uncompensated or "undercompensated" care (services for which the professional and the institution are not paid enough to cover their full costs). And all have an obligation to attempt to determine their "fair share" of such care. A decision to avoid any share in this burden constitutes a failure to carry on a tradition of community service and personal compassion which is one of the basic moral responsibilities of the health care profession. Beyond that, we agreed to the following ancillary principles:

1. Individual providers can meet this obligation by donating a certain percentage of their time to work in free or reduced-fee clinics, or by persuading their group practice or managed care group to make a commitment to accepting non-paying or reduced-fee patients as some minimum percentage of the total services provided by the group. Just as lawyers are expected to provide pro bono legal services, health care professionals should make a principled effort to determine their fair share of uncompensated service in light of the needs of the communities they serve and the other resources available to meet those needs.

2. Institutional providers should also provide uncompensated or undercompensated care to needy individuals at least to the extent that these institutions have resources provided by civic or religious groups, or by government, to pay the costs of doing so. For not-for-profit institutions, the calculation of available resources should include, but not be limited to, the implied tax benefits available to such institutions. Part of the job of the executives and trustees of health care institutions is to try to assemble the resources necessary to support this activity including not just monetary contributions, but also the services of professionals or aides who volunteer their time.

3. Individual and institutional health care providers should develop mission statements that commit them to their fair share of uncompensated or undercompensated service to the community. These mission statements can guide decisions about whether to accept particular non-paying patients in specific cases. Executives and trustees of institutional providers should be willing to subject these self-developed mission statements and guidelines to public scrutiny.

4. Charges to full-paying patients have traditionally helped to cover some of the costs of those unable to pay. While this practice also raises fairness questions, in the absence of some form of universal health care coverage, members of the group believe it to be an ethically defensible practice, as long as the extra income from paying patients is committed to providing services to individuals who cannot pay.

5. However, as third-party payers and managed care organizations increasingly use their market power to negotiate favorable terms with hospitals and other providers, it will become increasingly difficult for institutions that provide uncompensated or undercompensated care to cover those costs by charging higher rates to paying patients. Therefore, it is incumbent upon members of the medical community to join other citizens in promoting system-wide reform that will move the health care system in this country toward a more adequate means of meeting this obligation. Even if some form of universal coverage is adopted, the problem and the ethical dilemma of undercompensated care will probably not be eliminated. Therefore, the responsibility for developing clear ethical guidelines for individual decisions and for developing a shared sense of responsibility with other institutions within one's geographic area, will be a continuing one.

B. When Providers Own or Profit from Patient Utilization of Specific Resources

In recent years, a number of physicians and other health care professionals have invested in testing facilities, clinics, or companies that provide specialized medical services and then, occasionally or even frequently, refer their own patients to these services. The ethical issues raised by such practices were among the most controversial issues discussed by the Woodstock group. After much debate, the group decided that to properly evaluate the ethical considerations

of such practices it is necessary to distinguish two different business contexts: the fee-for-service context in which the physician or other professional earns separate fees for each service or cluster of services provided to the patient; and the managed care, prepaid, or "capitated" environment, in which the professional, or the HMO or group in which the professional practices earns a fixed fee for providing care for a given patient, regardless of the services provided.

1. In the Fee-for-Service Context

Within the fee-for-service context, it is necessary to distinguish between services that are integral to the practice of the physician or professional, and ancillary services that are outside the ordinary practice of the physician or professional, but to which the professional may frequently, or occasionally, refer a patient. (If the service is so remote from the practice of the professional that he or she will never have occasion to refer a patient to that service, then there is little potential for conflict of interest, and there would not normally be any ethical problems in a decision by the professional to invest in the service.)

a. Out-of-office ancillary services

Where the patient or third-party payers pay a separate fee for each service provided, the practice by physicians and other professionals of investing in ancillary clinics, testing facilities, or companies that provide specialized services sets up a conflict of interest that seriously compromises the objectivity of the professional in referring patients to those services. Because trust is so important in the practice of medicine, even the appearance of a conflict of interest is corrosive and must be avoided.

The crux of the dilemma is that the health care professional can generate investment income for himself or herself by referring patients to the ancillary service. This conflict of interest inherently compromises the objectivity of professional judgment, which must be primary. Thus, referral of patients to facilities in which the referring health care professional has an investment interest is almost always ethically inappropriate. The Woodstock group believes that a health care professional's sources of investment income should not be so intimately related to his or her professional practice and primary source of income. The inherent conflict of interest in such cases is severe enough that Medicare laws prohibit referral by a physician for clinical laboratory services and many other health services if the referring physician has a financial relationship with the firm providing the service.

Nonetheless, there may be extraordinary circumstances where it would not violate ethical principles for a physician or health care professional to invest in the establishment of some ancillary clinic or service. For example, there may be some rural environments where financing for such a facility or service would otherwise be unavailable unless the professionals in the community invest out of their own resources. Professionals who make such investments, however, might have to live with the fact that they will not be reimbursed by Medicare if they refer their patients to those services. And they would have an absolute ethical obligation to disclose their special interest to their patients, and to the third-party payers. Finally, they should divest themselves of such financial interests as soon as other investors can be identified to replace them.

b. In-office services that are integral to the professional's practice

The above arguments apply to all services that are outside the ordinary practice of the professional. Services that are an integral part of the practice of the professional, which the professional directly supervises, or in which the professional otherwise clinically participates, may be considered an extension of the practice of the professional, and do not necessarily raise the ethical problems of self-referral. But even these services raise concerns about the tendency of the professional in the fee-for-service environment to overutilize services. As with all services provided by health care professionals, each professional has an ethical obligation to recognize that resources appropriated in the care of one patient are generally drawn from some common pool, and therefore diminish, to some extent, the resources available to treat other patients. Thus, professionals need to be mindful of the relative costs and benefits of all the services they provide, and should develop the habit of practicing cost-effective medicine.

2. In the Prepaid or Capitated Payment Context

Where the ancillary services are not billed separately but are included in the fixed charge to the patient, the Woodstock group found little reason to believe that conflict of interest would be a problem for a physician or other professional in referring the patient to those other services, even though the professional may have an investment interest in those services. Indeed, because such referrals may result in extra costs, but no extra income to the managed care group, ethical problems are more likely to arise because financial considerations push the professional in the other direction, toward failing to refer patients to other available services. Physicians and other health care professionals working in such a system are obligated to provide, or advise their patients of the availability within the group of all services that, in the unbiased judgment of the professional, are medically appropriate. Physicians and other professionals must not permit their judgment about medical appropriateness to be influenced by the possibility of personal financial gain or loss, however. In the next section, we address other ethical issues that may arise in such a context.

C. When Rules and Regulations Conflict with Professional Judgment

Instances are arising ever more frequently in which a physician's or other health care provider's proposed plan of treatment or therapy is denied funding by an insurance carrier or other third-party payer. Two common areas of disagreement, for example, are the length of hospital stays and referrals to specialists. Many third-party payers are attempting to control costs by limiting reimbursements for hospital stays to the number of days needed by an "average" patient with a particular condition. Third-party payers may also agree to pay for treatment by a specialist only if the referral to the specialist was approved in advance, and the specialist was drawn from an approved list. Such rules are intended to limit expenses and distribute limited funds more equitably and efficiently across the entire population that is insured by a given plan. The conflict, then, is between a health care professional's best judgment for a particular patient and the economic constraints imposed by the payer.

When faced with such situations, we suggest the following guidelines:

1. The health care professional should not falsify requests or reports in order to carry out a preferred plan of treatment for a patient.
2. In the face of financial constraints, it is now professionally and ethically incumbent upon health care providers to be knowledgeable about various alternative ways of arranging services to respond to the total health care needs of patients. Physicians, especially, should recognize the expertise of other health professionals, and the health benefits that can result from their involvement in patient care, and they should be prepared to refer patients to them when appropriate.
3. The referring physician must be sufficiently informed about the competence and qualifications of these alternative health care providers to have confidence that the alternative provider can competently attend to the needs of the patient. Executives of managed care organizations that impose limits on referrals must help provide physicians with the information they need to make these judgments.
4. If a third party refuses funding for a course of treatment deemed by the provider to be indispensable for the health or survival of a patient, it is ethically proper for the health care provider to express strong disagreement, carry out the treatment, and strive to justify this decision after the event in order to secure funding. Failing successful resolution, the health care provider or the health care institution may have to absorb the cost, if it is entirely beyond the means of the patient. If this becomes a frequent or recurrent pattern, then, in the interest of patients, a health care professional and/or institution has an obligation to try to reform the system to rectify the offending resource constraint guidelines.

D. When Truthfulness May Be in Conflict with Patient Confidentiality

Cases arise wherein reporting requirements of health care management, insurance, or reimbursement systems may harm the patient or come in conflict with a patient's right to or desire for confidentiality. One example that members of our group had actually confronted was of an adolescent admitted to a hospital emergency room for a drug overdose. The attending physician faced the following dilemma: the patient threatened suicide if the provider told his parents or reported the incident accurately to the insurance company, the effect of which would be that the young person's family would find out; but if the admitting condition were not reported, the hospital and attending physicians would not be compensated.

Members of the group agreed to the following ethical guidelines in such situations:

1. The health care professional should never give false information on insurance or medical reports in order to safeguard confidentiality for the patient. If a patient has a special, and legitimate, need for confidentiality, the professional may advise the patient of alternative ways to get help (perhaps at the patient's own risk or expense). A patient who does not want the records of his or her current health care plan to reflect that he or she has sought psychiatric counselling,

for example, should be advised that it is possible to seek counselling outside the plan, as long as he or she can find alternative means to pay for it.

2. Providers should not allow themselves to be manipulated by unethical patients into withholding or modifying the accuracy of information.

3. Providers should weigh whether a patient would actually be well served by withholding information from parents, spouse, or other parties, and, if appropriate, convey these conclusions to the patient. Such information should not be divulged, however, without the consent of the patient, except in those situations (such as a homicidal patient) where the health or safety of the family member or other party may be threatened if the information is withheld.

4. If added stress on a patient could have seriously destabilizing physical or emotional effects, the attending physician or other health care professional would be ethically justified in delaying filing a full report with the third-party payer until the patient's emotional condition has stabilized.

5. Physicians, nurses, and other health care professionals should exercise their influence to see that health care management, insurance, and reimbursement systems change or eliminate regulations that compromise patient confidentiality, and work to maintain the confidentiality of records that must be passed on to other organizations.

E. When Patients' Own Behavior Contributes Significantly to Their Problems

An ethical dilemma arises for a health care professional when a patient's own behavior contributes significantly to illness or injury. Is it fair to other patients and to the community one serves to authorize repeated or intensive use of society's scarce resources to respond to or counteract individual choices that are destructive or imprudent?

Smoking, for example, is known to contribute to the probability of lung and heart disease, riding a motorcycle without a helmet contributes to the severity of injuries in the case of accident, and driving while intoxicated increases the probability of serious injury. Likewise, patients who neglect to take their medications, or refuse to follow dietary restrictions, may require repeated treatment when their symptoms recur or when their illnesses fail to improve.

We subscribe to the following guidelines for health care providers confronted with treating patients who exhibit such behavior:

1. When a patient is in urgent need, physicians or other providers must address that short-term need regardless of their suspicions about the proximate or contributing causes of the patient's condition, subject only to the resource constraints dealt with above (see Section III A).

2. Only in very rare instances would a health care professional be ethically justified in temporarily withholding resources or delaying treatment of such a person. One such instance might be when resources are especially constrained and immediate allocation decisions must be made between two or more patients. In that instance, resources may be applied to the needs of others whose conditions might be similar but who are judged to have more promising prognoses because their expected behaviors are less likely to undermine their recoveries. In such a case, the

moral basis for the decision to withhold treatment of the patient with the behavior problem is not a moral judgment about that patient's motives or behavior, but it is an application of the triage considerations discussed above.

3. Having said that, respect for human dignity and responsibility for treating the whole person require that the health care professional address the patient's self-destructive and socially destructive behaviors.

4. Health care providers will from time to time encounter patients who are abused by their families or care givers, or who are emotionally unstable, or mentally incompetent, or otherwise unable to choose consistently to behave in healthy ways. Faced with treating such people for acute care problems, physicians or other practitioners should view it as part of their professional responsibility to become knowledgeable about and to call on resources of social and mental health services when these services can address the behavioral and environmental issues that influence the patient's health. In most states and communities, health care professionals already have legal responsibilities to report suspected incidents of abuse to social service authorities. These requirements always apply to treatment of minors and are being expanded to include elderly persons as well.

F. Where New Technologies Are Emerging Rapidly

The pace of technological advance in health care is now such that there are always new procedures and therapies available, and new applications of old technologies that show promise in the treatment of some illnesses and conditions, but that have not yet been sufficiently proven to be regarded as standard medical practice. The ethical issues in any decision by a physician or other professional to recommend or administer such procedures or therapies involve at least two different principles discussed in Section II. These are the professional competence and the careful stewardship of resources. Each will be discussed separately below.

1. New Technologies and Competence

Physicians and other health care providers may benefit financially and in terms of their reputations among their colleagues by being at the forefront of developments in medical technology in their practices. But new developments are not necessarily better medicine. Competence and commitment to the welfare of the patient require not just technical proficiency, but attention to cost-effectiveness, and to the total impact of the treatment plan on the patient. For example, some high-tech services may so reduce the quality of life for patients that they would be equally well-served, or even better-served, by less intrusive, less technology-intensive kinds of therapies even though the latter may provide a smaller chance of full recovery. It is the ethical obligation of the physician or other professional to weigh carefully, in consultation with the patient, the cost-effectiveness of elaborate, highly intrusive, or new and unproven therapies, where costs include the risks to the patient and the impact of the treatment on the quality of life, as well as the cost in dollars.

2. New Technologies and Stewardship

Third-party payers obviously have an interest in seeing that health care resources are used in cost-effective ways and that reimbursements cover proven, efficacious therapies rather than treatments that are experimental or unproven. On the other hand, especially where there are no known therapies that are proven and efficacious, resources must be made available to support testing of experimental treatments even while they are still under development. (See recommendations in section H of Appendix.) Emerging technologies should be subjected to rigorous scientific assessment before being made widely available to patients. In the meantime, physicians and other health care professionals must be attentive to the cost-effectiveness of new technologies. They should also participate in clinical trials where appropriate, carefully record and share information with proper authorities about the effects and side effects of the use of new therapies, and caution patients against expecting or demanding unproven treatments.

SECTION IV CHECK POINTS

In view of the foregoing description and analysis, we provide here a checklist of questions that individual health care professionals can and should ask themselves as they confront the daily temptations and dilemmas of their practice and attempt to respond in a manner consistent with the highest ethical standards of their profession.

A. When deciding whom to treat, and how to allocate scarce resources in short-term crisis situations:

1. Is there any way that I (or my institution) can respond to the needs of all the patients who have presented themselves, even if only temporarily or provisionally, by reallocating resources under my control?
2. Can I (or my institution) alleviate the crisis by calling on support resources outside of my institution?
3. If compelled to choose among urgent cases, am I (and my institution) setting priorities on the basis of disinterested professional judgment, according to medical need and the possibility of medical benefit, and without regard to such factors as the race, gender, lifestyle, economic status, or age of the patients, except insofar as such factors are medically relevant?
4. Is my (or my institution's) decision making about urgent medical care biased by concerns about the patient's ability to pay for services?

B. When drawing up a mission statement or otherwise determining my private commitment or institutional commitment to providing uncompensated or undercompensated care:

1. Have I (or my institution) situated my practice, both geographically and in terms of the kinds of services I provide, so that it is open and accessible to needy individuals as well as to the wealthy and the fully insured? If so, do I make sure that all individuals who come to my office or clinic for testing or services feel welcome and are treated with respect?

2. Have I made a sincere effort to determine the needs and resources in my community and arrive at a principled estimate of my fair share of uncompensated or undercompensated care? Have I committed myself (and my institution) to at least this level of service to the needy?

3. Have I, in determining my own commitment to service, identified a special set of needs in my community (such as prenatal care for poor mothers) that I can serve with my special skills? If so, have I devised a strategy for outreach, so that individuals who need my services know they are available?

4. If my institution or practice has targeted a wealthy or fully insured clientele, have I made arrangements to provide my fair share of services to needy individuals through a commitment of volunteer time to free or reduced-fee clinics?

C. When the needs of my patients or my community exceed my capacity to provide uncompensated or undercompensated care:

1. Have I made an effort to solicit resources from others in my community to support additional uncompensated care?

2. Have I advised my patients about my limits and helped to direct them to other resources?

3. Have I set priorities among the patients who come to me in ways that are consistent with my mission statement and based on medical need and potential benefit, without regard to such factors as race, gender, lifestyle, economic status, or age, except where such factors are medically relevant?

4. When I accept a patient knowing that he or she will not be able to pay, will I be bearing the cost of treating that patient personally? If not, is accepting this patient consistent with the previously agreed upon terms of the commitment and mission statement of my institution or group practice? If, by my agreement to accept this patient, costs will be imposed upon others who have not previously agreed to support such work, have I notified them of what I am doing, solicited their support, or agreed to compensate them so that I am not thereby appropriating resources unilaterally and without consultation?

5. Have I used whatever influence I have to work toward institutional reform so that all individuals will have access to adequate health care services?

D. When confronted with opportunities to invest in testing services or ancillary medical services:

1. Given the strong presumption against the ethical appropriateness of such investments, is there any reason why I can't simply rule them out? Is there any compelling reason why I should look any further into this particular opportunity?

2. If there is such a reason, can I say in good faith that such an investment is compatible with my primary obligation to my patients, and with my duties as a citizen who has unique powers to affect and control a fundamentally important and limited resource?

3. If I determine that the availability of such services is indeed important for the health of my patients and my community, have I made an exhaustive effort to find investors other than myself and other health care professionals to finance the facilities or services, so that I can maintain an appropriate arms-length posture in future dealings with the firm that provides the services?

E. If, after careful consideration of the questions in D above, I decide to invest in ancillary testing facilities, or medical service companies, then, in future dealings with the firm that operates these facilities:

1. Can I say, in good faith, that the tests, procedures, and consultations I order to be provided by this firm are only those that are medically necessary and that will contribute significantly to my ability to provide quality health care to my patients?

2. Am I absolutely scrupulous about informing my patients and all third-party payers in a timely manner of my financial interest in the testing or service firm?

3. Can I assure my patients and all third-party payers that the services available from the firm in which I have invested are not readily and conveniently available from other firms serving the same geographic area, and that they are comparable in price and comparable or superior in quality to services available in other geographic areas? Have I provided my patients and all third-party payers with independently audited comparative pricing and performance information to this effect?

F. In administering resources and serving my patients in a cost-conscious way:

1. Have I made every reasonable effort to be aware of the latest scientific understanding about the benefits of various testing and treatment paths for my patients in general? And for the health problem for which this specific patient is seeking my counsel?

2. Am I ordering only those tests, procedures, or consultations that are, in my best judgment, medically indicated, in the belief that they will contribute to my patient's health in some significant way?

3. Have I counseled my patients about the costs and benefits of various paths of treatment? If I am in a position to do so, have I helped to disseminate information to the public about such costs and benefits? Have I recommended the least-cost path wherever it is equally efficacious or at least consistent with good care for my patient?

4. Have I exercised caution in advising my patients about the use of new, or marginally beneficial therapies, or technology-intensive therapies? Have I been careful to give my patients all the reasons for hope that are medically appropriate without unduly raising their expectations and encouraging them to demand costly, but unproven, treatments?

G. Whenever the rules and regulations of third-party payers conflict with my professional judgment:

1. Have I provided the third-party payers with appropriate and relevant information about my patient's presenting conditions, actual services I have performed for my patient, my recommended treatment path, and the patient's progress?

2. Have I made a good faith effort to understand the spirit and purpose of the rules or regulations, so that I can seek a compromise that responds to my patient's needs and to the legitimate interest the third-party payer has in cost control?

3. Do I believe my preferred test or treatment or referral is important enough to the health of the patient that I would recommend it to the patient on the terms that the patient were paying for it out of his or her own resources? Do I think it is important enough that I would be willing to provide it on a pro bono basis?

4. Have I informed my patient about the conflict, and about the various treatment options available, and invited the patient to participate in a resolution?

5. If the conflicts are general and chronic, am I making every effort to get the rules and regulations changed?

H. In the course of ordinary record-keeping and billing:

1. Am I careful to record fully all the relevant medical information in my patients' medical records?

2. In billing third-party payers, am I scrupulously honest about reporting services that I actually perform?

I. When truthfulness conflicts with patient confidentiality:

1. To the extent that it is possible to do so under our health care reimbursement systems, do I maintain the confidentiality of my patients' records by following appropriate procedures and instituting them in my office?

2. When called upon by third-party payers, public health authorities, or others with a legitimate interest in the content of medical records under my care to divulge confidential patient information, do I carefully consider the legitimacy of the specific request, and make available only the information that is essential to satisfy the needs of the requester?

3. When called upon by a patient to withhold information from third-party payers, spouses, family members, employers, or others who may have a legitimate interest in that information, do I counsel the patient about the urgency and appropriateness of informing others who may be affected by the information? Do I avoid giving false information to third-party payers? Do I override my patients' legitimate interests in privacy only when urgent public health and safety concerns are at stake?

J. When patients' behavior contributes significantly to their problems:

1. Do my personal views on my patients' behavior lead me to withhold from them care that is medically required or to deny them attention and respect?

2. Am I treating my patients with respect while counselling them on the destructive nature of their behaviors and helping them find ways to change those behaviors?

K. Whenever I am troubled by decisions or actions I am taking:

1. If, after careful reflection, I am uncertain about whether a specific action is ethical, have I consulted with a respected colleague or other appropriate professional?

2. If I am repeatedly troubled by a specific regulation, procedural requirement, expectation, or practice that colleagues seem to have accepted as appropriate, have I sought ways to challenge the practice, to substitute a more ethically acceptable procedure or practice, or at least to bring the issue up for debate and discussion?

SECTION V CONCLUSION

The group that participated in this project argued vigorously over some of the positions taken in this document, as well as over the precise language in which those and other positions were expressed. The resulting document is not perfect, nor does it resolve all of the issues in unambiguous ways. Rather, our results are more modest. We acknowledge that certain ethical dilemmas will always exist in the field of health care as it relates to business practices. And we suggest that, regardless of the systemic reforms that are made, health care professionals must acquire or develop their own maps, compasses, and other tools to help them find their own path through the ethical mazes they will confront.

Some of these tools and guides health care professionals will be able to find through their previous education in the humanities and the social sciences; some they will find through reflection on the religious and professional traditions that have seen health care as much more than a business enterprise providing a consumer service; some they will find by deepening their sense of the ultimate meaning of what they do and by renewing their own commitment to the ideals and goals that first drew them into the work of health care.

This document is intended to provide one such tool. We hope that other health care professionals can benefit from our struggle to develop this tool. Finally, in the following appendix, we ask that those who are instituting changes or reforms in the system be sensitive to the ways in which institutional design can exacerbate certain dilemmas.

APPENDIX

A REQUEST FOR INSTITUTIONAL ARRANGEMENTS THAT SUPPORT ETHICAL BEHAVIOR

The choices and decisions of health care providers are inevitably shaped by the institutional and cultural context in which the providers operate. Institutional arrangements embody certain cultural messages about what constitutes appropriate behavior. Policies and customs can help to clarify responsibilities and support ethical decision making, or they can exacerbate conflicts of interest, create incentives for unethical choices, and undermine accountability. Because ethical decision making is so important to healthy human relationships, institutional arrangements that send contradictory messages about what is appropriate, or that undermine or discourage ethical decision making, are socially destructive.

We believe that one of the responsibilities of health care providers is to use their influence, in collaboration with others, to create a health care system and institutions within that system that will minimize unnecessary ethical conflicts of interest and clarify priorities. Thus, we offer these observations about the ways that institutional and systemic reforms can clarify the social covenant, and help create a climate that fosters rather than frustrates ethical decision making. This is particularly important in an area of human life that touches on so many matters that are of intimate personal concern and of profound religious meaning.

A. Decent Minimum Care for All

Belief in the fundamental dignity and worth of each individual leads members of our group to a conviction that a civilized society has an obligation to provide compassionate, humane care to every one of its members if they are injured or sick. To ensure that such care is available to all, sufficient financial and social resources must be made available.

Too often, the existing health care system in the United States produces erratic and highly arbitrary outcomes, with some individuals unable to get basic care, while others expend enormous resources on therapies of marginal or questionable benefit. This places a huge ethical burden on some members of the health care profession, such as emergency room physicians and executives of inner-city hospitals, to determine who will get access to certain resources. And it induces some professionals to evade any direct confrontation with such tough decisions by locating their practices in settings where they are likely to encounter only patients who have the means to pay for their services.

The members of our group believe that health care professionals have a responsibility to participate in decisions about allocating available resources. But it is the responsibility of society

as a whole, including both citizens and professionals working through public debate and the political process, and not of individual health care professionals alone, to determine what the minimum standards of care should be, and, importantly, to seek to provide financial support to be sure that those standards can be met. To date, our society has not yet solved this problem, and as a result, many decisions about how much care is to be provided to whom are being made in an ad hoc way, adding significantly to the ethical burden borne by health care providers.

We ask, therefore, that public officials and leaders of the health care field confront this issue directly. Medical professionals, health care consumers, taxpayers and other third-party payers, and policymakers, should all join in a national conversation about this issue. Political and professional debates should attempt to determine policies that will provide a decent minimum of care for all, that will emphasize primary and preventive health services, that will be responsive to the needs and choices of patients, and that will use resources in ways that will be both fair and efficient. Once decisions are reached, society must make available the resources necessary to achieve the distribution of health care services that it has chosen to provide.

B. Restraint and Equitable Allocation of Finite Resources

In asking for definition of, and provision for, a basic minimum level of health care, we acknowledge that there are limits to our nation's capacity to provide resources for health care. Therefore, we agree that it is legitimate and appropriate for society to impose some standards, limits, and rules about how resources are to be used. Otherwise, we will have an unfair and morally objectionable distribution of services that will be detrimental to the common good and the population as a whole.

C. Design of Health Care Financing Systems

Participants in the policy debate should understand that any scheme for financing health care that fails to provide some form of universal coverage has the effect of forcing onto health care providers, in one way or another, the difficult decisions about who should get what level of care under what circumstances. Moreover, all third-party payment schemes are subject to certain distortions in the incentives of both health care providers and their patients. These distorting incentives were discussed in Section I under "Third-party payers," and "Managed care groups."

No system can completely eliminate all of these dilemmas. But the Woodstock group asks that health care entrepreneurs who are creating new payment and delivery systems for health care, as well as participants in the policy debates about health care reform, be mindful of the ethical dilemmas they may create as they choose one system or another. An ethically defensible system will acknowledge the dilemmas, will encourage focus on the interests of the patients and will attempt to provide guidance to the professionals about what is expected of them. It will also build in safeguards to protect ethical behavior, and sanctions against unethical behavior, even when ethical behavior may work against the financial interest of the institution within which the professional works.

D. Information about Budget Constraints

The government should work with insurance companies and providers to develop information about the social costs and benefits of various therapies and treatments. Such information would help health care professionals understand the social costs of selected paths of treatment and counsel patients about these costs and expected marginal benefits of various treatments. If health care professionals must practice within an overall budget constraint, they should be kept informed of the total budget, and the status of expenditures within the budget, and should be allowed to participate in decisions about reallocating resources within the budget. Together with the patients, then, health care professionals will be better able to choose treatment paths that keep costs as low as possible, consistent with good care for the patients.

E. Information about Peer Performance

Physicians and other providers who must occasionally refer their patients to other physicians or specialists, especially if their work arrangement requires them to choose providers from within a limited group, must have the necessary information to make a judgment about the competence of the various providers from whom they must choose. Therefore, we recommend that government agencies, insurance companies, and provider associations work together to develop appropriate performance measures. Information about how individual providers rank in terms of these measures should be available to physicians and other providers who must make referrals.

Schools of the health professions should teach physicians and other providers how to conduct peer review and how to interpret various performance measures.

F. Coping with Demands of Multiple Roles

Providers must often play multiple roles and express multiple loyalties in the same situation, such as patient advocate and gatekeeper to health care resources. These different roles can create ethical conflicts. Therefore, we ask that health care delivery systems be constructed in such a way as to reduce the occasions when providers must play conflicting roles, and to clarify to the extent possible which roles should dominate in which situations. Patients have a right to know if a physician is playing a gatekeeper role. Whenever a physician or other health care professional must play such a role, patients should be fully informed about the implications of that dual role for the physician's decision-making process and degree of discretion. If possible, patients should have the option to choose an alternative mode of care or insurance system in which the physician is not required to play that role.

Education of all health care providers should include instruction in the values and requirements of the multiple roles that health care providers must play. Providers should be made aware of the potential for ethical conflicts and be trained to address them. They should make it clear to all parties concerned the patients, the institutions they represent, and themselves that, at least with respect to certain decisions, they are playing multiple roles and have multiple loyalties.

G. Validating Roles for a Wider Variety of Providers

Some of the difficult policy goals broader coverage, wider availability of basic health care, and greater cost-effectiveness could be more readily achieved if a wider range of health care

practitioners were utilized better. Specialized providers, such as midwives, advanced practice nurses, or physical therapists can and should play important roles in providing basic health care services. The high level of training required to become a physician in this country is not necessary for providing many necessary and basic health care services. While such services should be provided only under the direction of fully licensed practitioners, there may be many unnecessary institutional barriers such as rules about reimbursement, state professional practice acts, and outdated prejudices and gender discrimination, that are contributing to underutilization and unnecessarily low status of health care providers who are not physicians. It is important, therefore, that such potential institutional barriers and prejudices be examined to determine if system-wide reforms are called for.

H. Adequate Funding for Research

As the current system of delivering and financing health care is transformed, policymakers should make certain that adequate provision is made for the support and funding of research and teaching institutions, as well as for technology assessments, clinical trials, and especially, "outcomes" research conducted in the field. Outcomes research assesses the link between medical care and outcomes in the context of the everyday practice of medicine rather than under controlled conditions. It can also be used to provide information about which providers or systems of health care deliver a better quality of health care than others. Outcomes research will be a centrally important instrument for assessing changes in the health care system, whether these are initiated by the government or by private institutions. The long-term investment needed to sustain the great work of fundamental medical and biological research and to improve the quality of medicine both in our country and in the world at large should not be diminished. It should, however, be carefully assessed in ways that respect its character as free and disciplined inquiry.

I. Attention to the Needs of "Whole Persons"

HMO's, and other managed care groups should make sure that every patient who enters the system has a primary care physician, nurse practitioner, or physician's assistant who provides each patient with a human contact, someone whose responsibility it is to see that care for that patient is integrated, and to serve as that patient's special advocate within the system.

Schools of the health professions should stress the therapeutic importance of a focus on patients as whole persons and accordingly include some sensitivity training as well as training in communications skills for physicians, nurses, and other providers. The training of physicians and other practitioners should also teach them how to engage patients and/or their guardians in discussions about their prognosis, and their expectations and values regarding their quality of life. Such discussions could then assist the practitioners in making responsible decisions about highly intrusive therapies or "heroic" measures to extend life.