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Cover Page Footnote

I extend special thanks to Professor Jeanne Guillemin and Professor Ritchie Lowry for their comments on earlier drafts of this work.

The Professional Decline of Physicians in the Era of Managed Care

Aimee E. Marlow

Physicians have long enjoyed prestige, power, and autonomy, but the rise of managed care organizations has drastically changed their status. Many doctors are in thrall to the financial well-being of the corporations that employ them, their knowledge and expertise controlled and manipulated in the interest of profit maximization. This article investigates the professional decline of physicians, citing the use of gag clauses, incentives to withhold care, and the breakdown of their authority. In an effort to regain some measure of control, physicians have taken their concerns to the public, supporting state and federal legislation that attempts to curb questionable managed care practices, but this new alliance is unreliable. The author evaluates the history and ultimate failure of California's propositions 214 and 216, both created to protect patients and physicians. The results clearly suggest that physician influence alone can no longer sway public opinion.

Physicians, facing deprofessionalization in the new corporate structure of medicine, are losing a tremendous amount of power. Some no longer control the simplest medical decisions, for example, what they may tell patients and what tests they may or may not administer.¹ The few who downplay the importance of such restrictions fail to recognize that "the fate of patients is tied to the fate of doctors."² In other words, the attenuation of medical practice is an issue not only for physicians, but for all who consult them. This article examines several of the myriad details regarding the state of U.S. medicine.

What Is a Profession?

Sociologists have long studied the rise of U.S. professionalization, a product of the late nineteenth and early twentieth centuries, which increased dramatically during and after the Industrial Revolution, leading to growth of large bureaucracies.³ As society developed more complex structures, institutions flourished, and the need for experts and leaders quickly became evident.⁴ Technical training and leadership capabilities separated the professional from the lay person.⁵ The literature of sociology acknowledges that in aspiring to professionalization, an occupation generally "strives to attain" the following characteristics and goals:

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1. Altruistic service to clients and society;
2. A basic liberal education followed by professional and technical training;
3. Licensure by the state . . . The criteria for licensure and practice . . . should be drawn up [in]. . . consultation [with] practitioners representing the profession.
4. The competence of professionals is judged by other professionals;
5. Professional practices continually directed by the body of theory and research relevant to the field; and
6. A code of professional ethics . . . continually developed, corrected, and enforced by the profession itself.⁶

The link between integrity, service, and appreciation for knowledge, evident in all six points, places a large responsibility on members of an occupation to uphold its professional status. Their reward for achieving success is great, for the professional gains the right "[of] freedom, not only to do his work according to his own best judgment . . . but also to choose his own style of work and economy of effort."⁷ This model reflects medicine as it should be and what most Americans expect it to be: an altruistic profession embodying integrity, autonomy, and ethical accountability.

Professional knowledge and theory are particularly important. Physicians, who traditionally rely on their interpretive wisdom to separate them from other professions, secure a coveted niche in society as healers. Basic medical knowledge, a touchstone offering them a sense of the role they should play, serves to separate patient from physician. We trust physicians with one of our most valued possessions, our health; their role encompasses strong "moral and social functions."⁸ Everett Hughes notes that, in general, professions "also claim a broad legal, moral, and intellectual mandate."⁹ He adds, "Not only do the practitioners, by virtue of gaining admission to the charmed circle of the profession, individually exercise a license to do things that others do, but collectively they presume to tell society what is good and right for it in a broad and crucial aspect of life."¹⁰ Medicine fits this mold exactly. Physicians and patients have a give-and-take relationship: patients give their trust to doctors, whose moral and intellectual obligations, they are confident, will safeguard them from harm.

In rising to dominance, physicians met all the criteria noted above, benefiting first from structural changes in society and later from their collective power. Prior to gaining authority in the late nineteenth and early twentieth centuries, doctors encountered a host of obstacles.¹¹ Without a scientifically sound body of knowledge and a lack of "unity . . . and collective authority," physicians required grounding.¹² The traditional view of illness that dominated society aggravated the issue. Paul Starr writes, "Many Americans who already had a rationalist, activist orientation to disease refused to accept physicians as authoritative. They believed that common sense and native intelligence could deal as effectively with most problems of health and illness."¹³

The late nineteenth century, a time of great cultural, scientific, and social change, greatly influenced the state of all professions. The United States embarked on a "cultural revolution," when "Americans became willing to acknowledge and institutionalize their dependence on professions."¹⁴ In addition, the Industrial Revolution brought about the urbanization of life in America and a new reliance on complex organizations with hierarchical structures, which became comfortable and accepted. The term "professional" represented power, wealth, and advanced education, all qualities revered in society.

Concurrently, physicians acquired the knowledge that granted them access to and control over grounded scientific "evidence." Advances in "diagnostic technology . . . strengthened [their] powers . . . in physical examination of the patient." Science also developed tests for "specific . . . disease," and in the 1880s, the organisms "responsible in tuberculosis, cholera, typhoid, and diphtheria were isolated"; by the 1890s, "laboratory tests had been introduced to detect [them]."¹⁵ Thanks to science and to society, physicians started gaining power.

But other hindrances remained; structural changes came from within the profession and physicians at first lacked a strong collective society that could represent them. More troublesome was the profession's lack of a "fixed track" for education; "whether or not a physician went to medical school and if he did, for how long and with what general education, were all variable."¹⁶ Such ambiguities left plenty of room for alternative forms of treatment like homeopathy and eclectic medicine to enter the market. Even as late as 1900, "the ports of entry into medicine were still wide open and the unwelcome passed through in great numbers."¹⁷

The formation of the American Medical Association (AMA) in 1847 was an attempt to give physicians an organizational foundation, but more important, the AMA sought to standardize medical education with a view toward eliminating alternative medicine.¹⁸ Initially, the organization suffered from internal conflict and lack of structure but remained dedicated "to [addressing] the problem that originally motivated its formation, control of medical education."¹⁹ In 1904 the AMA formed the Council on Medical Education, which set standards for medical schools, including increasing the preparation time necessary to become a doctor of medicine and mandating that all physicians pass state licensing examinations before being allowed to practice.

The 1906 Flexner committee, in a report that investigated the country's 160 medical schools, concluded that only 82 achieved adequate standards for medical education.²⁰ The best were encouraged to remain open, while the weaker would be closed or merge with stronger institutions. This tremendous overhaul of the educational system "greatly increased the homogeneity and cohesiveness of the profession [and] instilled common values and beliefs among doctors . . . and . . . discouraged sectarian divisions."²¹

Standardization of medical education provided other benefits as well, enabling doctors to truly define the role of physician. The lines of distinction drawn between doctors and other health care professionals were changed in the twentieth century. Hughes extrapolates: "The elaboration of the organization of hospitals, clinics, and public-health agencies combined with great technological change in medicine and an immense increase in the demand for medical services has led to a great reshuffling in the whole medical system."²² The reshuffling led to more power and autonomy for physicians. The profession simply passed along certain duties, such as taking blood pressure or filing forms, to other workers.²³ This served to set physicians even further apart, for menial, time-consuming tasks were no longer their responsibility.

By pushing forward and successfully taking advantage of the structural changes occurring on the national level, physicians ascended to the professional ranks, continuing through the post-World War II era. The new advances in scientific technology that appeared, "making [medicine] more effective in treating illness," were coupled with federal money for new hospitals and "the explosion of private health insurance."²⁴ Physicians attained an unimaginable level of resources and wealth.

The boom in the medical industry presented people with previously unimagined

prospects for making money; many physicians took advantage of the potential bonanza, adding the role of businessman to their persona.²⁵ Investment opportunities took many forms, but none was as lucrative as those offered by pharmaceuticals, an industry which by the mid-1950s was worth \$4.5 billion.²⁶ It seemed reasonable for physicians to invest in these companies, for as Howard Wolinsky and Tom Brune noted, “doctors knew something about the drugs they prescribed.”²⁷

But the public did not buy this explanation. For the first time, people were forced to realize that “doctors’ clinical judgment [could be] influenced by their business interests.”²⁸ Overwhelmingly, they rejected the physician as businessman. People were clearly uncomfortable and threatened by the thought that doctors could be persuaded to prescribe the products of drug companies in which they had a financial interest rather than more appropriate medications.²⁹ Recognizing the loss of public trust, the AMA denounced doctors’ involvement with these organizations. In a further effort to polish the tarnished image of physicians, AMA delegate Dr. Edwin B. Dunphy declared in June 1952, “The medical profession is not a luxury business but a profession dedicated to rendering service to humanity. Reward or financial gain is a subordinate consideration. Physicians should never lose sight of this principle. If they do, the medical profession will certainly be government regulated eventually *and* [emphasis added] with public approval.”³⁰ One might assume that such bad publicity and public disapproval would have deterred physicians from involving themselves in business ventures, but as history tells us, it didn’t. For the most part, corporate medicine found physicians to be willing participants.

Evolution of For-Profit HMOs

Dunphy had no inkling of the future of medicine and its business alliances. Today, reflecting on his words, one questions how far medicine has come and if the lessons of the past taught anything. The success of physicians in their pursuit of professionalism involved luck. Being positioned more than once in history to take advantage of societal changes is remarkable for any profession; the specific events noted above comprise a few such fortuitous examples in the chronicles of physicians. But what is also evident from Dunphy is that more than forty years ago, doctors, even when they held the upper hand, feared a corporate threat to their integrity.

Modern for-profit HMOs and corporate medicine do not offer physicians the power to reject or dispute the corporations. The managed care concept first gained popularity in the early 1980s.³¹ Most HMOs maintained a nonprofit status until 1987, their main theoretical purpose for existence based upon utilitarianism and rationalization, namely, to provide for as many people as possible quality health care at the least expense. As Wendy Mariner stated, “The goals of managed care came to be seen as the efficient use of health care resources . . . to provide quality care.”³² By 1987, “there were 650 HMOs with about 29 million members.”³³

Early nonprofit HMOs, seemingly adhering to the original purpose, “encouraged coordinate care, [including] preventive services, in long-term personal relationships between patients and primary care providers.”³⁴ Moving managed care into the competitive market and making it a for-profit industry apparently offered improved quality and efficiency overall since “increased competition could achieve the goals [of] providing good quality care.”³⁵ The success of profit-making HMOs depended largely on physicians’ ability to keep a “foot in both the medical and the business camps” and its success in performing “both medical and business functions, taking actions to provide or

withhold care that touches the traditional sphere of medicine, and, at the same time, acting like ordinary business enterprises with no moral obligation or, at least, obligations that have little to do with traditional medical ethics.”³⁶

In the model under discussion, medical ethics and business concerns are accorded equal priority. Although this was the intent of for-profit HMOs, it was not borne out in reality. When faced with conflicts between providing “quality medical care and . . . obligations to preserve their assets,” profit-making HMOs favored the needs of the corporation, not the profession.³⁷ Business concerns that “put profits before patients” are now “the palpable force destroying care.”³⁸

Recent Voices: Ignored but Prophetic

The rise of for-profit HMOs and the subsequent deprofessionalization of physicians should not surprise Americans. Although many people spend time and effort evaluating the present state of medicine, they fail to integrate one crucial piece of information: physicians and sociologists predicted all of today’s events more than ten years ago. The most compelling prophecies were those of Paul Starr and Eliot Freidson, both medical sociology experts, and George Lundberg, longtime editor of the *Journal of the American Medical Association*.

In the final chapter of *The Social Transformation of American Medicine*, Starr painted a dreary picture of the future of American medicine. He envisioned a time when the corporation, or “private sector,” would step in to “rationalize” medical services, taking over faltering public institutions. As corporations appropriated medicine, new challenges to physician autonomy and prestige would be inevitable, and in an extreme case, “doctors will no longer have as much power over such basic issues as when they retire.”³⁹ One backlash of this trend also brings to light for Starr another obstacle, namely, boundaries. He says, “Another key issue will be the boundary between medical and business decisions; when both medical and economic considerations are relevant, which will prevail and who will decide? . . . A regime of medical austerity will test the limits of professional autonomy in the corporate world.”⁴⁰

Also at issue, according to Starr, was the “different techniques for modifying the behavior of physicians, getting them to accept the management’s outlook.”⁴¹ Physicians will be “socialized” not merely as doctors but as corporate spokesmen, learning “to do things the way the plan or the company has them done.”⁴²

But his most chilling vision of the future seemed to be the most prophetic. Starr believed that the medical profession’s and the public’s complete inability to control the situation was an invitation to corporations to turn medicine into a for-profit industry. “Instead of public financing for prepaid plans,” he wrote, “there will be corporate financing for private plans . . . whose interests will be determined by the rate of return on investments.”⁴³

Freidson also feared for the future of medicine. He too recognized the emergence of the corporation as the biggest threat to the profession and, more specifically, turned attention to the detrimental role of inducements to cut health care costs. Freidson asserted that “considerably less emphasis on economic incentives would greatly improve the spirit in which practitioners approach their work.”⁴⁴ More idealistic than Starr, he believed that a “greater emphasis on professional values” would be the only way to repair the ailing reputation of American physicians.⁴⁵

Freidson predicted that the medical community would face a “critical choice” that

would determine the future. "We can passively accept a health care system that, in the interest of cost containment, slowly moves toward mechanizing and bureaucratizing services. Or we can actively choose to struggle for a system that . . . [is] designed to do everything it can to improve the unique lots of all those who need help."⁴⁶ The first choice has "physicians and health care workers [following] elaborate rules of procedure" and "patients [as] standardized objects," while the second focuses on "truly human health services."⁴⁷

In closing, Freidson takes issue with the way the industrialization of medicine will inevitably lead to "the loss of something precious" for both physicians and patients. Within a mechanized health care system, doctors "will have lost the opportunity to do autonomous, challenging, and creative work" and patients will "lose the opportunity to regain . . . their full potential."⁴⁸

Sociologists were not alone in addressing the problems facing the medical community and physicians. In a 1985 editorial, Lundberg lashed out at his own profession, focusing on how "we, the aggregate medical profession, are in big trouble with the public at large."⁴⁹ The problems he reports surround the issue of trust, but not technical or personal trust. Rather, he believes that the real issue is patients who do not trust physicians economically or morally. He states, "Never in modern history has the medical profession been weaker . . . To a great extent, physicians are becoming seen as highly successful businessmen who are functioning with the business ethic rather than the professional ethic . . . We are viewed by many as a restrictive cartel."⁵⁰ Thus, industrializing medicine has bankrupted the profession of any morality. In this scenario, both physicians and patients pay.

Lundberg substantiates this point by citing longitudinal data that reflected a severe decline in patients' trust of physicians, specifically in the area of money. "In 1982, 42% of the public queried expressed the opinion that physician fees were reasonable. This declined 15 points to 27% in 1984, a shocking change."⁵¹

As an insider in the medical profession, Lundberg, is critical of the conflict of interest between the physician as businessperson and the physician as healer. He offers various solutions to the problems at hand, calling on doctors to "reestablish the fact that . . . as physicians, we will represent the best interests of our patients and the public."⁵² Changing their image was not enough; Lundberg challenged physicians to "change reality, thereby becoming viewed as primarily proactive rather than reactive . . . promoting rather than opposing progress."⁵³

In financial matters, Lundberg implored all physicians to be aware of each person's "financial circumstances," to adjust payment to need when necessary. He emphasized the need for physicians to take a "leadership position" in cost management and containment and to be "intolerant of devious cost shifting and of questionable creative accounting."⁵⁴ Above all, physicians "should promote openness and full disclosure of facts because the truth is more central to medical science and to the practice of medicine than any other human endeavor."⁵⁵

Lundberg's conclusions provided room for hope, positive change, and the possibility of a bright future, but it was all contingent on physicians' reverting to "caring for the public," choosing altruism over greed, and taking a stand against unethical practices.⁵⁶ So far doctors have failed to rise to the occasion. Why is that so important? From a professional point of view, it means no more than successfully adhering to the Hippocratic oath, which asserts "that physicians have duties to (1) be loyal to patients; (2) act in their patients' interests; (3) make their patients their first consideration, even when

their own financial well-being is opposed.”⁵⁷ Physicians are, more than just technicians, accepted experts of the body working in an American society obsessed with life and death. We expect a social contract in which the professional physician serves us as effectively as possible.

Declining Power and Prestige

The shifts in American medicine are clearly leading to physicians’ losing power, which results in deprofessionalization. In the six criteria for all professions, profit-making HMOs rob physicians of their ability (1) to be “altruistic servants,” as indicated by the role of monetary incentives to reduce treatment; (2) to have their work and competence judged by other physicians, because the very structure of managed care works against camaraderie and collective activity; and most important, (3) to use medical knowledge to its fullest in a variety of contexts, for their authority and autonomy are tempered by gag clauses in managed care contracts, which determine what physicians can and cannot tell their patients and the public.

Altruism has long been a tenet of the medical profession. Many who enter the field speak of “the call,” the need to help others and to save lives.⁵⁸ The ethics and mission of medicine encourage nothing less than physicians doing everything possible to help patients, but for-profit HMOs remove this crucial element by establishing financial incentives for physicians to reduce services.

Managed care corporations introduced incentives only a few years ago, recognizing that “other approaches, such as administrative monitoring and penalties for overuse [were] less effective” in curbing physicians from excessively offering or wasting resources.⁵⁹ There are obvious flaws in this reasoning according to Marc Rodwin. “If incentives to provide services cause physicians to use too many resources and to perform unnecessary procedures, would not incentives to reduce services result in too few services? . . . How can we be sure physicians will reduce only unnecessary or wasteful services?”⁶⁰

Financial incentives are wrapped in various packages. In their most blatant form, they deter physicians from administering expensive diagnostic tests.⁶¹ In another form, HMOs “significantly reduce hospitalization,” often forcing patients out the door after major surgery.^{62, 63} A large proportion of a physician’s salary may be contingent on such incentives. In 1995, “74% of independent-practice association HMOs and 50% of group-model or staff-model HMOs [based] physicians’ payment in part on measures of utilization and cost.”⁶⁴ In doing so, such for-profit managed care organizations as US Healthcare bind “primary care physicians’ interests to [those of] the [firm] . . . Income is tethered to conduct that furthers corporate profitability.”⁶⁵ Physicians are rewarded, “sometimes quite directly, for doing less for their patients,” an “inherent conflict of interest.”⁶⁶ This cuts to the very heart of the altruistic nature of the profession, calling into question the moral and ethical implications of such activity.

The declining importance of altruism is related to how and by whom physicians are judged. Doctors have long enjoyed the ability to oversee their profession’s educational standards, ethical codes, and the opportunity to rate one another’s performance.⁶⁷ Performance review is of specific concern. Physicians working within the for-profit HMO structure find that the quality of their work is based not on their ability to be good practitioners, providing excellent care and developing trust with patients, but on their ability to cut costs and generate returns.

The system of for-profit HMO denies physicians the opportunity to foster relationships not only with patients but with other physicians. The new wave of corporate medicine includes a loose collection of physicians who work in various locations for the same entity. Thus, some HMOs are composed not of "a core of dedicated staff" but of "networks and private practitioners linked by part-time contracts."⁶⁸ Solidarity among physicians is impossible in an arrangement that has "forced practitioners to reorganize into larger units."⁶⁹ Such an elaborate structure makes measuring performance and quality of care an intricate, at times frustrating experience.

These issues are important indicators of the deprofessionalization of medicine. Yet the control of medical knowledge through the restrictions is the most solid, telling gauge of the trend. The value of medical knowledge and the public's trust in it is a significant element in the physician-patient relationship. Placing a high value on knowledge presumably upholds the "legal, moral, and intellectual mandate" of medicine.⁷⁰

But in the new design of managed care, expertise and knowledge are exploited and controlled for the good of the corporation, perhaps best exemplified by the use of gag clauses or rules. Generally, these take several forms, all of which potentially impose constraints on the physician-patient relationship and on doctors' overall autonomy. The clauses, to which physicians have to agree, are written into their contracts with managed care organizations. Gag clauses eliminate alternative treatments that the managed care organizations view as unnecessary or inappropriate for any number of medical conditions. Physicians who defy these stipulations face, at the least, reprimands, and at the most, dismissal.

Legal experts identify four types of gag rules, the first of which places "restrictions [on] doctor-patient discussion of treatment alternatives."⁷¹ The rules specifically prohibit physicians from "disclosing treatment options that the [managed care organization] determines are inappropriate."⁷² This restriction declares that physicians may not discuss alternative treatments with a patient "until the plan has agreed to pay for them"⁷³ and gives its approval. If the corporation deems them unsuitable, physicians may not reveal an alternative to the patients.

This type of clause also prohibits physicians from "making statements to patients that would undermine the patient's confidence in the [HMO]."⁷⁴ A doctor who disagrees with an organization's actions may not reveal his or her opinion to a patient. In addition, "suggesting that a course of treatment may be beneficial or even life-saving, but reporting that the plan will not cover it, could be construed as disparaging or as suggesting that the plan offers substandard care."⁷⁵ The physician, unable to share all treatment options with the patient, may feel trapped.

A second type of gag clause prevents physicians from "discussing conflicts of interest with patients."⁷⁶ A doctor may not reveal the terms of his or her agreement of association with the managed care organization. Most important, physicians cannot reveal how they are paid, for this is considered a "business secret requiring protection."⁷⁷ They cannot bare the fact that the amount of their paycheck is, to a large extent, contingent on the treatment options they choose for patients — less treatment translates to larger salary — which could negatively affect a patient's health.

Another gag clause restricts doctors' ability to recommend facilities where patients can receive treatment outside their care organization. Physicians are forbidden to recommend "uncovered treatments" even if they believe such alternatives could help their patients⁷⁸ This rule also prevents physicians from giving advice on the nature of managed care organizations or "offering their perspective on what plans are better for

patients in general, or [one] patient in particular"; therefore, some of their expertise is denied to patients.⁷⁹

A final gag rule precludes physicians from publicly "making negative comments about the plan" with which they are associated.⁸⁰ It serves to keep physicians silent in the public debate on managed care, for they are "unable to offer candidly their experiences and expertise to patients and political debates alike."⁸¹ Public discussion is compromised by the denial of a voice to these eminent actors.

The nationwide debates on the subject of gag clauses grow more heated as these stipulations are gradually leaked to the public. Yet because of vague language that "disguises" them, the clauses are sometimes difficult to locate in managed care contracts. Additionally, a "lack of any [nationwide] centralized clearinghouse for contract information" that monitors all managed care contracts makes the search even more cumbersome.⁸² This scarcity of information adds controversy to the mixture. Proponents of managed care organizations deny the very existence of such clauses in physicians' contracts, claiming that the agreements are fashioned with patient protection in mind. Opponents insist that these clauses are commonplace, that they blatantly "violate the physician's ethical duties," and that they must be outlawed immediately.⁸³

Controversy aside, the very notion of gag clauses leads to disturbing conclusions about this method of cost cutting. Such rules directly threaten the welfare of patients by controlling the use of medical knowledge. They "threaten to erode the doctor-patient relationship by silencing physicians and keeping patients uninformed."⁸⁴ They raise important legal, ethical, and even constitutional questions. Legally, they pose dilemmas specifically around the doctrine of informed consent: patients "should be autonomous over their bodies, which requires that physicians inform patients of their conditions and options for treatment."⁸⁵ According to the doctrine, a doctor must inform a patient of all alternatives. As previously noted, rules that do not allow for full disclosure of information violate the doctrine of informed consent. "Gag clauses that prohibit physician disclosure of uncovered treatment threaten to turn back the clock to a time when patients were kept uninformed of their alternatives and physicians made treatment decisions without regard to the patient's concern."⁸⁶

Failing to adhere to the doctrine of informed consent suggests that, legally, physicians are not doing their job, which can leave them wide open to charges of malpractice.⁸⁷ Ethically, gag clauses place physicians in potentially difficult situations, unable to "advance the patient's health," the overarching goal of medicine.⁸⁸ Ethics seems to run a distant second to profit maximization in the new calling of corporate medicine. John McArthur and Francis Moore write, "When a corporation employing physicians seeks profit by selling [its] services, the physician-employees cease to act as free agents. Professional commitment to patient care is now subordinated to new rules of practice that assure profitability of the corporation."⁸⁹

Another important consideration is the way gag clauses threaten constitutional rights of doctors by withdrawing their freedom of speech.⁹⁰ Some forcibly keep physicians' voices out of the public domain on health care issues, and violation of these terms is cause for the dismissal of doctors. Therefore, "a gag rule is an example of the loss of free speech, not by order of public law, but by the dictates of health care corporations."⁹¹

US Healthcare, one of the nation's largest for-profit HMO corporations, provides an excellent example of manipulation through gag rules. In 1995 it cared for 2.4 million members, earning a profit of \$1 million a day.⁹² Steffie Woolhandler and David

Himmelstein note the following clauses from a US Healthcare contract with one HMO. "Physicians shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in US Healthcare or the quality of US Healthcare coverage . . . Physicians shall keep the Proprietary Information [payment rates, utilization-review procedures, and so on] and this Agreement strictly confidential."⁹³ Translated, these clauses state that physicians cannot openly disagree with US Healthcare on any ground and that any cost the HMO assumes or does not assume must not be disclosed to the patient.

In addition, releasing an employee who disagrees with company policy is also part of the reality. After coauthoring "Extreme Risk," and speaking out against certain HMO policies on national talk shows, David Himmelstein, "on December 1, 1995, received notice from US Healthcare of his termination."⁹⁴

Gag clauses, which reduce the value of a physician's knowledge to monetary terms, deleting moral and intellectual components from the picture, are only one of several questionable tactics created by managed care corporations whose primary concern is profit realization. In an effort to combat corporate control, more and more physicians are turning to the public for support, a move that has both positive and negative effects. On the positive side, physicians and patients working together represent increased people power and increased opportunity for physicians to educate the public about the potential harm profit-making HMO policy can generate. For example, many professional doctors organizations have produced offspring in the form of patient organizations. Physicians Who Care, a group of more than 30,000 doctors, is allied with the 15,000 members of Patients Who Care.

Yet bringing concerns to the public and inviting citizens to join forces with them has not necessarily resulted in success for the physicians. They face the fact that quality health care alone may not be enough to sway public opinion. Indeed, physicians place themselves in the position of having to deal with countervailing modes of influence. The history of propositions 214 and 216, two proposals aimed at ending unfair and unethical managed care practices in the state of California, are prime examples of this phenomenon. Both propositions, introduced as precursors to the creation of the Health Care Patient Protection Act of 1996, called for the following measures, reported in the Fall 1996 *Physicians Who Care Newsletter*.

- A. Banning all written gag clauses;
- B. Outlawing financial bonuses tied to the denial of necessary care;
- C. [Giving] patients the right to [pursue] a second opinion before denying doctor-recommended care and [publicizing] HMO guidelines for denying treatment;
- D. Requiring "just cause" for [terminating services] of physicians and other professionals.⁹⁵

Proposition 216, the more radical of the initiatives, also added clauses that included establishing "a consumer watchdog organization, and [imposing] taxes on health-care mergers and acquisitions, hospital closures, and bed reductions."⁹⁶

The goals of both propositions offered something for everyone. Not only would patients be protected against financial incentives that may influence a physician's quality of care, but the doctors themselves would be free from the threat of the gag clauses that silence them. Both measures gained huge support from more than 150 interest groups

and individuals on the state and national level. Activist Ralph Nader proclaimed, "Passing the Patient Protection Act is the single most critical health care battle this year for California and as an example for the rest of the nation. . . . The denial of care, gag rules for doctors and nurses . . . are a national scandal."⁹⁷

It is also important to realize that neither proposition called for "new taxes, litigation, or government agencies."⁹⁸ Considering the propositions' comprehensive programs, it was almost impossible to imagine the public's not passing them. Yet both failed on the ballot, even with the support of thousands of physicians and ordinary citizens nationwide. In a poll conducted days before the election, 46 percent of the 824 people surveyed indicated that they would vote against both propositions, while an additional 25 percent and 26 percent remained undecided about 214 and 216, respectively.⁹⁹ On Election Day, 214 failed by a ratio of 58 to 42 percent, and 216 by 61 to 39 percent.¹⁰⁰

A perplexing question is central to examining the failure: How could the citizens of California, a state with more than 30 million residents, 58 percent of whom are enrolled in HMOs, vote against propositions so clearly designed to protect them from unethical managed care? Some groups, Taxpayers Against Higher Health Costs, for example, interpreted the defeat as an indication that "Californians [were saying] no to more government involvement in health care," which reflects today's probusiness, promarket, antigovernment sentiment.¹⁰¹ Health care reform appears to be unnecessary if the market provides checks and balances as it should. One opponent of the propositions stated, "Those opposed to [managed care] think we will suffer as soulless bean counters deny [us] needed care . . . But free-market capitalism creates a powerful check on such tendencies."¹⁰²

Another explanation points to the lack of voter understanding surrounding the propositions. When asked specifics about each proposition in a preelection poll, respondents' answers reflected "confusion about what is what and what each would do" and highlighted an overall general confusion about managed care.¹⁰³

The media's role in the failure offers a further possibility. The proponents of these proposals, physicians included, were unsuccessful in transmitting the message that for-profit managed care organizations, through the use of gag rules and unethical incentives, pose a legitimate threat to the health and well-being of patients. The print media opposed the propositions. Editorials in fifty major newspapers across California recommended a no vote on both.¹⁰⁴ The state's largest newspaper, *The Los Angeles Times*, held nothing back in its attack. It recognized the "[legitimate] problems" of the HMO system but stood firmly for the rights of the corporation. In its evaluation of the propositions, the *Times* concluded, "They [are] fuzzily worded provisions. Both [for example] try to eliminate gag rules by allowing caregivers to disclose information 'relevant to the patients' health care.' While physicians are certainly entitled to freedom of speech, managed care companies should be able to impose some restrictions." Focusing on the need to contain costs, the editorial further declared that the propositions "would tie the managed care companies, making it difficult to effect the nimble balance between quality and cost effectiveness."¹⁰⁵

In sheer numbers and ability to reach and educate the public, the battle for power between a media supporting managed care organizations in California and physicians desiring to change unethical policies is really no contest. Yet in appealing to the public for support, physicians must face the media as well as such other forces as antigovernment sentiment that sway opinions. If propositions 214 and 216 suggest anything, it is

that physicians collectively cannot overcome the many powers that influence the public. On the subject of managed care, they are "pushed and pulled from all directions in the debate . . . and are likely to remain neutralized."¹⁰⁶

Finding a Solution for the Future

Several issues emerge from the foregoing. First, much as physicians would like to believe otherwise, they have for decades had to grapple with finding a niche in their professional role for the businessperson. One must realize that although the public never approved of this new role and was often frightened and threatened by it, the profession persisted in its attempts to embrace it. Because their professional status and power allowed it, doctors could manipulate the public and control the interference of corporations and business in their work.

Now that physicians need help in reclaiming their professional power, they appear to have nowhere to turn. Corporate takeovers are still rampant in medicine, and although some state and federal legislation has managed to ban a number of unethical incentives and gag clauses, problems persist. Americans should be deeply concerned about the deprofessionalization of medicine and the dangers associated with "bad managed care, investor-owned, for-profit entities operated by insurance companies and managers with little or no experience in health care delivery," but confusion and lack of awareness distance them from the issues.¹⁰⁷

Attempting to dismantle managed care is not an appropriate solution — the managed care model of medicine is apparently here to stay. The number of people in some sort of managed care arrangement increases every year. For example, "In 1995, 54 million Americans were enrolled in health maintenance organizations and as many as 130 million [were] insured in one or another form of managed care."¹⁰⁸ This number represents an increase of 13 percent from 1994.¹⁰⁹ Therefore, abandoning the managed care concept is currently not practical or possible.

To accomplish anything, physicians must come to grips with their position rather than ignoring indicators that suggest the decline of their professional status. As Freidson and Lundberg asserted years ago, they must focus on the original goals of their profession, primarily patient advocacy. Furthermore, unless doctors resist the businessperson mentality, which historically has always undermined them, their autonomy will vanish. We will enter an era in which medical knowledge, and its use and distribution, is controlled by businesspeople. As this occurs, patients will suffer and continue to lose faith in physicians, widening an already large rift between the two camps.

The success or failure of physicians and patients in regaining control of health care will depend largely on the degree of willingness of all parties to be radical and progressive. Specifically, physicians must be ready and willing to work with the public and other health care professionals to effect change. As Woolhandler and Himmelstein assert, "We must scale care to a human size . . . Unless HMO physicians, workers, and patients are centrally involved in planning this transformation, and the movement for reform, it will surely fail."¹¹⁰

Glimmers of this mentality and its possible benefits are coming to the surface. For example, in June 1996 the American Medical Group Association (AMGA) was formed "from the merger of the American Group Practice Association and the Unified Medical Group Association."¹¹¹ This new confederation of more than 350 group practice associations, which brings together administrators, physicians, and patients, states that its

primary goals include serving as “an information resource for group practice administrators and as an advocacy group for physician decision-making and managed care reform.”¹¹² The group also plans to continue to build upon a “patient-centered outcomes database,” thus creating for patients a “sounding board” on which they can voice their concerns and rate their quality of care.¹¹³

The birth of the AMGA is certainly an encouraging sign, but for real change to occur, a more radical approach is necessary. I suggest that the American Medical Association become the organization that unifies patients, physicians, and other health care workers in their battle against corporate medicine. The AMA already identifies itself as “a grassroots organization [that] has served as a national leader in efforts to extend access, contain costs, and improve the quality of the American health care system. The AMA is extremely active in public health campaigns, working vigorously for healthy lifestyles.”¹¹⁴ If this is indeed the mission of the AMA, it should have no problem taking a stand against the corruptive nature of so many for-profit HMOs, but as Howard Wolinsky and Tom Brune report, the AMA has never truly attempted to help patients, and in fact billed itself as one of the “most powerful political lobbies [not] to protect our rights as patients . . . Rather, it has worked hard to look after physician income and interest.”¹¹⁵

In the health care crisis sweeping the nation, the AMA has the potential to play a tremendous role. It could, without much internal turmoil, undertake the following:

1. Advocate socially responsible investing — encourage people to divest their stock portfolios of profit-making HMOs that use financial incentives and gag clauses.
2. Support any state or federal legislation that encourages increased patient and physician protection, such as propositions 214 and 216, providing funds and manpower for campaigns.
3. Launch a national HMO awareness campaign — flood the media with information concerning gag clauses and other pros and cons of managed care.
4. Develop a code of ethics for all managed care corporations, creating an obtainable balance between business concerns and medical ethics.
5. Change medical school curricula to include a mandatory internship in a managed care setting for all students. As of now, only 16 percent of schools have this requirement.¹¹⁶
6. Create a patient organization that works closely with other AMA groups in advocacy projects.
7. Invite patients to serve on patient-physician committees designed to monitor activities of the many large for-profit HMOs.
8. Provide financial support to patients who rightfully sue HMOs for breach of contract or malpractice.

More radically, the AMA could use its vast resources to support many grassroots organizations, such as Health Care for All of Boston, which attempt to provide quality medical care to those who cannot afford it. The possibilities are endless.

Robert Larsen states, “There is a window of opportunity for someone to step up to the plate and provide the vision that can eliminate many of the current [health care] dilemmas.”¹¹⁷ I believe that the AMA can accomplish this task. It comes down to the

organization's willingness to change reality, not simply an image, as Lundberg suggested. The American Medical Association stands ready to deliver, but will it meet the call or retreat? Only time will tell. Until then, we have to wait, hoping that the situation does not become progressively worse. ❀

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Notes

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