Professional Standards In Health Care: Calling All Parties To Account

Professional accountability involves all health care players—not just physicians—says AMA ethicist.

by Linda L. Emanuel

Many physicians and nonphysicians in the health care industry believe that high-quality care can be delivered within the managed care paradigm. To achieve trustworthiness in care, the medical profession must reclaim its role as a professional body, project its voice on professional values, and put action into its words. There is a resurgence of interest in professionalism at many medical training institutions and health care delivery organizations.¹ Position statements, including opinions of the American Medical Association (AMA), increasingly seek to apply standards of professionalism to the challenges of managed care.² These steps are excellent.

Nonetheless, individuals and institutions are always at risk. A necessary consequence of capitation and financial incentives—two cornerstones of managed care’s efforts to contain costs—is that the physician’s fiduciary obligation to the patient will be challenged. In parallel fashion, the economic motives of health service organizations will be at risk of conflicting seriously with the professional standards for institutions. Brad Gray’s observation about the need for a fiduciary obligation to patients needs to be taken both seriously and further. If the fiduciary ethic and the broader scope of professional ethics are to be fostered and protected, more force must be given to professionalism, not only among physicians but among all of the parties involved in health care.

Accountability For All Parties

Accountability can be not only a supplement to physicians’ ethics but also a vehicle for assuring professional standards for the many parties in the health care industry. These include not only physicians and health service organizations, but also employers who purchase health plans for their employees, investors, private insurance payers, government, and patients.

Many of the newly powerful forces in medical service delivery operate under an industry or corporate mind-set. Such enterprises traditionally have not been required to hold themselves to professional standards and cannot be expected to do so voluntarily. However, there is a more receptive disposition to such standards than before. The field of business ethics is no longer seriously defended as limited to fiduciary obligations to the shareholder. Businesses today are more sensitive to fulfilling obligations, whether in the arena of environmental responsibility; employee protections for matters of safety, liberty, or benefits; or community enhancement. Therefore, it is now a good time to create tangible professional accountability standards for the business parties in health care that befit their degree of influence and power.

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Physicians. Physicians were among the first parties in health care to be held to standards of professional accountability. The parties to whom physicians are accountable, on what domains, and by what procedures have been described elsewhere. Even more practical detail has been provided for the domain of ethical conduct.

Managed care organizations. Managed care organizations also must be accountable to professional standards. Having accountable health plans was an original goal of President Clinton’s health care reform proposal. However, the accountability that emerged from that proposal was focused on satisfaction, cost, and outcome measures of quality. These areas are necessary but not sufficient and effectively bypass some professional understandings of what it takes to engage in the activities of health care and healing, including the fiduciary ethic. To refocus health care delivery’s accountability to a full complement of professional standards, it is necessary to actively define and demand those standards.

Employers. A somewhat novel but necessary next step is to focus on employers’ accountability to professional standards. Employer accountability might include that several parties—patients, health care delivery organizations, physicians, and professional organizations—should be able to require sufficient diversity in plan choice so that stability and quality in providers is reasonable. So, too, government should be able to require portable coverage, as the recent Kassebaum-Kennedy bill begins to do. Also, physicians and other parties should be able to insist, as they have, that there be no physician “gag” clauses.

Investors. Another novel and necessary focus is on investors’ accountability to professional standards. Whereas the entirely free market would dictate a pure capital-gain motive, accountability to professional standards requires that there be limits to that motive. Limits would apply whenever pure gain might compromise professional conduct. For instance, investors could compromise professional conduct by putting such pressure on organizations that physician incentives are overly intense or otherwise misaligned with health-motivated clinical judgments. Investors should be held accountable by physicians and others for their observation of such limits.

Private payers. Less novel but no less important is accountability of private payers. In the era of fee-for-service medicine, private payers oversaw steady growth in health care costs, and they made sufficient profits that they accounted for a large portion of the country’s market stability. Private payers have been held strictly accountable now that managed care has taken over their function. Nonetheless, they will continue to exist and should be held accountable in a more modulated way by several parties. These should include private payers’ customers (the employers who purchase insurance from them), government, patients, physicians, and health care delivery organizations.

Government. Because government accountability is well discussed in other venues, it is not worthwhile to reiterate this discussion in detail here. However, government accountability to professional values for health care delivery structures is essential, too.

Patients. Last but not least, the patient has some obligations. These are articulated, for instance, in the counterparts to patients’ bills of rights in professional and institutional statements. Because being ill makes a person vulnerable, obligations must be limited, and there should be few or no external procedures for accountability. Nonetheless, patients have critical perspectives and influences, and thus they have some obligations, if their health permits, to use them prudently.

The Standards

Who should set the standards? Accountability differs among the parties in health care on the question of to whom the parties are accountable, on domains of accountability, and on procedures. Despite these differences, there must be one party with broad responsibility for setting standards. Professional associations—whether national, state or county,
specialty, licensing, or accrediting—are the natural parties to articulate tangible standards for professional accountability. Almost by definition, there are no other entities that have such ability and extensive responsibility to be the guardians of health care values—for the medical profession and for society.

■ **On which domains?** Most of the domains for accountability are directly related to professional standards. Articulated elsewhere, these include competence, legal and ethical conduct, adequacy of access, and public health promotion. A remaining domain, financial performance, demands different performance standards than those in non–health care spheres and therefore belongs on this list. For each party, the content of the domain must suit the activity. It will take years of experience and scholarship to define these tailored domains for all parties as well as they have been defined over the years for physicians. Some examples, however, are immediately available. For instance, competence for physicians refers to medical skill, while for health service organizations it must refer to organizational matters. For employers and patients, competence must refer to the ability to make informed choices and to use the powers of voice and exit responsibly. Special considerations might exist. For example, consider the use of exit, or dropping of plans, by employers. Employers’ powers of exit may be sufficiently driven by cost considerations so that quality, access, and other ethical considerations are overpowered. Thus, it will be necessary to strengthen accountability for these more vulnerable standards.

■ **By which procedures?** For each party and area of accountability, procedures must be developed. Each procedure must be reliable, effective, and without undue interference in or burden on the actual activities of health care delivery. The procedures will often be well established in professional activities but also can be drawn from the consumer and other paradigms. Depending on the parties and domains involved, procedures can involve anything from a moral disposition, with only an internal conscience for monitoring accountability, to such external controls as continuing medical education requirements, report cards, or legal enforcement. Where moral disposition and internal conscience are the primary elements of rendering accountability, the consequences of abrogation are less tangible but potentially forceful, as they often include loss of reputation. The necessary first step here is to make sure that the parties have a mind-set of professionalism.

External accountability can be secured in several ways. For instance, a proposal has been made to amass a database for report cards on professional standards in managed care organizations. This database then would become available to all of the relevant parties in health care. Such a database, if reliable and available, could become a powerful tool for promoting and preserving accountability to professional standards.

**NOTES**

7. AMA, *Code of Medical Ethics*.
8. Emanuel and Emanuel, “What Is Accountability in Health Care?”
9. Emanuel, *Professionalism, Accountability, and Managed Care*. 