Virtual Mentor
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THE CODE SAYS

The American Medical Association *Code of Medical Ethics*' Opinions on the Physician as Businessperson

Opinion 6.11 - Competition

Competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of services, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc, is not only ethical but is encouraged. Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely between and among competing physicians and alternate systems of medical care.
Issued July 1983.

Opinion 8.054 - Financial Incentives and the Practice of Medicine

In order to achieve the necessary goals of patient care and to protect the role of physicians as advocates for individual patients, the following statement is offered for the guidance of physicians:

(1) Although physicians have an obligation to consider the needs of broader patient populations within the context of the patient-physician relationship, their first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice.

(2) Physicians, individually or through their representatives, should evaluate the financial incentives associated with participation in a health plan before contracting with that plan. The purpose of the evaluation is to ensure that the quality of patient care is not compromised by unrealistic expectations for utilization or by placing that physician's payments for care at excessive risk. In the process of making judgments about the ethical propriety of such reimbursement systems, physicians should refer to the following general guidelines:

(a) Monetary incentives may be judged in part on the basis of their size. Large incentives may create conflicts of interest that can in turn compromise clinical objectivity. While an obligation has been established to resolve financial conflicts of interest to the benefit of patients, it is important to recognize that sufficiently large incentives can create an untenable position for physicians,

(b) The proximity of large financial incentives to individual treatment decisions should be limited in order to prevent physicians' personal financial concerns

from creating a conflict with their role as individual patient advocates. When the proximity of incentives cannot be mitigated, as in the case of fee-for-service payments, physicians must behave in accordance with prior Council recommendations limiting the potential for abuse. This includes the Council's prohibitions on fee-splitting arrangements, the provision of unnecessary services, unreasonable fees, and self-referral. For incentives that can be distanced from clinical decisions, physicians should consider the following factors in order to evaluate the correlation between individual act and monetary reward or penalty:

(i) In general, physicians should favor incentives that are applied across broad physician groups. This dilutes the effect any one physician can have on his or her financial situation through clinical recommendations, thus allowing physicians to provide those services they feel are necessary in each case. Simultaneously, however, physicians are encouraged by the incentive to practice efficiently.

(ii) The size of the patient pool considered in calculations of incentive payments will affect the proximity of financial motivations to individual treatment decisions. The laws of probability dictate that in large populations of patients, the overall level of utilization remains relatively stable and predictable. Physicians practicing in plans with large numbers of patients in a risk pool therefore have greater freedom to provide the care they feel is necessary based on the likelihood that the needs of other plan patients will balance out decisions to provide extensive care.

(iii) Physicians should advocate for the time period over which incentives are determined to be long enough to accommodate fluctuations in utilization resulting from the random distribution of patients and illnesses. For example, basing incentive payments on an annual analysis of resource utilization is preferable to basing them on monthly review.

(iv) Financial rewards or penalties that are triggered by specific points of utilization may create enormous incentives as a physician's practice approaches the established level. Therefore, physicians should advocate that incentives be calculated on a continuum of utilization rather than a bracketed system with tiers of widely varied bonuses or penalties.

(v) Physicians should ascertain that a stop-loss plan is in place to prevent the costs associated with unusual outliers from significantly impacting the reward or penalty offered to a physician.

(3) Physicians also should advocate for incentives that promote efficient practice, but are not be designed to realize cost savings beyond those attainable through efficiency. As a counterbalance to the focus on utilization reduction, physicians also should advocate for incentives based on quality of care and patient satisfaction.

(4) Patients must be informed of financial incentives that could impact the level or type of care they receive. Although this responsibility should be assumed by the health plan, physicians, individually or through their representatives, must be prepared to discuss with patients any financial arrangements that could impact patient care. Physicians should avoid reimbursement systems that, if disclosed to patients, could negatively affect the patient-physician relationship.

Issued June 1998, based on the report "Financial Incentives and the Practice of Medicine," adopted December 1997; updated June 2002.

Opinion 4.04 - Economic Incentives and Levels of Care
The primary obligation of the hospital medical staff is to safeguard the quality of care provided within the institution. The medical staff has the responsibility to perform essential functions on behalf of the hospital in accordance with licensing laws and accreditation requirements. Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. The organized medical staff has an obligation to avoid wasteful practices and unnecessary treatment that may cause the hospital needless expense. In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority.
Issued June 1986.

Opinion 8.0321 Physicians' Self-Referral
Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(1) Ensure that referrals are based on objective, medically relevant criteria.

(2) Ensure that the arrangement:

(a) is structured to enhance access to appropriate, high quality health care services or products; and

(b) within the constraints of applicable law:

(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;

(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and

(iii) adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.

(3) Take steps to mitigate conflicts of interest, including:

(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;

(b) establishing mechanisms for utilization review to monitor referral practices; and

(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.

(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

Issued June 2009 based on the report "Physicians' Self-Referral," adopted November 2008.

Opinion 6.03 - Fee Splitting: Referrals to Health Care Facilities
Clinics, laboratories, hospitals, or other health care facilities that compensate physicians for referral of patients are engaged in fee splitting, which is unethical. Health care facilities should not compensate a physician who refers patients there for the physician's cognitive services in prescribing, monitoring, or revising the patient's course of treatment. Payment for these cognitive services is acceptable when it comes from patients, who are the beneficiaries of the physician's services, or from the patient's designated third party payer.

Offering or accepting payment for referring patients to research studies (finder's fees) is also unethical.

Issued prior to April 1977; updated June 1994 and June 1996, based on the report "Finder's Fees: Payment for the Referral of Patients to Clinical Research Studies," adopted December 1994.

Opinion 8.132 - Referral of Patients: Disclosure of Limitations
Physicians should always make referral decisions based on the best interests of their patients, regardless of the financing and delivery mechanisms or contractual agreements between patients, health care practitioners and institutions, and third party payers. When physicians agree to provide treatment, they assume an ethical obligation to treat their patients to the best of their ability. If a physician knows that a patient's health care plan or other agreement does not cover referral to a non-contracting medical specialist or to a facility that the physician believes to be in the patient's best interest, the physician should so inform the patient to permit the patient to decide whether to accept the outside referral.
Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to disclose medically appropriate treatment alternatives. Physicians should also promote an effective program to monitor and improve the quality of the patient care services within their practice settings.

Physicians must ensure disclosure of any financial incentives that may limit appropriate diagnostic and therapeutic alternatives that are offered to patients or that may limit patients' overall access to care. This obligation may be satisfied if the health care plan or other agreement makes adequate disclosure to enrolled patients.

Issued June 1986; updated June 1994, based on the report "Financial Incentives to Limit Care: Ethical Implications for HMOs and IPAs," adopted June 1990; updated June 2002; updated November 2007, based on the report "Opinion E-8143. 'Referral of Patients: Disclosure of Limitations,' Amendment," adopted November 2007.

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