

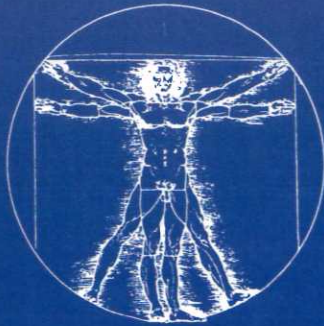
Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law *Year 1995*

Mid-Atlantic Ethics Committee
Newsletter, Summer 1995

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MID-ATLANTIC ETHICS COMMITTEE

N E W S L E T T E R

A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia
Published by the Institutional Ethics Committee Resource Network
Law & Health Care Program
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ETHICAL ISSUES IN MANAGED CARE

Driven by the winds of strong economic and business forces, the “era of managed care” suddenly blew into the Mid-Atlantic region one day, with a storm. And before anyone had time to prepare, it brought with it fierce competition in the health care market; new and continuously changing relationships among health care providers (with everyone playing “Let’s Make A Deal”); and a host of complicated ethical issues, not the least of which involves potential conflicts of interest between physicians and their patients which strike at the very heart of that traditionally sacred relationship.

Many of the ethical issues arise because health care delivery in the era of managed care is best defined by containment and limits, a sharp contrast and perhaps reaction to the health care system of the previous 30 years, which was characterized by unparalleled growth—in technology, therapeutic treatments, patient choice, patient rights, and physician reimbursement and power.

Current statements from professional societies and other analysts focus on three areas of concern:

- 1) the changing role and responsibilities of the physician;
- 2) financial conflicts of interest,

Letter From the Editor

After spending the past year on Capitol Hill, working for Senator Barbara Mikulski on the Senate Subcommittee on Aging and handling her health legislation issues, I have a new awareness of the need for greater ethical reflection on matters of health care policy. For this reason, we have decided to devote this issue of the newsletter to ethical issues in managed care and some of the issues managed care may raise for ethics committees. Our feature story, by Ruth Gaare, focuses overall on ethical issues in managed care, in particular some of the conflicts it creates for physicians. Our case study also involves a managed care patient and some problems this creates for his physician/neurologist. The case includes three sets of comments—two from managed care physicians and one from a neurologist. We hope that the issue will stimulate discussion among ethics committees on managed care issues and that you will write and tell us about some of your own views and experiences with ethical issues in managed care.

Diane E. Hoffmann

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NETWORK NEWS

Baltimore Area Ethics Committee Network (BAECN)

The first fall meeting of the BAECN will occur in October; the topic and location of the meeting will be announced in September. Anyone interested in hosting the meeting or suggesting a topic for this or future meetings should contact Jack Syme, M.D., President, BAECN, at the Department of Neurology, St. Agnes Hospital, Baltimore, MD at (410) 368-3020.

The BAECN's new subcommittee for Ethics Case Review is up and running and available for consultation review of hospital ethics committee decisions. This retrospective review process may take the form of a written analysis or of an entire meeting of the committee dedicated entirely to a discussion of the issues presented. To request a consultation review, contact Jack Syme, M.D. at (410) 368-3020.

Virginia Bioethics Network (VBN)

The third annual meeting of the VBN is scheduled for Friday and Saturday, October 20 and 21. The meeting will begin with dinner at 6 p.m. on Friday. Dr. Paul Schuyve, Vice President for the JCAHO, is expected to critique the document *Recommended Guidelines on Procedures, Process, Education and Training to Strengthen Bioethics Services in Virginia*, which the VBN has been developing over the past two years. The agenda for the meeting will include the final vote on the *Guidelines*.

The VBN, Trigon Blue Cross/Blue Shield, and Continuing Medical Education at the University of Virginia will co-sponsor three-hour educational sessions at six member institutions this fall. The sessions will focus on (1) Treatment of Pain, (2) General Care of the Dying Patient, and (3) Advanced Care Planning for End of Life Decisions. All Virginia physicians are

invited to attend these sessions. They carry three CME hours and are offered free of charge. Please call (804) 924-5974 for further information.

Richmond Bioethics Consortium (RBC)

The Summer 1995 issue of the RBC's Newsletter, "Bioethically Speaking," focuses on the role of religion in ethical decisionmaking related to health care. The articles discuss medical ethics from the perspectives of various world religions and the legal right of adults and children in the United States to base their medical decisions on religious beliefs. It also presents a case study and commentaries involving a minor patient, a Jehovah's witness diagnosed with acute leukemia. For a copy of the newsletter, write to Joel Blum and Patti Brandt, Editors, Bioethically Speaking, P.O. Box 8477, Richmond, VA 23226.

The annual members meeting of the RBC is scheduled for Wednesday, September 27, and is open to the public. Officers and new board members will be elected at this meeting, which will take place at St. Mary's Hospital, Richmond. For information about the exact time and location, call (804) 287-7450.

West Virginia Network of Ethics Committees (WVNEC)

In the most recent issue of the Network's quarterly newsletter (Summer 1995), the WVNEC presents a case consultation and invites commentary from member ethics committees. The case involves an ethics committee consultation, requested by a pulmonologist, on the use of life-sustaining treatment for an elderly patient who is dependent on a mechanical ventilator, suffers from the effects of a massive stroke, has no Medical Power

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Managed Care

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particularly between physicians and patients; and

3) the ethical responsibility of managed care plans.

The Physician in the Era of Managed Care

Whereas in the not so distant past, the physician and patient were an isolated two-some outside of any organizational context, physicians in an era of managed care are challenged to redefine their role as they struggle to negotiate and understand contracts that make their medical practice essentially a three-some: physician, patient, and the corporate entity.

Many of the ethical dilemmas at issue in managed care are due to inherent conflicts between the managed care plan's responsibility to provide cost effective medical care for a "group" and the traditional physician role to advocate for "each patient." The Woodstock Theological Center's report, "Ethical Considerations in the Business Aspects of Health Care," describes this conflict: "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." Other similar constraints, such as limitations on the specialists or laboratories to whom physicians can refer, can cause ethical conflicts, such as when primary care physicians have concerns about the quality of services offered by those on the managed care plan's approved referral list.

Professional reports and guidelines have begun to address these issues and generally argue strongly for continuing the primacy of the physician-patient relationship. Physicians also are urged to be strong advocates for individual patients in the corporate structure, when

necessary; as well as to be actively involved in corporate policy-making.

The American Medical Association's Council on Ethical and Judicial Affairs recently issued guidelines for "Ethical Issues in Managed Care" (an edited version follows):

* The duty of patient advocacy is a fundamental element of the physician-patient relationship, and physicians must continue to place the interests of their patients first.

* Broad allocation guidelines that restrict care should be established at a policy-making level so that individual physicians are not asked to engage in ad hoc bedside rationing.

* Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients.

* In cases in which the physician thinks care has been denied that would "materially benefit the patient," the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline, but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline.

* Physicians should assist patients who wish to seek additional appropriate care outside the plan when the physician believes the care is in the patient's best interests.

* Physicians should promote full disclosure to patients enrolled in managed care organizations. Physicians must tell patients all of their treatment options, regardless of the cost and regardless of whether they are covered by the insurance plan.

The Woodstock Report also issued guidelines that propose an aggressive role for physicians and health care professionals when rules and regula-

tions conflict with their professional judgement:

* 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.

"The duty of patient advocacy is a fundamental element of the physician-patient relationship, and physicians must continue to place the interests of their patients first."

Compensation Packages and Conflicts of Interest

Another major source of ethical concern is the reimbursement arrangement offered by managed care groups to physicians, who often are compensated by a fixed-fee salary, by a share in the profits of the plan, or by bonuses. This can create financial incentives for physicians to undertreat, cut corners, or reduce the services they provide. Such incentives to withhold care are generally believed to pose more of a threat to the patient than the traditional fee-for-service incentives to overtreat because a patient has no way of knowing when a treatment has been withheld, and therefore, would not realize the need for a second opinion.

The AMA guidelines also address financial incentives:

* Financial incentives are permissible only if they promote the cost effective delivery of health care and not the withholding of medically necessary care.

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* Any incentive to limit care must be disclosed fully to patients by the managed care plan on enrollment and at least annually thereafter.

* The amount of fee withholds, bonuses, and other financial incentives should be limited.

“Managed care plans, as moral entities, also have special obligations which include duties of fairness to all enrollees, and special obligations as community resources to society at large.”

* Payments should be calculated according to the performance of a sizable group of physicians, rather than on an individual basis.

* Health plans should develop financial incentives based on quality of care, to complement financial incentives based on the quantity of services used.

The Ethical Responsibility of Managed Care Plans

As a business involved in the provision of professional services, a managed care plan may be obligated to articulate a mission statement and carry on its business with a standard of behavior expected of health care professionals. Managed care plans, as moral entities, also have special obligations which include duties of fairness to all enrollees, and special obligations as community resources to society at large.

For instance, since managed care plans are responsible for distributing health benefits to a population of enrollees, decisions about whether to cover benefits that disproportionately respond to the needs of a particular subset of their populations should include discussions of distributive justice, and not be solely determined

by a utilitarian analysis of overall costs and benefits, or by the marketing advantages of providing certain benefits (that might attract a healthier population).

The AMA report proposes a few specific guidelines for managed care plans:

* Managed care plans must adhere to the requirement of informed consent and full disclosure of material information, which means that plans must inform potential subscribers of limitations or restrictions on the benefits

package when they are considering entering the plan.

* Managed care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines.

* Managed care plans should have adequate appellate mechanisms in place so that patients and physicians can challenge decisions to deny or limit medical care.

Given the changing structure of health care delivery and the new triad (physician, patient, and managed care organization) involved in medical care, ethics in the era of managed care must focus more seriously on health care systems and organizations.

Role of Ethics Committees

Physicians troubled by the conflicts they are beginning to face as a result of participating in managed care plans, may start to bring cases to institutional ethics committees. These committees must be prepared to take on these issues. In addition, managed care plans should consider establishing formal mechanisms within the organization that would promote a discussion of the ethical values of the organization and

the inevitable conflicts that arise, and that monitor the ethical practices of the organization and individuals.

References:

1. Woodstock Theological Center, *Ethical Considerations in the Business Aspects of Health Care*, Georgetown University Press, 1995.
2. Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*. *Journal of the American Medical Association*, January 25, 1995: 330-335.

Submitted by
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Case Presentation

One of the regular features of the Newsletter is the presentation of a case considered by an ethics committee and how the committee resolved it. Individuals are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information of patients and others in the case should only be provided with the permission of the individual. Unless otherwise indicated, our policy is not to identify the submitter or institution. Cases and comments should be sent to: Editor, Mid-Atlantic Ethics Committee Newsletter, University of Maryland School of Law, 500 W. Baltimore St., Baltimore, MD 21201-1786.

Case Study From The Lahey Hitchcock Medical Center Burlington, Massachusetts

A 48-year-old man who is enrolled in a managed care program is becoming progressively incapacitated from the type of multiple sclerosis known as *chronic progressive MS*. He has fallen on a number of occasions, and his disease is interfering with his ability to work at his job and to participate in activities he finds pleasurable.

Within the past year, B-interferon has been demonstrated to reduce the number of new attacks and the incidence of new lesions in another form of multiple sclerosis called *relapsing-remitting MS*. Although patients with chronic progressive multiple sclerosis are being studied, there is no current proof as to whether B-interferon would be effective or not in this form of the disease.

Many neurologists, including the patient's, believe that the two forms of the disease differ only in the ages at which they present and that the B-interferon should work as well for one

form of the disease as for the other. The patient's neurologist has prescribed it for him.

The cost to treat the patient with B-interferon for one year will be approximately \$10,000. The patient's managed care plan has requested a letter from the neurologist documenting that the patient has the relapsing-remitting form of the disease. The neurologist is concerned that if he is honest about the form of the disease that the patient has, the patient will be denied coverage by the managed care plan.

This case and the following comments from Dr. Sabin were (with some modification) taken from the Lahey Hitchcock Clinic Section of Medical Ethics Newsletter June 1995, David Steinberg, M.D., Editor.

Case Discussion: Comments From a Managed-Care Plan Physician

We should start by probing the premise that a physician has "a moral obligation" to provide B-interferon to his patient. Suppose a patient is poor, has no insurance, and his physician happens to have \$10,000 to spare in his checking account. Is he morally obliged to withdraw the funds to purchase the B-interferon for him? Doing so would be an admirably generous act, but he would not be violating a moral obligation by not doing it. Given the physician's belief that B-interferon might be of great benefit to his patient, he is correct in his decision to inform his patient of that possibility, but I doubt that he really means to endorse the view that he himself is obliged to provide it.

Many physicians, however, would advise that even though a physician is not personally required to provide the B-interferon through his own funds, he would be justified in lying to the insurance company to get it for him. I disagree.

Health insurance is a social mechanism by which groups of people pool resources to pay for health care.

Because the resources are limited, insurance administration requires rules and regulations to determine how the available money will be spent. The entire insurance system ultimately depends on trust between the involved parties—patients, doctors, insurers, and the corporate and government entities that purchase the insurance for employees or groups of citizens.

The physician might argue, however, that his patient's suffering is so severe and, the likelihood of benefit to him is so great that lying is justified. After all, honesty is not an absolute value. If the Gestapo asked us if we were hiding Jews, the correct answer would be "no" whether we were or weren't. And if a patient's insurance program covers a million people, a \$10,000 treatment for the patient will cost each member only a penny, so the funds the physician's lie would commandeer from each subscriber are trivial.

If we physicians lie to insurers when we believe that doing so will benefit our patients, the system—and ultimately the common good—will deteriorate in several ways. Insurers aren't dumb. They will implement new ways of checking up on us or will decide to limit coverage. Other doctors will lie for less defensible reasons than this one. And when our patients see us lying to the insurer, their overall trust in the integrity of our profession will go down.

Managed care plans don't print money—they manage the collective funds of those who purchase the insurance. They may do this well or poorly, but that is their job. They are not simply deep pockets for us to raid as Robin Hoods in white coats.

I recommend the following course of action to this physician:

- 1) Tell the patient that although B-interferon is not a validated treatment for his disease, you believe it might benefit him, and explain why.
- 2) Explain the insurance restrictions, and what the cost of the treatment would be to him.
- 3) Tell the truth to the insurance company, and explain why you think

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Case Discussion

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the policy is wrong and the treatment should be provided.

4) Since the same question will come up for other patients and neurologists, work with colleagues and MS advocacy groups to promote your perspective on coverage policy.

In countries where collective budgets provide insurance coverage to all citizens (almost all first world economies except for the United States), it is easy to see that trade-offs and hard choices must be made. If B-interferon is not a validated treatment for chronic progressive MS, I doubt that other countries would cover it because doing so would mean not covering something else of more potential benefit. This physician's wish to see the policy changed is totally legitimate, but it would be unethical to pursue this objective by lying to the insurance company and commandeering the pooled resources in the insurance fund without the consent of the subscribers who create the fund.

Submitted by
James Sabin, M.D.
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Community Health Plan

Case Discussion: Comments From a Neurologist

Multiple sclerosis (MS) is a neurologic disorder of unknown etiology. It characteristically begins in young adulthood, and the sufferers of this disease are subject to unpredictable attacks of blindness, weakness, numbness, double vision, or incoordination. These attacks are called exacerbations or relapses. Often these relapses remit over several days to weeks with sometimes little or no residual deficit. The frequency and number of these relapses and remissions varies greatly from patient to patient. Some can have a few attacks early in life and never

again, and some have a lifelong series of attacks. After several years of relapses, many patients begin to have permanent deficits. Eventually many of them enter a chronic phase of the disease that is characterized more as a progressive deteriorating course, than a relapsing and remitting one. This is called the chronic progressive phase of MS. About 10% of patients with MS have a chronic progressive course from the outset.

Until recently the only treatment available was a short course of intravenous or oral steroids during an attack. This has been shown to improve long term outcome in some situations, but does not change the severity or frequency of relapses. Beta interferon is the only medication so far proven to be effective in preventing relapses.

Beta interferon for treatment of relapsing/remitting MS was approved by FDA in 1993¹. Studies showed that beta interferon reduced the number of moderate and severe exacerbations significantly over placebo, and that the patients who received a higher dose of beta interferon had an even more significant result. Most impressively the medication had a significant effect on the appearance of active and new MRI brain lesions over the course of the disease. However, at the end of the three year trial period the disability scores of those on beta interferon were essentially the same as those on placebo. This suggests that while the exacerbations are less frequent and the MRI lesions less numerous, no long term benefit could be proven. The most common significant adverse effects were flu-like symptoms, and injection site reactions.

The medication is given as a subcutaneous injection every other day. Unfortunately, as the case indicates, the medication is very expensive, approximately \$10,000 a year. This alone raises questions about who should be paying for an expensive medication with no clear long term benefit, but for which there is no substitute. Beta interferon is only now being studied in patients with chronic progressive MS and it is not currently known if it is beneficial or not in this form of MS.

In this case the neurologist seems to be faced with a dilemma. The role of the physician includes several *prima facie* duties. Among them the duties of veracity, beneficence and fidelity. That is, the physician should tell the truth, seek to maximize the patient's well being, and be loyal to or advocate for his or her patient. Of these, the duty of veracity is perhaps the strongest and would require compelling reasons to justify overriding it. At first glance it appears that the duties of veracity and beneficence are in conflict, i.e. either the neurologist lies about the patient's condition, or the patient does not get a potentially beneficial medication.

Perhaps the neurologist can claim that the patient has relapsing-remitting MS without lying. Clinically it can often be difficult to determine when a patient has made a transition from the relapsing-remitting to the chronic progressive form. It may not require too much deception on the part of the neurologist to say that the patient is in the chronic progressive phase of relapsing-remitting MS. However we are not given any clinical details about the patient, and this solution to the dilemma seems too convenient, so for purposes of discussion I will assume that he is one of the 10% of patients who have had chronic progressive MS from the initial diagnosis, and therefore, has a disease without proven benefit from beta interferon.

Is there any basis then for the neurologist to tell the insurer that the patient has relapsing/remitting MS? According to Beauchamp and Childress² the following are requirements to justify the infringement of a *prima facie* duty:

- 1) the moral objective justifying the infringement must have a realistic prospect of achievement;
- 2) infringement of a *prima facie* principle must be necessary in the circumstances, in the sense that there are no morally preferable alternative actions that could be substituted;
- 3) the form of infringement selected must constitute the least

infringement possible, commensurate with achieving the primary goal of the action; and
4) the agent must seek to minimize the effects of the infringement.

The moral objective in this case is to improve the patient's well-being by reducing attacks of MS with beta interferon. However, there is no proven benefit of beta interferon in chronic progressive MS, and there is no proven long-term improvement in disability scores in relapsing-remitting MS either. So in addition to the unknown chance of success, the potential benefit (fewer relapses) is relatively small given the nature of the infringement. Because of this lack of certainty and relatively small benefit, there is not a compelling reason to justify infringing upon the physician's duty to veracity.

If, after discussing the risks and benefits of the medication, the patient consents to beta interferon treatment, the physician is compelled to prescribe it and is compelled to help the patient obtain it because of the physician's *prima facie* duties of fidelity and beneficence. Also, there are other means for the patient to get the medication other than by the physician lying to the insurers. If the patient is wealthy enough then he could pay for the medication himself; if not, the manufacturer has set up a financial assistance program to help those who have no insurance coverage, and cannot afford the medication on their own.

References

1. *Interferon beta-1b is effective in relapsing-remitting multiple sclerosis. The IFNB Multiple Sclerosis Study Group. NEUROLOGY* 43. 1993. pp. 655-661.

2. *Beauchamp and Childress. Principles of Biomedical Ethics. 3rd ed. page 53. Oxford University Press. 1989.*

Submitted by
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Case Discussion: Comments From a Physician/Ethics Committee Chair

B-interferon has been approved by the FDA for treatment of the relapsing-remitting form of multiple sclerosis, yet the research to date has shown no improvement in functional status after three years of treatment. The drug however does decrease the number of relapses, thereby improving the patient's quality of life. It also carries significant burdens: It is very expensive; it can cause skin reactions, depression, a flu-like syndrome, and other effects; and its long-term side effects are unknown. B-interferon currently is being investigated for its usefulness in the chronic progressive form of MS.

In the case in question, the patient has the chronic progressive form of the disease. His neurologist believes that B-interferon will help him, and has ordered it for him, but the managed care plan only will cover the cost if the patient has relapsing-remitting MS. This case raises issues about the quality of care under managed care, allocation of increasingly scarce resources, and the duties of physicians to their patients in the managed care setting.

This neurologist believes that B-interferon will help his patient, but there is currently no rigorous proof supporting that belief. Should an individual physician be allowed to garner a large portion of the collective, and finite, funds of the health plan members for his patient because of his personal, and unsubstantiated, belief? Multiply this scenario thousands of times, and you have one factor in the explosion of health care costs over the last two decades.

The profession of medicine now is gravitating towards the development and use of practice guidelines based on clinical research and outcomes studies to determine which treatments to apply to which conditions. In Northern California, Kaiser Permanente, which

is a large, non-profit, integrated health care system covering 2.4 million members, the issue of B-interferon use in MS is dealt with in a way that tries to ensure a consistent, fair, and research-based approach. A committee of neurologists who specialize in multiple sclerosis reviews every case in which a neurologist from the region requests B-interferon treatment for a patient with MS. The committee has criteria for approval, which it developed after extensive review of the literature, and which it applies consistently. To be approved for B-interferon, the patient must meet the criteria of the patients in the studies who benefited from the treatment; that is, patients with the relapsing-remitting form of MS and the ability to walk, and other criteria. To ensure fairness, the name of the patient and of the referring neurologist are encoded and the case is presented anonymously to the committee.

This is an example of how managed care can actually lead to improvements in the quality of medical care by providing beneficial treatments to patients who are likely to benefit, and preventing unproven treatments, with their attendant side effects, from being used on others. This system also removes the inequities of having each patient's therapeutic fate depend on the advocacy skills, energy, and interest of their primary physician.

What about the patient with chronic progressive MS who is willing to risk the side-effects and lack of proven benefit from B-interferon, because there is no other treatment available? Desperation is not a reason to subject a patient to the side-effects of an unproven treatment. However, in this clinical setting, the treatment would be experimental, and its use could be justified easily by enrolling the patient in a study of the drug. The patient may still be randomized to the placebo arm of the study, but at least he would have a chance at getting the drug he desires, in a setting that would lead to improved knowledge about the drug's efficacy for his type of disease. If

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Case Discussion

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patients were provided with all of the unproven treatments they thought might help them, we would never have the studies to show us if new treatments bring about more help or more harm.

What is the duty of the physician in the managed care setting when faced with a conflict between what he or she thinks the patient needs, and what the plan will pay for? Regardless of the setting, the primary duty of physicians is and always will be to benefit the patient. Some managed care organizations are cutting corners, establishing strong financial incentives to reduce costs, and erecting barriers to the provision of good patient care to the extent that the physicians find themselves in a real conflict between their duty to provide good care and their economic interest. In this case, if the treatment the patient needs is clearly beneficial, then the physician has a duty to advocate for the patient. The physician should not, however, lie to the health plan in order to secure payment for a treatment. If the physician is working for or with a health plan which refuses to provide a needed treatment, it is time to part company with that plan. This may entail a real hardship in today's changing health care environment, where doctors now find themselves an expendable commodity, but it is preferable to providing care through a company which will not allow appropriate and needed treatments. Having said this, we do not believe that the neurologist for the man with chronic progressive MS should either lie to the health plan to secure the B-interferon or advocate for its use, because it is not a proven beneficial treatment.

Submitted by
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STUDIES ON END-OF-LIFE TREATMENT DECISIONS AND ADVANCE DIRECTIVES

Our Winter 1995 issue of this newsletter reported the results of a University of Virginia survey on Virginians' attitudes towards end-of-life treatment decisions and advance directives. Similar studies have been done in other states in the region, including West Virginia and Maryland. Their results in large part parallel the findings of the Virginia survey, with several interesting differences.

A recent Maryland study, conducted by investigators from the University of Maryland Schools of Law, Medicine and Social Work, interviewed senior citizens from urban and suburban areas on the subjects of (1) their knowledge of and attitudes towards living wills and durable powers of attorney for health care (DPAHC) and (2) their preferences for life-sustaining treatment (CPR, ventilatory support, or artificial nutrition/hydration) under scenarios involving terminal cancer, permanent unconsciousness, or advanced Alzheimer's disease. The respondents also read and completed the Maryland Advance Directive Form, part of the Maryland Health Care Decisions Act.

The study found that although a large majority of the respondents were familiar with the concept of a living will (only half were familiar with a DPAHC), only a quarter of respondents actually had a living will or DPAHC, a finding that parallels the Virginia survey's figure of 20 percent but is significantly higher than West Virginia survey results of five percent. Factors significantly associated with having a living will or DPAHC (in the Maryland study) were the presence of a will for estate distribution purposes, the respondent's race (Caucasian), absence of children in close physical proximity, and education beyond high school. The most common reason for obtaining some sort of an advance directive was the respondent's negative experience

with the illness or death of a relative.

In their responses to questions about life-sustaining treatment, three-quarters of respondents uniformly indicated they would not wish to receive such treatment, regardless of the scenario or treatment involved. Again, these results are similar to those of the Virginia survey. Factors significantly associated with the decision to refuse life-sustaining treatment were personal experience with some form of life support, race (Caucasian), age (younger than 75), gender (female), education beyond high school, living alone, and absence of a child with whom the respondent was emotionally close.

Finally, many respondents found the Maryland Advance Directive Form confusing and generally difficult to complete. As a result, when responses on the form were checked for internal consistency as well as consistency with responses to the interview, high rates of inconsistency were found. These findings point to the fact that much needs to be done to explain the function of advance directives and increase their relevance and accessibility to the general population.

Network News

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of Attorney or Living Will, and lacks decisionmaking capacity. Three of the patient's four children agree with the pulmonologist's approach of providing comfort care while removing the patient from the ventilator, but the youngest child threatens violence if this approach is followed.

Ethics committees that wish to participate in the dialogue among WVNEC members with regard to this case or future case consultations or would like a copy of the newsletter should contact Alvin Moss or Cindy Jamison at the Center for Health Ethics and Law, 1354 Health Sciences North, P.O. Box 9022, Morgantown, WV 26506-9022, (304) 293-7618 or FAX (304) 293-7442. The best case commentaries will be printed in the October issue of the newsletter.

LEGISLATIVE UPDATES . . .

VIRGINIA LEGISLATION ON EMERGENCY SERVICES IN MANAGED CARE

The New York Times reported on July 9 of this year that as enrollment in health maintenance organizations soars, doubling in the last eight years nationwide, many HMOs are increasingly denying claims for care provided in hospital emergency rooms. Such denials create obstacles to emergency care for managed care patients and often leave them responsible for thousands of dollars in medical bills. HMOs, however, claim that their costs would become uncontrollable if they allowed patients unlimited access to hospital emergency rooms.

Most HMOs promise to cover "emergency medical services," but there is no standard definition of the term. Thus, HMOs may define the term narrowly, reserving the right to deny payment if they conclude, in retrospect, that the conditions treated were not emergencies. Hospitals, on the other hand, are required by federal law to provide an "appropriate medical screening examination" and sufficient care to stabilize any patient who requests care in the hospital's emergency room. As a result, managed care organizations are able to shift costs to patients, physicians and hospitals.

A few states, among them Virginia and Maryland, have passed legislation to address this problem. This year, Virginia adopted an amendment to its existing health maintenance organization law, adding a definition of emergency services and basing that definition on a "prudent layperson" standard. Its approach was similar to that taken in Maryland in a bill passed in 1993. In the Virginia statute, "emergency services" are defined as

. . . those health care services that are rendered by affiliated or

nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, or (ii) danger of serious impairment of the individual's bodily functions, or (iii) serious disfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

VA. Code Ann. Section 38.2-4300 (Michie's Sup. 1995)

The amendment also provides that emergency services provided within a managed care plan's service area by non-plan providers must be covered by the plan, but only if the delay caused by obtaining care from a plan provider could reasonably have been expected to cause the plan member's condition, if left unattended, to deteriorate.

Similar efforts are underway at the federal level: Representative Benjamin Cardin, Democrat of Maryland, has introduced a bill that would establish a uniform definition of emergency based on the judgment of a "prudent layperson." The bill would prohibit HMOs from requiring prior authorization for emergency services and impose stiff fines for violations. The American College of Emergency Physicians, which represents more than 15,000 physicians, has been urging Congress to adopt such changes and supports the legislation.

MARYLAND MANAGED CARE LEGISLATION

The Maryland legislature in the 1995 session passed several bills dealing with managed care. The most controversial one, referred to as the "Any Willing Provider" bill, will make it easier for health care providers to participate in provider panels used by managed care plans and will apply to provider contracts issued or renewed on or after January 1, 1996. The bill (HB724/SB449) passed despite strong opposition from a coalition of health insurers, health maintenance organizations (HMOs), and the Maryland Chamber of Commerce.

In addition to regulating procedures used by managed care plans to process and respond to applications from health care providers for participation in a provider panel, the law bars plans from denying a provider's application if the plan provides services within the provider's scope of practice, unless the plan's panel has a sufficient number of similarly qualified providers. Moreover, managed care plans will not be allowed to reject or terminate providers for filing complaints against the plan or for advocating the interest of a patient through the plan's internal review system. If a provider is terminated for reasons other than fraud, patient abuse, incompetency, or loss of license, the law gives health plan enrollees the right to continue to receive services from that provider for a transition period of up to 90 days.

The Maryland General Assembly also passed SB 694, which authorizes the Maryland Department of Health and Mental Hygiene to require Medicaid recipients in the state's Medical Assistance Program to enroll in managed care plans. This provision is conditioned upon the state receiving a § 1115 Medicaid waiver from the U.S.

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Legislative Updates

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Department of Health and Human Services. Another bill (SB 310/HB 351) prohibits HMOs from denying coverage for the use of a so-called "off-label" drug (a drug not specifically approved by the Food and Drug Administration for a particular treat-

ment) if the drug is recognized for that treatment in standard reference sources or the medical literature.

Finally, although vetoed by the governor, the legislature passed HB 615, which would have required HMOs to reimburse health care providers for any health care services provided to an HMO member in a hospital emergency facility. An HMO could not have required a health care

provider to obtain prior approval for payment as a precondition for reimbursement, but the bill would have required the provider to attempt to notify the HMO as soon as practicable after services had been rendered. (See also *Virginia Legislation on Emergency Services in Managed Care*, page 9.)

CALENDAR OF EVENTS

SEPTEMBER

- 12 Southern Regional West Virginia Network of Ethics Committees Forum. "Ethical Issues in the Care of the Dying." Co-sponsored by St. Mary's Hospital, Cabell Huntington Hospital, and Hospice of Huntington; at St. Mary's Hospital, Huntington, WV. Call Cindy Jamison at (304) 293-7618.
- 14 Medical Humanities Hour. "Why Pain is Bad: A Discussion of Problems for Rationality and Ethics," Douglas McLean, Ph.D., University of Maryland Baltimore County. 4:30 - 5:30 p.m., at Shock Trauma Auditorium, University of MD Medical System, Baltimore, MD. Call Henry Silverman, M.D. at (410) 706-6250.
- 14-17 Society for Bioethics Consultation Ninth Annual Meeting, Cleveland, OH. Contact: Francoise Baylis, University of Tennessee, Department of Philosophy, 814 McClung Tower, Knoxville, TN 37996-0480, tel. (615) 974-3255.
- 15 Roanoke Memorial Hospitals Ethics Conference. "Deciding How We Die: The Use and Limits of Advance Directives." Sheraton Inn-Airport, Roanoke. Cost: \$25 for Carilion Affiliates, \$50 for others; registration deadline is September 1, 1995. For information, contact the Department of Education, Roanoke Memorial Hospitals at (540) 981-7009.
- 15 Shore Memorial Hospital Seventh Annual Bioethics Conference. "Language, Informed Consent and Truth Telling." 8:00 a.m. - 5:00 p.m., at the Sheraton Inn, Atlantic City West, NJ. Contact: Shore Memorial Hospital at (609) 653-3828.
- 19 Metropolitan Washington Bioethics Network Meeting. Topic, time and location TBA. Call Joan Lewis at (202) 682-1581.

CALENDAR OF EVENTS (cont.)

- 20 Richmond Bioethics Consortium Education Committee Meeting. 7:30 - 8:30 p.m., at St. Mary's Hospital Cafeteria, Richmond, VA. Call Patti Brandt at (804) 287-7450.
- 20 D.C. Bar Association, Health Law Section Seminar. "Health Care Delivery in the District of Columbia." Co-sponsored by the D.C. Affairs Committee of the Bar. For time and location, call the D.C. Bar Sections Office at (202) 626-3463.
- 27 Richmond Bioethics Consortium Annual Members Meeting and Election of Officers and New Board Members. Open to the public. For information about time and location, call (804) 287-7450.
- 29-30 American Society of Law, Medicine and Ethics 1995 Annual Meeting. "Managed Care, Integrated Delivery Systems, and Consolidation - Law, Medicine and Ethics." Co-sponsored by the Center for Biomedical Ethics, U. Minnesota; at the Boston Park Plaza, Boston, Massachusetts. Contact: Annual Meeting Registrar at (617) 437-7596..

OCTOBER

- 10 William S. Albrink Memorial Lectureship in Bioethics. "Capitation for the Dying: Opportunities and Cautions," Joanne Lynne, M.D., George Washington University School of Medicine. At Byrd Health Sciences Center, University of West Virginia, Morgantown. Call Cindy Jamison at (304) 293-7618.
- 12-15 Society for Health and Human Values Annual Meeting. "Values in Health Care: Diverse Perspectives." At the Red Lion Hotel, San Diego, California. Call (703) 556-9222.
- 19-20 Annual Workshop. "Ethics in Healthcare Institutions: New Issues, Controversies, and Practical Considerations." Sponsored by the Center for Biomedical Ethics, U.Va. Health Science Center, at the Sheraton Inn, Charlottesville, VA. Cost: \$75 for graduates of the DHEP and DNHEP programs, \$100 for others. Call (804) 924-5974.
- 20-21 Virginia Bioethics Network Annual Meeting. "Recommended Guidelines on Procedures, Process, Education and Training to Strengthen Bioethics Services in Virginia - A Critique," Dr. Paul Schuyve, Vice President, JCAHO. Beginning 6:00 p.m. on Friday. Call (804) 924-5974.
- 24 Metropolitan Washington Bioethics Network Meeting. Topic, time and location TBA. Call Joan Lewis at (202) 682-1581.
- 27 14th Annual Sister Margaret James Lecture. "Ethical Issues in Managed Care," Arnold Relman, M.D., Editor Emeritus, *New England Journal of Medicine*, 4:00 p.m., at St. Agnes Hospital, Baltimore, MD. Open to the public. Call (410) 368-2119.

