Whose Patient Am I, Anyway? How New Economic Threats to Continuity of Care Can Undermine the Doctor / Patient Relationship

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New structures for the financing and delivery of health care and serious efforts to control costs all create tensions in the relationship between doctors and patients and heighten the need for clarification of that relationship. These tensions are well known and have been extensively addressed in the professional and popular literature. Nearly a decade ago, discussing the implications of various methods of paying physicians, Alex Capron emphasized “the continuing importance of ethical precepts in protecting as much of the old norms of medical practice as possible.”¹ Now, the conflict is often palpable between the welfare of patients and economic factors. Thus, in a recent newspaper announcement of his retirement from practice in Santa Fe, Dr. Luis Bernardes wrote, “Times have changed, as has the practice of medicine: from art and science to a ‘health industry’. So it’s time for me to move on....”² In the words of Arnold Relman, “Health care has become commercialized as never before, and professionalism in medicine seems to be giving way to entrepreneurialism.”³ The conflict between caregiving and economics also encompasses the exclusion of the uninsured and great anxiety about future health care costs and quality even among the well-insured.

We all want to maintain the traditional sense of a personal, caring, intimate, privileged, stable, and trusting relationship between doctor and patient, but we know that economic incursions into that relationship threaten to make it a thing of the past. At present, it typifies the best of medical care, and serves as an important model even in those contexts in which it is not fully realized, such as in total institutions like the military or prisons, or for those who receive most of their health care as walk-ins to emergency rooms. One increasing lament is that even in the best of settings, however, the relationship between doctors and patients is under assault from risk managers and practice managers, insurance company accountants, and other nonprincipals involved in the organization and financing of health care, but not directly involved in its provision. This issue is explored well in Ruth Macklin’s probing book about threats to the quality of care, which concludes with the observation that “as the professional autonomy of doctors is weakened, so too is their ability to advocate vigorously for their patients’ interests.”⁴

Malpractice suits are also a factor, of course, raising costs, distorting decisions, and introducing a pernicious undercurrent of suspicion and fear into the doctor/patient relationship. Further, conflicts of interest intensify as the economic stakes for doctors rise with respect to opportunities as well as risks. For example, physicians with a vested interest in facilities to which they refer patients betray those patients when they make referrals which are not medically indicated. Such physicians may even believe that they only make medically indicated referrals, but the human capacity for self-deception is massive, and excessive referral is frequent. As Marc Rodwin notes in his extensive exploration of the conflicts of interest that can cloud medical decisions, “Medicine

*An earlier draft of the following text, which is still undergoing development, formed the basis for Samuel Gorovitz’s address to the Center for Philosophic Exchange in October 1993. All rights reserved.
today is practiced in a market environment, which already disposes physicians to think of their own welfare. There is a need to balance this trend and to guard physicians from being influenced by self-serving incentives which may affect adversely the patient."

My focus here, however, is on one specific incursion into health care that is little noted: the distortion of the relationship between physician and patient that can result from economic disputes among the providers themselves, especially where one disputing provider is the treating physician and the other is an institutional provider which controls the organizational context within which treatment is received. This problem is illuminated by four recent lawsuits.

In C. v. P., the plaintiff was Dr. C. His patient had bronchial pneumonia and multiple orbital fractures of the right eye. Dr. C. refused to discharge the patient from the hospital when the insurance company's care manager — a pediatrician in another state who had not seen the patient — said he must. Dr. C. held that for this particular patient, DRGs, norms, and statistics notwithstanding, the discharge would be premature and contrary to the patient's welfare. Nonetheless, the patient, who had been insured for twenty years through his employer, was informed that his coverage would be discontinued and that if he stayed in the hospital, it would be at his own expense. Dr. C. was then dropped from the insurer's roster, his relationship with the patient abruptly severed. He sued the insurer P, et al.; the case settled out of court with undisclosed terms. Here, the conflict was between one physician serving as a provider of care and another serving as a limiter of care in behalf of a skillfully designed complex of corporate structures that insulated the hospital and the insurance company from various kinds of liability.

The AMA Council on Ethical and Judicial Affairs, in its statement of the Principles of Medical Ethics (1989), included a number of provisions that seem especially pertinent:

4.04. In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority.

5.01. Physicians practicing in prepaid plans or HMOs are subject to the same ethical principles as are other physicians.

8.07. 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.

It is hard to square these unambiguous affirmations of principle with the experience Dr. C.'s patient had. Such principles are not externally imposed on the medical community; they reflect the profession's sense of itself as a calling, and they arise from the internal values of the profession. Neither are they purely internal to the profession; they are fashioned in awareness of the values of the larger social context that has established and sustained the profession, and which empowers it.

Admittedly, there are important distinctions among the physician, the hospital, the care manager, the insurance company, and others. These distinctions are significant in litigation, but not in the patient's experienced reality of illness and hospitalization. From the patient's perspective, the physician is the principal determiner and organizer of care, and the patient typically thinks of him or herself as the patient of a specific doctor, not of a medical practice corporation or other collective entity.

This sense of the importance of being the patient of a particular physician was salient in the case of Scheer v. Entel. Alan Scheer, a clinical radiologist, left Georgetown
University Hospital and moved to Pinellas County, Florida, where he worked under contract to a medical practice corporation of which he was an employee but not an equity partner. No complaints were voiced about his clinical competence, but he wasn’t a rainmaker, aggressively working to expand the practice. He was abruptly fired one day, cut off summarily from those he considered to be his patients. He sued the physicians who were partners in the corporation.

At trial, the plaintiff’s attorney presented evidence that the firing was based solely on the corporation’s desire to replace Dr. Scheer with a more profitable employee. The abrupt severance of his relationship with his patients had caused him to appear to have behaved in ways that are ethically unacceptable. Some of his patients had even arrived at the clinic for appointments with him only to be told that he was gone and that his whereabouts were unknown.

He seemed to have disappeared, abandoning his patients. His abrupt departure not only invited but mandated the speculation — if not the conclusion — that he was guilty of some significant failure or defect. Many patients complained — “But he was my doctor.” As one patient was quoted in the press as saying, “When you start with a doctor, you like to finish with a doctor.” And Dr. Scheer complained that they were his patients. But the clinic claimed the patients as its own, reassigning them without their prior knowledge or consent to other doctors. The jury found for the plaintiff; the judgment was $1.85 million.

If you work as a doctor for a corporation — such as an HMO, PPO, clinic, hospital, or managed care plan, what is the force of saying that I am your patient and you are my doctor? Can the organization just assign me to another doctor for business reasons? If so, how does that affect the mutually possessive relationship between us? Can that possibility harm both you as a physician and me as a patient?

Any statement of the form “x is my y” depends for its significance on what sort of possessive relationship is implied. These relationships can involve ownership (“That is my car.”), familial ties (“He is my son.”), legally defined responsibilities (“She is my ward.”), or professionally determined obligations and privileges (“He is my client.”). We understand some of these relationships well and others not well enough. If “She is my student,” I have obligations and responsibilities in respect to her, and she has entitlements from me. These are very different from what is entailed when a car is mine, or a child, or a spouse. What, then, is the force of saying that a doctor is my doctor? And what is the force of a doctor’s claim that I am her patient?

In Kalamazoo, Michigan, Dr. H. sold his private practice to X Research, Inc., a corporation owned by a local hospital, which then invested in the practice, sought to expand it under his medical directorship, grew discontent about its growth rate, and, to his astonishment, one day fired him abruptly in a manner analogous to what had happened to Alan Scheer. X claimed the patients, reassigned them, and sent Dr. H. packing. He sued, achieving a satisfactory out-of-court settlement in Spring 1992. In preparation for trial, Dr. H.’s attorney gathered letters from patients who expressed their own sense of betrayal. He was my doctor, not some corporate entity, they complained. Many of them were not even aware of the relationship between his practice and X.

And in June, 1992, the case of Floyd Bryan, a vascular and general surgeon, went to trial in Orlando, in Federal District Court. Bryan’s hospital privileges had been revoked at Holmes Regional Medical Group’s hospital in Melbourne, Florida, the defendants claimed, because he was an oft-warmed, disruptive influence within the staff. He acknowledged irascibility in defense of high standards of care, and a wealth of testimony supported the claim that he was a fine surgeon who fought aggressively within the

http://digitalcommons.brockport.edu/phil_ex/vol25/iss1/5
hospital for better — although sometimes less profitable — treatment of patients. The jury found for the plaintiff, with a judgment in excess of $4.18 million plus reinstatement.12

Dr. Bryan was a feisty and sometimes irritating battler in defense of his patients. What emerges from these various cases, however, is a troubling picture of some physicians fighting harder over patients, in behalf of the health care corporations they represent, than they do for patients.

The Bryan case is of particular interest in that it highlights growing conflict between hospitals and physicians. The defendants have appealed the jury's verdict, and an amicus brief for the defense has been filed by the American Hospital Association and the Florida Hospital Association. But a brief for the plaintiff has been filed by the American Medical Association and the Florida Medical Association, which, while acknowledging the importance of protecting the rights of hospitals to make autonomous judgments about the disciplining of medical staff, nonetheless sees the case as sufficiently unusual and important to justify its exceptional entry on the plaintiff's behalf. Each understands that part of what is at stake is the distribution of authority for making decisions about the care of patients.

Those who are nostalgic for the good old days of medical care often miss a more personal, informed, and caring relationship between doctors and patients than what is common today. But another change may deserve attention — loss of collegial rapport between doctors and the hospitals or other collective settings in which they work. The conflict between Dr. Bryan and HRMG may be extreme, but the issues are not unique to that case. Thus, citing hospital/physician relations as "a constraint to health reform," Jeff Goldsmith writes, in a recent issue of Health Affairs, that:

Physicians crave order but despise authority. Long deprived of their power to influence directly the operations of hospitals or medical schools, physicians have resorted to guile and guerilla warfare to win their battles. While many physicians...believe that their medical training endowed them with superior management judgment, most are incapable of submitting to the authority of anyone, even a fellow physician...many lack the interpersonal skills or civility to function as part of a larger enterprise....They passively resist initiatives that they cannot overtly oppose....will agree in public meetings and then subvert privately....In short, they are terrible employees.13

Yet, increasingly, physicians are employees. As a recent front page story in The New York Times notes, "Worried doctors across the country are selling their offices to investor owned public companies," for which they then work, as Dr. H. worked for X.14 Noting that "Critics warn of putting profit ahead of care," the article concludes by quoting one economic analyst's conjecture that "this is just the beginning of the corporatization of physicians." Such powerful trends will inevitably change the ways in which doctors and patients interact.

The large judgments and settlements obtained in the cases cited here exert another upward pressure on health care costs. They are not malpractice judgments; no complaints about clinical competence are involved in any of them. But the conditions that give rise to such litigation undermine doctor-patient relationships.

To be a good patient — not good in the sense of compliant and accepting, but in the deeper sense of being effective in advocating and defending one's own interests in the context of medical care — requires a keen awareness of what patients should tell and ask their physicians.15 Now, a new question emerges: If you become my doctor, in what sense
will you be my doctor? What will that relationship mean for each of us, and how is it constrained by your obligations to others? Will you care for me when I am in medical need, or might I one day find myself wondering, “Whose patient am I, anyway?”

These issues should be considered explicitly by the medical community and the rest of us who care about that community as a social institution of the first importance. We know that patients may legitimately expect certain general standards to be met by their doctors, such as adherence to canons of confidentiality, and that doctors are barred from abandoning patients in their care. But little is clear about entitlements to continuity of care.

New requirements of advance disclosure may be needed to specify the limitations of the relationship between doctor and patient within each context of care. The possibility of and explicit conditions for imposed reassignments should be acknowledged at the time a patient begins any association with an organizational provider, but this standard of disclosure has not yet been generally accepted.

One health plan recently sent me its promotional literature, including a section headed “Answering Your Questions.” It reads, “Q. Will I have my own physician? A. Absolutely!...the physician chosen by you becomes your physician...we offer personal care in a personal setting.” There’s no hint of any limitations on this personal relationship; I suspect this is typical. Neither is there disclosure of the ways in which decisions jointly made by doctor and patient may be constrained by the mechanisms of managed care. I suspect that this too is typical. It is therefore incumbent on doctors to make clear what arrangements are in place for alternate coverage, and to inform their patients about the possibility of reassignment — insofar as that possibility is understood by the doctors themselves.

It is also important to understand the diagnostic impact of continuity in the doctor-patient relationship. If, as has been argued, diagnostic efficacy is facilitated by trust, familiarity, and awareness on the part of the physician of how the present state of the patient fits into an on-going pattern of who and what this patient is, then continuity of relationship has value for diagnostic strategies. Whatever undermines that continuity, and the trust and familiarity it sustains, incurs a cost in diagnostic efficacy.

The diagnostic and therapeutic value of such continuity is the primary basis of objections to the Clinton health reform proposal as discussed by Emanuel and Brett in a widely reported essay. Calling “the interaction between patient and physician ...the final common pathway through which reforms will be played out,” they emphasize that:

Conscientious physicians provide quality medical care by learning about their patients’ particular reactions to their diseases, their social support systems, their tolerance for pain and disability, the effect of illness on their work and interests, and their general values and preferences regarding medical care. Physicians obtain this sort of information and understanding gradually by interacting with patients and their families over long periods of time, not by assembling records.”

These matters do not just involve bureaucratic arrangements attendant to the provision of medical care. They raise fundamental questions about medicine as a calling, challenging our understanding of the relationship between doctors and patients and necessitating a refinement of our understanding of the relationship between physicians and society.

It was reported in June 1993 that American Medical Association lawyers “have laid the groundwork for an aggressive legal and political campaign against...limits on national
spending for health care and on doctor charges.\textsuperscript{17} The conceptual basis of that campaign is the notion that the practice of medicine is "a property right, protected by the Fifth Amendment." This argument may seem to have more force here, where most physicians incur heavy debts in pursuit of medical education, than in other countries — where medical education is publicly supported as an investment in the public good. Yet it is unconvincing.

The right to practice medicine is not generally enjoyed as a right of citizenship. It is granted only in the context of a complex social institution — the enterprise of medical care — and then only to specific persons based on their satisfaction of demanding criteria. The licensed physician then enjoys remarkable privileges, and undertakes remarkable responsibilities. The granting and acceptance of that license constitute a social compact that is subtle, complex, and not nearly as explicit as would be desirable in these tumultuous times. Certainly, the ability to practice medicine depends on being the beneficiary of much scientific, technical, and clinical knowledge developed at public expense; that fact, along with the complex pattern of privileges and obligations, makes "property rights" a suspect analogy for the practice of medicine.

The concepts of property, its uses, and the benefits of its ownership, are the foundational concepts underlying the existence, purpose, and functioning of corporations. The concepts underlying health care as a social institution have historically been very different, emphasizing healing, service, and fiduciary agency. Thus, Pellegrino emphasizes that:

Ultimately, we must place our trust in the person of the physician.... We must be able to trust her to do what she is trusted to do, i.e., to serve the healing purposes for which we have given our trust in the first place.... We must trust also that our vulnerability will not be exploited for power, profit, prestige, or pleasure.... Trust must be engendered and built up gradually by fidelity to promise from the first moments of a professional relationship.\textsuperscript{18}

As these two very different cultures — that of the corporation and that of the healer — come closer together and increasingly intersect, trust becomes more fragile and conceptual conflict is inevitable. In a period of such instability in the various relationships among doctors, patients, payers, institutional providers, and public policy, we should be especially wary when concepts central to one of these two cultures, such as the concept of property rights, are invoiced to provide explanations or justifications for decisions central to the other culture.

Just as the relationship between doctors and patients is undergoing challenge and change, so is the relationship between doctors and the society that sanctions and sustains the enterprise of medical practice. Not all those changes — of either kind — are in the interests of patients. Thus, a recent interdisciplinary project on the quality of caring in medical care (at the Center for Advanced Studies in the Behavioral Sciences at Stanford) focussed its agenda at one session with the question "Why aren't doctors nicer to their patients?" There was vigorous debate about the most persuasive answer, but none about the appropriateness of the question. All agreed, however, that the structural context within which medicine is practiced is an even more powerful factor than the training and motivation of the physician in determining whether the doctor/patient relationship will be a caring one. (Two reports from that project are pending publication; "Organizational and Economic Aspects of Caring," and "The Caring Physician in the Era of High Technology Medicine." Information is available from the Center; Stanford, CA 94305.)
In clarifying both the doctor-patient relationship and the doctor-society relationship, we need as much understanding as possible of the particulars of what happens to people in the context of medical care, and of how what happens depends not only on what doctors and patients do, but on what is done by the many others who influence the relationship between doctors and patients without being part of it themselves.

Those particulars are essentially human particulars, which cannot be understood, except superficially, on the basis of any array of data about frequencies, recovery rates, costs, trend lines, averages, norms, or anything else. Such information, albeit useful and often necessary, is limited by a sterility which obscures the personal stories that alone can convey a sense of what it is like to be a patient in a given situation, or what it is like to try to practice good medicine within a specific set of complex and unwelcome constraints. Yet what it is like — in those very human terms of anxiety, trust, terror, hope, frustration, and confidence — is what most powerfully motivates the decisions that people make as patients and as health care providers. Similar motivations will largely shape our reactions to health care reforms that are proposed and implemented. At the heart of that experience of medical care, the relationship between doctors and patients is at once both powerful and fragile. And at the core of that relationship, at its best, is the confident knowledge that a particular physician is one’s own — not as is a restaurant waiter on a given evening, nor as is a spouse over the years, but something between, continuing with a commitment that we need to clarify.

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