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Incentives to physicians: Wise policy or risky temptation?

Expert: Managed care tool encourages cost savings but can impede care

With the advent of managed health care came the need for managed care organizations (MCOs) to develop ways to convince physicians of the need to cut unnecessary medical costs. The resulting growth of incentives to physicians — both real and perceived — brought on debate that has yet to abate among health care professionals, legislators, and the public.

At the heart of the issue is what has always been patients' and physicians' complaint about managed care — who really determines the course of health care?

In a recent Massachusetts case, a jury awarded \$1 million to the family of a 46-year-old man after finding that the man's doctor had been negligent in failing to order tests or prescribe medications for the man's stomach pains during several years of treatment, which ended with the man's death from gastric cancer.

The attorney for the patient's family, Max Borten, MD, JD, said in a press release after the verdict that records uncovered during the progression of the lawsuit showed the physician was paid bonuses by the patient's health maintenance organization (HMO) to keep costs down and was motivated by those bonuses to not order tests Borten says could have resulted in the patient being diagnosed much sooner.

Although the Massachusetts case arose from a death in 1999, the issue of how much influence HMO incentives have over patient care has not changed in the ensuing years.

"I published an article in the *Journal of Law and Medicine* on this in 1996, and hardly anything about it has changed since then," says **Stephen R. Latham**, JD, PhD, director, Center for Health Law & Policy, at Quinnipiac University School of Law in Hamden, CT.

"There aren't any regulations out there about limiting incentives, but while managed care organizations in general are still using bonus and incentive schemes, they don't use the harsh kinds they used in the 1980s," he points out.

Latham says incentives are a tool that encourages cost control

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while giving physicians what they most want — autonomy over their patients' care.

"If there's anything physicians in managed care don't like, it's someone looking over their shoulder. With financial incentives, the physician doesn't have to give in to them, so they leave the physician with much more responsibility and autonomy, while giving [him/her] a way to control costs and provide a steady stream of referrals."

While physicians might understand that incentives are one way to provide cost-effective yet appropriate care, the person potentially most affected by a physician-MCO relationship — the patient — may not understand them at all.

Building a better incentive plan

Latham says that while there are many different versions of incentive plans used under managed care, none of them are ideal.

"The core problem is this: We want to keep costs down, and we want the physician to prescribe the most cost-effective course of treatment — the thing that will do the job, but at the least cost," he explains. "But nobody has figured out how to structure an incentive that pushes them to control costs but also pushes them to make decisions not to withhold necessary care when they are faced with a tough call."

There are better and worse ways to go about building an incentive plan, Latham says, but "every way is designed to push physicians, when they have a close call, away from ordering that marginal procedure. So the health plans have to depend on the individual physicians not to give in to financial incentives when that marginal procedure is what the patient needs."

Depending upon state law, MCO policy, and the physicians themselves, incentives from MCOs can take several forms.

In the United States, most physicians who contract with MCOs fall under two models that define their relationship with the MCO. The individual contracting arrangement exists when an MCO maintains its own network of physicians and allied services, and pays for those services and physicians directly. The other main category is the group-contracting model, under which an MCO contracts with a group or groups of physicians that receive payments to cover enrolled patients' care.

Under the individual contracting model, if the cost of providing health care is greater than the premiums paid by patients, the MCO loses money; under the group-contracting model, if the cost of care exceeds the agreed-upon reimbursement from the MCO, the physician or physicians group loses money.

To help control costs, MCOs generally offer or demand incentives that can include bonuses and penalties. And, according to **Douglas A. Mains**, DrPH, of the department of health management and policy at University of North Texas Health Science Center School of Public Health, when

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Editorial Questions

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balanced with a patient's best interest, contracts and incentives can be good things, controlling expenses and ensuring oversight of clinical outcomes that can provide better service.

"Providers must consider the economic effects of individual clinical decisions at the same time that they must protect their traditional role of maximizing clinical benefit to patients regardless of the cost," he says.

Latham offers some features that can make incentive plans beneficial to patients and the health care system as a whole, and some traits of incentive plans that almost guarantee a crisis of choice for the physician.

"Some health plans are very sophisticated, and will give physicians bonuses if they do a lot of preventive care, make sure their patients are completely vaccinated, and that sort of thing," he says. "This helps the patient and keeps health care costs down by using screening and prevention to keep patients healthy.

"Also, they might reward the physician if [he/she] gives cost-effective care that is reviewed by a physician peer group. Or, they might reward the physician's entire practice group, rather than just one physician, so that if one physician draws a lot of high-cost patients, [he/she] won't feel under pressure to withhold care, because the costs, as far as the reward system goes, will be spread out over the whole group."

Some signs that an incentive program might spell trouble for both physician and patient could include a requirement that if a physician's total costs of referral for his or her patients are kept below a specific dollar amount within a set period, he or she will get a cash bonus.

"The problem is that you go along, making your decisions, using your best judgment, and then right at the end of the year, your decisions could make a \$20,000 difference," Latham says. "So you start making close decisions, or you might defer a referral until after the first of the year.

"Concrete cutoff points can get dangerous; whereas, if you have a bonus program that is scaled, rather than a cutoff point of a certain amount within a certain time period in which your bonus gets bigger or smaller based on how you do, then no one case can make or break the entire bonus."

Ultimate responsibility is the MD's

Just talking about incentives from MCOs "makes physicians crazy," Latham says.

"Their common response is that they don't pay attention to these [incentives]," he says. "Some really don't pay attention, because they see patients with eight different health plans with eight different incentive structures, and when that patient walks in, the physician doesn't know where [he/she] stands with any one of the plans, so [the physician] just administers care as [he/she] thinks best."

But there is some research has shown that there is a "tipping point," particularly when a physician is dealing with a patient enrolled in a plan that the physician is very familiar with, at which the incentive structure does influence the administration of care.

If physicians are perceived as rationing care to the detriment of patients because MCOs require them to do so, they can find themselves named in lawsuits when outcomes go bad. Several states have given patients the right to sue HMOs, but the issue is still being debated on the congressional level, and ultimately, patients view their physician as the arbiter of their care.

And physicians not MCOs — *should* be the ones who determine care, according to the American Medical Association (AMA).

"Under no circumstances may physicians place their own financial interests above the welfare of their patients," states the AMA's conflict of interest guidelines. "If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit."

According to Mains, "Central to the discussion of the ethics of managed care is the potential tension between doing what is best for the patient and allocating scarce resources."

Michael Goldrich, MD, chairman of the AMA's Council on Ethical and Judicial Affairs, says that the past five years have seen positive change in managed care, with physicians regaining some freedom and leeway in deciding on patient care.

AMA policies approved in the past several years, he says, reaffirm that regardless of MCO contracts, physicians have the ultimate responsibility for their patients.

"No matter what outside forces the physician has to weigh, the obligation to the individual patient has to run to the top of the physician's various thoughts," he says.

The AMA's guidelines on financial incentives and the practice of medicine state that while the broad goals of managed care — to control health

care costs and help ensure the administration of good care to a large population — should be considered when making treatment decisions, “[W]ithin the context of the patient-physician relationship, [the physician’s] first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician’s clinical practice.”

Who’ll tell the patient?

Lawsuits in recent years forced courts to determine whether physicians should be responsible for explaining to patients the payment arrangements they have with MCOs, and the verdict is that it is up to the insurer — not the physician — to disclose that information to patients.

Nevertheless, the AMA says that physicians have an ethical, if not legally mandated, duty to make sure their patients are informed of all pertinent information that impacts their treatment.

So-called “gag clauses,” once pervasive in physician-MCO contracts, were sometimes so restrictive that they barred physicians from disclosing payment information to patients under penalty of violating their contract. While courts have stated that insurers have the right to protect proprietary information, such gag clauses have almost entirely been dropped from managed care contracts. But a study published last year indicates that some physicians may be gagging themselves because of MCO restrictions.

A study published in the July 2003 *Health Affairs* reported on findings of a survey of 720 physicians nationwide who were asked in 1998 how often they decided not to offer useful services to patients because of health plan rules.

Nearly one-third (31%) said that they sometimes

did not offer services to patients because of coverage restrictions. Of those physicians, 35% said they withheld information on uncovered services more often than they did five years previously.

“People want financial incentives in place to keep costs down,” Latham says. “Employers want to keep insurance costs down, and patients who are responsible for copayments and minimum out-of-pocket expenses want to keep costs down, so there is value to offering incentives to physicians.

“But there’s inevitable risk that goes with it, so the only solution relies in constant tinkering with the process.” ■

Parents of dying children mourn what they didn’t say

Those who talked to them about death had no regrets

Children who know they will die soon face many common fears, including loss of control, pain, and causing sadness to their families. Swedish researchers have found that parents who talked openly with their dying children about these and other related issues did not regret it, while parents who avoided the painful discussions now wish they hadn’t.

“Pediatric oncologists can now say, based not only on their own experience but also with the support of hundreds of parents in the study, that no parents regret having spoken with their child about his/her death,” says **Ulrika Kreicbergs, RN**, the lead researcher who conducted the study as part of her doctoral dissertation. Several factors, ranging from the child’s age, the parents’ degree of religious belief, and the child’s knowledge of his or her own condition influenced whether parents talked with the children about death.

The study team contacted all parents of children who died of cancer in Sweden between 1992 and 1997 — 561 questionnaires were sent out, and 449 parents responded. Parents were contacted four to nine years after their child’s death, and asked 129 questions about the child’s care, whether parents had spoken with the child about death, and the parents’ mental health status in the years following the child’s death.

Only 34% of the parents had talked with their child about death, according to the study. Of the 66% who did not, 73% were comfortable with

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their decision. But more than one in four (27%) said they regretted not talking to their child about death. None of the parents who had a discussion about death with their child regretted doing it.

Silence not really golden

One hundred forty-seven parents reported they had talked with their children about death, and none reported feeling regret over having done so.

However, 69 of the 258 parents (26.7%) who had not spoken with their children about death later regretted not having done so. Most said their regret stemmed from the knowledge that their children knew they were dying.

“If the child seemed to be aware of his/her impending death, which most of them are, then this communication is even more vital,” Kreichbergs says.

The researchers wrote in their report that they were surprised that two-thirds of the parents had not talked at all to their ill children about death. The authors said parents need to follow their intuition.

“The shielding and the taboos we have are obsolete — they’re old-fashioned,” wrote co-author **Gunnar Steineck, MD**. “They should not hinder us from talking about death when we feel it’s right.”

The parents told researchers that their child’s age, both at the time of the diagnosis and at the time the child died, appeared to be a factor in the parents’ decision to talk about death. Parents of children younger than 3 years were the least likely to have brought up the subject.

Parents who considered themselves religious — whether slightly religious or strongly so — also were more likely to broach the topic of death with their child. In fact, they were nearly twice as likely as people who said they were not at all religious.

One of the strongest predictors of whether a parent would discuss death with a child was whether the child seemed to be aware of his or her own imminent death. If a parent believed the child was aware that the illness was terminal, parents were more than four times as likely to discuss death with their child. Also, parents with another, older child or older children were more likely to talk to their dying child about death.

“Caring staff should pay attention to whether a child is aware he/she is about to die, and in affirmative cases they should support parents who are reluctant to talk to their child about death,” says Kreichbergs.

Discussing Death with Children

When discussing death, always use language that the child will understand. Parents and health care providers should consider the following:

- Infants do not have language skills; however, they do react to physical comfort. When an infant is dying, a comforting touch and holding are as important for the infant as the caregiver. Communicating love can be expressed through a gentle touch and cuddling.
- For toddlers and young children, use concrete language. Avoid misleading terms for death, such as “sleep” and “passed away.” A young child may be afraid to go to sleep if it is associated with death.
- Young children may ask very direct questions about death, if given the opportunity. It is important to be honest and consistent with your response. If they ask a question that you do not know the answer to, it is acceptable for you to say so, rather than make up an answer. Children at a very young age can detect falsehood in an answer. They also may receive inconsistent information if answers from different people are misleading or avoid the truth.
- Teenagers may want to discuss death with a friend or someone other than a parent. Encourage communication in any manner that will help the child express his/her fears and concerns.

It is important to assess the child’s and family’s beliefs and understanding of death and life after death when communicating with them. Children may have unexpressed fears or concerns that they are not comfortable talking about, or that they do not know how to express.

Source: Used with permission from: University of Virginia Health Systems, “Pediatric Health Topics — Discussing Death with Children.” Available on-line at www.healthsystem.virginia.edu/UVAHealth/peds_terminallyill/discuss.cfm

Many doctors and medical organizations encourage parents to discuss death with terminally ill children because they believe it helps the child. But little research has been done on the subject, Kreichbergs says, and some of her colleagues resisted the researchers’ speaking with their patients (the parents of the deceased children), because they were afraid talking about the children’s deaths would cause the parents more pain.

Betty Ferrell, RN, PhD, FAAN, professor in the Department of Nursing Research and Education, City of Hope National Medical Center in Los

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Angeles, is the author of a national curriculum, the End of Life Nursing Education Consortium, that trains nurses how to improve care for dying children and how to foster communication among the medical staff, parents, and children.

She says that parents “sometimes say the wrong things, or don’t speak up with the right things, out of compassion.” Nurses who care for terminally ill children should be attuned to what the child is feeling, and should be able to help parents talk with their children. (For more information on talking to children about death, see box on p. 125.)

In fact, it was Kreicbergs’ experience as a young nurse a decade ago that prompted her to come up with the study. She says she was unhappy with the way the staff of the hospital where she worked and the families of three dying boys avoided talking about the subject of death.

Cindy Squire, MS, APRN, of the University of Utah College of Nursing, Salt Lake City, points out that children — especially older children — usually know that they are going to die and face some common fears, including loss of control, causing hardship for others, suffering, fear of the unknown, uncertainty about the afterlife, being alone, and being forgotten.

Health care providers can reassure patients that their feelings and fears are to be expected, and should provide physical closeness and comfort to the child. She says nurse and physician providers should be sensitive to nuances in the child’s behavior that hint at when the child might want to talk about his or her disease and future, and how much they want to talk about it.

“Parents and providers need to talk with children about death in an honest, specific way and give children an opportunity to make decisions about care whenever possible,” she suggests. “This is particularly important when the patient

is an adolescent.”

Squire offers specific suggestions to parents for keeping communication open and making the child feel comfortable about talking; many hinge on keeping the child’s life as normal as possible:

- Require the child to follow reasonable family rules and behavioral expectations.
- Include siblings and pets.
- Continue to participate in social events and family celebrations.
- Keep the child near the center of family activity in the home.
- Engage in activities that might otherwise have been postponed or neglected because of the child’s illness.

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Soliciting for ‘gift of life’ causes controversy

Does direct organ donation rob more needy patients?

A Texas man whose family circumvented the national organ donor registry by mounting an Internet and billboard campaign asking for a donated liver not only was successful in obtaining a liver, but also succeeded in escalating the national debate over the ethics of soliciting anonymous directed donations.

“I think it’s pretty straightforward — jumping ahead on the waiting list is not fair,” says **Peter Ubel**, MD, professor of medicine at the University of Michigan and director of the Program for Improving Health Care Decisions at Ann Arbor VA Medical Center and University of Michigan.

But to families of the 87,000 patients awaiting organ transplants in the United States, the notion of doing something to boost their loved ones’ chances of rising to the top of the list can appear essential, especially given the national rate of donations (approximately 8,200 donors between January and October 2004).

Organs for transplant are donated primarily in three ways:

- anonymous, open donations, in which a patient or his or her family gives permission for organs to

be taken at death and donated to candidates who have risen to the top of a national registry;

- directed donations made by family members to other family members, such as a person who donates a kidney directly to a sibling who needs it;
- organ exchanges, in which a person donates an organ to an anonymous recipient and, in exchange, that person's relative or friend in need of an organ receives priority for available donor organs.

"But in cases like [the Texas man's], families who have the resources and savvy to get publicity, or have an attractive candidate, will jump the line," Ubel says.

ToddNeedsaLiver.com

The man whose transplant touched off the recent controversy is Todd Krampitz, 32, of Houston. In May, Krampitz went to a hospital because of severe abdominal pain, and was found to be suffering from a liver cancer so extensive that it was unlikely he would ever rise to the top of the waiting list for an organ. Medical experts said a transplant would not eliminate Krampitz's cancer, so he was not considered a good candidate to receive a donor organ.

Believing they had no alternative, his friends and family publicized his plight by a billboard and a web site — www.ToddNeedsaLiver.com — and, within a week, a family requested that their dying relative's liver go to Krampitz rather than to an anonymous recipient who likely would have been higher on the registry maintained by United Network of Organ Sharing (UNOS), the organization mandated by Congress to set rules for organ donation and maintain the national waiting list.

The type of directed donation made to Krampitz is legal, but unusual — most directed donations come from living donors who give whole or partial organs to a relative or friend. But there were enough questions about the procedure that at its June meeting, the UNOS board of directors ordered that an ad hoc committee be assembled to study the growing number of public solicitations for donor organs.

Annie Moore, spokeswoman for UNOS, says that although directed cadaveric donations are allowed by federal law, only a handful have been reported each year. She says UNOS had decided it was time to study public solicitation before the Krampitz case arose. "At the June board meeting, members acknowledged that it's an emerging issue, and a special committee was formed to make recommendations on that topic," she states.

The committee still is being appointed at press time, but the board's aim is to have a preliminary report presented at its meeting in November, according to Moore.

Among the concerns of the UNOS board is that solicitation for organs can cause donors to direct organs to those who can draw the most attention, rather than the patients in the most critical need.

In the meantime, the idea is gaining in popularity, with other sites like ToddNeedsaLiver.com now on-line.

Are donations justified by lack of supply?

During 2002, more than 24,000 organs were transplanted in the United States — nearly 18,000 from deceased donors, and 6,600 from living donors, according to the Scientific Registry of Transplant Recipients in Ann Arbor, MI. During the same period, more than 6,000 patients were reported to have died while waiting for a transplant.

Although the American Medical Association (AMA) does not have guidelines on use of organs obtained through directed donation or public solicitation, it does state that the allocation of any limited medical resource be based on ethically appropriate criteria such as urgency of need and the likelihood of benefit.

Critics of directed donations argue that in some cases, there are much sicker patients in need of the organs than the patients to whom they are directed.

Ubel says the only argument he can see in favor of directed donations solicited publicly is that someone may be moved to donate organs when they otherwise would not.

"In these cases, you let someone skip the line, and as far as I am concerned, the only justification would be if that [donor] family would donate only if they could direct it," he says.

The UNOS ethics committee has been weighing the benefits of public solicitation (specifically, the potential that it could cause an increase in the number of donations) vs. the ethical and legal implications.

Mark Fox, MD, PhD, chairman of the UNOS ethics committee, says concerns range from making sure federal and state laws are observed — for example, that directed donations are not directed away from certain religious or ethnic populations, and that no money is exchanged between donors and recipients — to the question of how best to use such limited resources. Should emphasis be placed on giving donor organs to patients who

have the best chance of recovery, or should all patients in need of organs be given equal access to donated organs even if their health does not give them good long-term prognoses?

Give an organ, get an organ

There are types of directed donations that rarely raise ethical questions — living donations of kidneys between family members, for example.

Another, more recent method of obtaining a better chance for a donor organ is the donor exchange. UNOS permits patients who are waiting for kidney transplants to move up on the list if a family member donates a kidney to an anonymous patient in need — Ubel says that unlike a patient soliciting for anyone to give an organ, the donor exchange model keeps the transplant candidate in line and under UNOS' established criteria for a transplant, but merely helps expedite the wait.

"Under the donor exchange program, two people get transplants who wouldn't get them otherwise," he says.

Tufts-New England Medical Center and the New England Organ Bank in Boston introduced their collaborative "Hope Through Sharing" program three years ago, to encourage organ donations. The program was approved by UNOS to expedite transplant patients whose friends or family members have donated kidneys. Although UNOS does permit transplant patients to be expedited when participating in a donor exchange program, that permission does not put donor exchange patients ahead of patients with medical emergencies or with special matching restrictions (individuals needing multiple organs, for example).

Richard S. Luskin, executive director of the New England Organ Bank, says living donations "keep the waiting list from being even longer."

"The exchange program, by allowing a medically incompatible family member to donate to the transplant list, expands living donation and [helps] reduce the number of patients waiting for kidneys," Luskin says.

Private membership services have tailored the exchange program idea into programs they say will allow members to obtain donor organs for themselves or family members more easily. LifeSharers, based in Tennessee, asks that members agree both to donate their organs when they die and direct those donations to other LifeSharers members. In exchange for this, the LifeSharers members get priority on organs donated by other members, according to the group's web site.

However, UNOS requires that directed donations be made to a specific person, and not to a group (such as, "a member of LifeSharers who needs a kidney"), and has been critical of organizations that it says takes advantage of desperate families. In particular, UNOS has specifically criticized organizations that charge a fee to participate.

LifeSharers, in a reply issued in response to questions on patient selection, states that it "does not interfere with UNOS' matching process," and merely instructs members to direct that their organs go to the highest ranking, qualified LifeSharers member on the UNOS waiting list.

Transplant centers have leeway

Hospitals and transplant centers are under no obligation to carry out transplants that the institution deems unethical, and certainly none that it believes are illegal, experts say.

Directed donation is allowed by state law (although some restrictions may apply in certain states), and is a legal alternative to the UNOS allocation policies. So, for the most part, such donation requests are honored as long as the recipients are available and medically suitable to receive the donations, according to Moore.

But in some cases, transplant centers can and do refuse, Ubel points out. "If someone decides to

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donate, but only to a Christian, or specifies that his organs cannot go to an African American, it's pretty well established that transplant centers don't have to do that and can turn those cases down," Ubel says. "And in those cases, they'd be morally right to not allow it.

"But [transplant centers and surgeons] are obviously torn. If a person in their care who is way down on the [UNOS] list makes a public appeal for an organ, and gets one, do they turn it down? It's tragic that people die waiting for organs. [Football great] Walter Payton died waiting for a liver transplant; he could have made a directed appeal, and people would have donated, and I admire him for not doing that." ■

AMA Code of Ethics still applies a century later

Panel evaluates code for relevance

Despite having been written 157 years ago, the American Medical Association's (AMA's) *Code of Medical Ethics* still is a critical tool for solving day-to-day ethical dilemmas, according to experts who recently evaluated the guide.

A panel convened to observe the World Medical Association's Medical Ethics Day in September examined the latest version of the code with an eye toward determining its value in daily medicine.

The current update contains 185 ethical opinions, including 12 new and 14 amended items. Since it first was published in 1847 — the year the AMA was founded — the code was merely a pamphlet articulating the ideals of professional education and practice. The current code consists of more than 200 pages dealing with inherent matters including privacy, etiquette, and errors, as well as such 21st century topics as genomic research, electronic mail, health-related web sites, and cloning.

Panelist and former AMA ethics standards director **Steven R. Latham**, PhD, notes that the code was written by doctors for doctors. It has therefore occasionally been criticized as a document used to protect doctors. But, he says, the code "embodies a promise" from physicians to their patients that they will maintain a practice within the ethical boundaries found in the code. For physicians, Latham says, the code's greatest strength is how doctors can "pull it off the shelf" and get answers to questions that are addressed nowhere else, as well as basic

questions like, "Who owns the medical files of physicians who leave a group practice?" (Answer: The practice should hold the files until instructed by the patient whether to keep them or forward them to another physician.)

An ethical persuasive force

Arthur R. Derse, MD, director of medical and legal affairs at the Center for the Study of Bioethics at the Medical College of Wisconsin in Milwaukee, differentiates between the code's usefulness in court and in the practice of medicine. He notes that the code does not have legal force, but it does have "ethical persuasive force" and that it has been cited in court decisions.

Derse says he uses 16 of the code's ethical opinions in his medical ethics class, and adds that surveys indicate that 86% of his students agree that using the AMA code is helpful in understanding medical ethics. "It's helpful for students to see in black and white what the largest and most influential medical organization has to say," he says.

Latham, however, counters that when the AMA ambitiously addresses issues like cloning in its code, it strays from the area of its biggest strength — providing useful advice on the correct way to run an ethical practice.

The *Code of Medical Ethics* preamble states that it is not a set of laws, but consists of "standards of conduct, which define the essentials of honorable behavior for the physician."

Resource

- The AMA *Code of Medical Ethics* is available as a free PDF download from the AMA web site at <http://www.ama-assn.org/ama/pub/category/8600.html> ■



Judge approves physician-Aetna settlement

The 11th U.S. Circuit Court of Appeals cleared the way for insurance giant Aetna to go forward with a settlement agreement reached last

year in a massive class-action lawsuit alleging the plan unfairly reimbursed doctors.

The Atlanta-based federal appeals court in late September affirmed the settlement that the company agreed to with the nation's physicians and organized medicine. A handful of physicians challenged the settlement that U.S. District Judge Federico Moreno in Miami approved.

The settlement includes \$100 million to be divided among physicians who are part of the class. Many physicians donated their portion to a foundation established under the agreement that will promote physician-directed improvements to the health care system. The agreement outlines the steps Aetna will take to improve business relations with doctors, including disclosing how the company determines what it pays for physicians' services. Aetna estimates the business practice improvements will be worth about \$300 million to physicians. ▼

Some British med students justify sex with patients

A small, British sample study published recently in the *Journal of Medical Ethics* indicates that while most medical students say a sexual relationship with a patient is not justifiable, four out of 10 said they could justify having a relationship with someone who has been under their care.¹ Researchers monitored the responses of 62 British medical students to a validated questionnaire on four separate occasions during the course of their training, and found the students' views changed little as their training progressed.

The questionnaire asked students to imagine that they were general practitioners on a small, remote Scottish island, and were presented with the opportunity to initiate a romantic relationship with a patient who was coming to the end of a period of lengthy treatment.

Sixty percent of the students said they would refuse, mostly on the grounds that it was unethical

or would compromise the doctor-patient relationship. Other reasons included abuse of power and a feeling that such behavior would be unprofessional. But four out of 10 students said they would pursue the relationship. The principal reasons given were the difficulties of meeting a future mate in such a setting, the belief that professional and private lives can be kept separate, and the feeling that this would be acceptable if the patient changed practice. These views remained fairly constant over time.

The authors cite international studies showing that sexual relationships between doctors and their patients, particularly in general practice, gynecology, and psychiatry, are relatively common. They cite U.S. research suggesting that one in 10 family doctors surveyed had had sexual contact with at least one patient, while an Australian study found that almost one-third of family doctors questioned knew of a colleague who had had sex with a patient.

"Particularly vulnerable are socially isolated, middle-age men experiencing a midlife crisis, who are eminent in their field," say the authors, pointing out that the risk of sexual misconduct increases with age, rising 44% with every decade. The authors conclude that far too little attention is paid to the issue of sexual or improper relationships in medical training, and that these issues need to be made more explicit.

Reference

1. Goldie J, et al. Sex and the surgery: Students' attitudes and potential behavior as they pass through a modern medical curriculum. *J Med Ethics* 2004; 30:480-486. ▼

Prosecution urged for flu vaccine price gouging

Department of Health and Human Services Secretary **Tommy G. Thompson** sent a letter to the Attorney General of each state in October, urging them to thoroughly investigate reports of price gouging involving the flu vaccine and to

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prosecute those found to be taking advantage of the vaccine shortage.

“It is extremely disturbing to learn of reports of price gouging by immoral individuals looking to make a quick buck off of a public health challenge,” Secretary Thompson wrote in the letter. “I am encouraging the attorney general of each state to thoroughly investigate reports of price gouging and prosecute those engaging in this immoral and illegal activity to the full extent of the law.”

Secretary Thompson said it will take the good faith and cooperation of all Americans — the public, doctors, nurses, and public health professionals — to ensure that the flu vaccine goes to those who truly need it most this flu season. Information on who is recommended to get the flu vaccine is available from the Centers for Disease Control and Prevention (CDC) at www.cdc.gov/flu/protect/whoshouldget.htm ▼

Health disparities persist between Hispanics, whites

Despite progress in combating health disparities, a significant gap persists between Hispanic Americans — the nation’s largest ethnic minority group — and whites in both access to care and prevalence of a leading chronic illness, according to the Centers for Disease Control and Prevention’s Oct. 15 *Morbidity and Mortality Weekly Report*. The country’s 35 million Hispanics are less likely than whites to have a regular health care provider (68.5% vs. 84.1% in 2001-2002) and to have health coverage (76.2% vs. 90%), the report shows. Hispanics also are less likely to receive important preventive care, including breast cancer and cholesterol screenings, and more likely to have diabetes.

In the key states studied, the overall prevalence of diabetes among Hispanics is twice that among whites (9.8% vs. 5%). “For society, these disparities translate into less than optimal productivity, higher health care costs, and social inequity,” the report says, noting that Hispanics will comprise an estimated one-quarter of the population by 2050. The report urges “using culturally appropriate programs to advise Hispanics about the importance of screening, expanding access to health care, and targeting specific barriers to care, such as poverty and lack of knowledge among health care professionals about how best to encourage Hispanics to use preventive services.” ■

CME Questions

17. The American Medical Association’s *Code of Medical Ethics* has been recognized as both a legal document and an educational tool.
 - A. True
 - B. False
18. Federal law in the United States prohibits which of the following in the case of organ donations for transplant?
 - A. Directed donations
 - B. Public solicitation for organs
 - C. Donor exchanges
 - D. Exchange of organs for money
19. Which of the following is/are a benefit of incentive programs for physicians who participate in managed care?
 - A. Control of health care costs
 - B. Better distribution of health care across a broad population
 - C. More responsibility and autonomy left in hands of physicians
 - D. All of the above
20. A Swedish study showed that parents of dying children were more likely to talk to their children about death when:
 - A. The parents considered themselves religious.
 - B. The children did not know they were dying.
 - C. The child was younger than age 3.
 - D. The parents had no other children.

Answers: 17. B; 18. D; 19. D; 20. A.

CME instructions

Physicians participate in this continuing medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity, you must complete the evaluation form provided at the end of each semester and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

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