10.1.1 Ethical Obligations of Medical Directors

Physicians' core professional obligations include acting in and advocating for patients' best interests. When they take on roles that require them to use their medical knowledge on behalf of third parties, physicians must uphold these core obligations.

When physicians accept the role of medical director and must make benefit coverage determinations on behalf of health plans or other third parties or determinations about individuals' fitness to engage in an activity or need for medical care, they should:

(a) Use their professional expertise to help craft plan guidelines to ensure that all enrollees receive fair, equal consideration.

(b) Review plan policies and guidelines to ensure that decision-making mechanisms:

(i) are objective, flexible, and consistent;

(ii) rest on appropriate criteria for allocating medical resources in accordance with ethical guidelines.

(c) Apply plan policies and guidelines evenhandedly to all patients.

(d) Encourage third-party payers to provide needed medical services to all plan enrollees and to promote access to services by the community at large.

(e) Put patient interests over personal interests (financial or other) created by the nonclinical role.

AMA Principles of Medical Ethics: I, III, VII

Background report(s):

CEJA 3-A-16 Modernized *Code of Medical Ethics*

CEJA 3-A-99 Ethical obligations of medical directors

10.1.1 Ethical Obligations of Medical Directors

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AMA Principles of Medical Ethics: I, III, VII

CEJA Report 3 – A-99
Ethical Obligations of Medical Directors

Resolution 8 (A-98) asked the Council on Ethical and Judicial Affairs to consider "under what circumstances those decisions of medical appropriateness made by a medical director of an insurance company, an HMO, or a related entity are within the 'practice of medicine,' thereby falling within the purview of state medical boards."

There are a variety of different types of medical directors, including directors of hospitals, nursing homes, group practices, insurance companies, and managed care organizations. In this report, the term "medical director" is used narrowly to refer to physicians who are employed by third-party payers in the health care delivery system (*i.e.*, insurance companies, managed care organizations, self-insured employers) or by entities that perform medical appropriateness determinations on behalf of payers. These types of medical directors have specific functions, such as making coverage determinations, which go beyond mere administrative responsibility. This report focuses on the ethical obligations that arise out of such functions.

The definition of the "practice of medicine" is a matter of state law. This report will provide background information regarding the legal debate surrounding the definition of the "practice of medicine" and the scope of the state medical boards' authority. The primary focus of the report, however, will be the ethical obligations of medical directors when they make the types of decisions that fall within the professional sphere of a physician. Whenever physicians employ the professional knowledge and values they gained through medical training and practice, and in so doing affect individual or group patient care, they are functioning within the professional sphere of physicians.

MEDICAL DIRECTORS AND THE "PRACTICE OF MEDICINE"

While there is no single definition of the "practice of medicine" the various interpretations available offer several overlapping conditions. The courts and the Federation of State Medical Boards (FSMB) each have interpreted the term "practice of medicine." When a court is required to interpret the term "practice of medicine" it is generally doing so within the confines of a state statutory or regulatory definition.

Legal interpretations

Black's Law Dictionary defines the "practice of medicine" as the "treatment of injuries as well as the discovery of the cause and nature of disease, and the administration of remedies or the prescribing of treatment therefor."[1] The courts have interpreted the term "practice of medicine" in a variety of contexts. In some cases, based on the state's definition, any action which touches on a physician's professional expertise may be considered the "practice of medicine" and thereby falls within the purview of the state medial board.[2] Other courts have narrowly construed the term and only include actions that are related to diagnosis, treatment or care of patients.[3] Based on these holdings, what actions constitute the "practice of medicine" remain open to a range of interpretation.

In Murphy v. Board of Medical Examiners of the State of Arizona,[4] the Arizona Court of Appeals addressed the issue of whether the medical director of an HMO was under the jurisdiction of the state medical board. Among other functions, the medical director denied coverage as a result of determining that the procedures were not medically necessary. The court stated that the medical director is not a provider of insurance, but rather an insurer's employee whose responsibility it is to use medical knowledge and judgement to make recommendations about coverage. In its opinion, "Although [the medical director] is not engaged in the traditional practice of medicine, to the extent that he renders medical decisions his conduct is reviewable by the Board of Medical Examiners."[5]

Morris v. District of Columbia Board of Medicine,[6] on the other hand, provides an example of a type of function of a medical director that was found to not constitute the practice of medicine, and thus falls outside the purview of the state medical board. In Morris, the medical director's duties included building the networks of health care providers and managing the post-treatment claims processing. Dr. Morris did not make pre-treatment coverage decisions nor did he manage the pre-treatment decision making process. The court noted that "conduct which merely affects, influences, or substantially impacts on the course of such care by others cannot itself be treatment without converting a major part of the business of health insurers into the 'practice of medicine.'" However, the court acknowledged that "[t]he focus must be on the actions of the individual administrator, not on his job title or identification as an 'M.D.'"[7]

Federation of State Medical Boards interpretations

The FSMB recommends that every state's medical practice act provide a definition of the "practice of medicine." Appendix A of this report provides information about the existing state definitions of "practice of medicine." FSMB further recommends that the definition include "rendering a determination of medical necessity or appropriateness of proposed treatment."[8]

Policies of the American Medical Association

The policies of the American Medical Association (AMA) are consonant with the position of the FSMB and generally are in line with the findings in Murphy and Morris. In H-285.987, "Guidelines for Qualifications of Managed Care Medical Directors," the AMA states that physicians who are employed as medical directors shall "hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state."[9]

Medical directors require the knowledge and values of trained, licensed physicians to fulfill the obligations of that position. Third-party payers generally acknowledge implicitly through their hiring practices that the knowledge of a physician is required to function as a medical director. Physicians who use their professional knowledge, judgment, and values must recognize that their ethical obligations as physicians are wedded to these skills and cannot be ignored simply on the basis of a title. Physicians must uphold their professional, ethical duties regardless of whether they are engaged in direct patient care or in clinical decision-making that affects patient care provided by another physician or licensed health care professional.

ETHICAL OBLIGATIONS OF MEDICAL DIRECTORS

In the current health care delivery system physicians function in various capacities and with varying degrees of proximity to patient care. In certain roles physicians are called on because of their medical training. Physicians do not need to be in direct contact with patients in order to use their medical knowledge to influence factors that affect patient care. Because physicians are responsible for a vulnerable population (*i.e.*, patients) they cannot abandon their professional responsibilities simply because they may be involved indirectly in the delivery of care. For example, physicians who are called on by government agencies to assist with the development of a national health care plan would be expected to conduct themselves according to professional standards since the actions of those physicians would affect the health care of the nation's patients. Whenever physicians employ the professional knowledge and values they gained through medical training and practice, and in so doing affect individual or group patient care, they are functioning within the professional sphere.

In Opinion 8.02, "Ethical Guidelines for Physicians in Management Positions and Other Non-Clinical Roles," the Council states:

> Physicians in administrative and other non-clinical roles must put the needs of patients first. At least since the time of Hippocrates, physicians have cultivated the trust of their patients by placing patient welfare before all other concerns. The ethical obligations of physicians are not suspended when a physician assumes a position that does not directly involve patient care.[10]

On the other hand, the Council has recognized that while certain job-related functions of physicians fall within the professional sphere of physicians, not all do. In clarifying its policy on self-referral the Council distinguished medical directors' provision of administrative services, stressing that "[t]he relevant factor is the physician's activity, not his or her title."[11]

Medical directors' decisions regarding medical appropriateness, also referred to as medical necessity, serve as an example of acting within the professional sphere. The term "medical necessity" is subject to many meanings. There is no unanimity about the meaning of the term among the insurers, medical professionals, legislators, scholars, or patients who use and rely on it.[12,13] Private payers frequently include highly legalistic definitions of that term in their contracts and patients may be misled by their reliance on a more common-sense meaning. Even under the strict contractual definitions, however, medical directors who are asked to determine whether a recommended treatment is medically necessary for an individual patient's medical condition must rely on their medical expertise in making that decision. They must assess the clinical indications for the treatment and make a medical judgement. Thus, when medical directors make medical necessity determinations, whether for the purpose of treating a patient or recommending payment for treatment, they are acting within the professional sphere of physicians. Medical directors in this role have specific ethical obligations.

Specific obligations when acting within the professional sphere

In general, physicians should act in and advocate for a patient's best medical interests. Nonetheless, in some contexts, physicians may have competing obligations to consider. One example is all physicians' general obligation to promote public health. Another example can be drawn from the role of physician-gatekeepers. Gatekeepers orchestrate the provision of health care to plan enrollees in order to be cost effective.[14] One way to achieve this goal is to ration medical resources. Rationing may be understood as withholding potentially effective medical care for the financial benefit of a party other than the patient.[15] Although this may seem unfair to the individual patient, the "current climate of fiscal scarcity"[16] and the "social goal of containing health care costs"[17] justify such practice under certain circumstances.

Medical directors, like gatekeepers, find themselves in the position of having to account not only for the best interests of individual patients, but also the best interests of plan enrollees as a whole, and possibly those of the employer. Medical directors' responsibility to implement their employers' plans may evoke a fiduciary relationship between medical directors and employers. However, this relationship will be limited by medical directors' overriding obligation to promote professional medical standards. Adherence to professional medical standards in this context includes placing the interests of patients above other considerations, such as personal interests (*e.g.*, financial incentives) or employer business interests (*e.g.*, profit). Professional medical standards also demand the use of fair and just criteria when making care-related determinations. Finally professional standards require physicians to work towards achieving equal access to adequate medical services, not only by enrollees but perhaps also by the community at large. These obligations are discussed in more detail below.

Primacy of patient interests

Medical directors must fulfill their professional obligations both to individual patients, and to plan enrollees as a whole. With respect to individual patients, medical directors clearly do not have the same professional responsibilities as do direct patient care physicians. Direct care physicians advocate to maximize individual patients' best interests while medical directors are constrained by the duty to assure care for all plan enrollees. For example, while it may be in the best interest of an individual patient to receive coverage for a certain procedure, doing so may limit the care afforded to plan enrollees as a whole. The plan parameters will, to a certain degree, dictate coverage criteria. Medical directors have a responsibility in this situation to ensure that the patient receives the most appropriate care within the plan's parameters and to apply the same standards to each patient equally under the plan engaging in neither discrimination nor favoritism.

Fair and just criteria

Medical directors' obligations to the plan enrollees as a whole include ensuring that the plan's policies and parameters are neither discriminatory nor detrimental to patient care. Promoting professional medical standards in this context requires medical directors to contribute their professional expertise to help craft plan guidelines that ensure fair and equal consideration of all plan enrollees. These responsibilities are similar to ones that the Council has explicated for direct care physicians who contract with capitated plans. Physicians in that context are advised only to sign contracts that provide sufficient financial resources for all necessary care and that are consistent with the interests of patients as a whole.[18] In addition, medical directors should review plan policies and guidelines to ensure that decision-making mechanisms are objective, flexible and consistent and apply only ethically appropriate criteria. For example, the Council has previously identified ethically appropriate criteria for the allocation of scarce resources.[19] These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

Adequate health care

Included in the obligation to uphold professional medical standards is the obligation to promote access to an adequate level of health care. This responsibility is articulated in Opinion 2.095, "The Provision of Adequate Health Care,"[20] and applies equally to physicians regardless of title or role. One way medical directors may carry out this obligation is by encouraging their employers to provide access to services that would be considered part of an adequate level of health care.

CONCLUSION

Most key activities of medical directors fall within the professional sphere of physicians since they draw on physicians' professional knowledge and values gained through medical training and practice and they affect individual or group patient care. Therefore, when medical directors are performing these activities they cannot do so without also adhering to ethical obligations. Assuming a title or position that removes the physician from direct patient-physician relationships does not override professional ethical obligations.

RECOMMENDATIONS

The Council recommends that the following be adopted and that the remainder of the report be filed:

The term "medical directors," as used here, refers to physicians who are employed by third-party payers in the health care delivery system (*i.e*., insurance companies, managed care organizations, self insured employers) or by entities that perform medical appropriateness determinations on behalf of payers. These types of medical directors have specific functions, such as making coverage determinations, which go beyond mere administrative responsibility.

1) Whenever physicians employ the professional knowledge and values they gained through medical training and practice, and in so doing affect individual or group patient care, they are functioning within the professional sphere of physicians and must uphold ethical obligations, including those articulated by the AMA's *Code of Medical Ethics*.

2) Medical directors acting within the professional sphere, such as when making decisions regarding medical appropriateness, have an overriding ethical obligation to promote professional medical standards. Adherence to professional medical standards includes:

    a) placing the interests of patients above other considerations, such as personal interests (*e.g*., financial incentives) or employer business interests (*e.g*., profit). This entails applying the plan parameters to each patient equally and engaging in neither discrimination nor favoritism.

    b) using fair and just criteria when making care-related determinations. This entails contributing professional expertise to help craft plan guidelines that ensure fair and equal consideration of all plan enrollees. In addition, medical directors should review plan policies and guidelines to ensure that decision-making mechanisms are objective, flexible and consistent and apply only ethically appropriate criteria, such as those identified by the Council in Opinion 2.03, "Allocation of Limited Medical Resources."

    c) working towards achieving access to adequate medical services. This entails encouraging employers to provide services that would be considered part of an adequate level of health care, as articulated in Opinion 2.095, "The Provision of Adequate Health Care."

Appendix A[21]

DEFINITION OF THE PRACTICE OF MEDICINE
A State-by-State Survey

NOTES:
+ means not an overt definition or defined in the negative
* means definition appears in very broad language

		AL	Ala. Code § 34-24-50 (1997)
	*	AK	Alaska Stat. § 08.64.380 (Michie 1997)
	*	AZ	Ariz. Rev. Stat. Ann. § 32-1401(1997)
	*	AR	Ark. Code Ann. § 17-95-202 (Michie 1997)
	*	CA	Cal. Bus. & Prof. Code §§ 2051, 2052, 2054 (Deering 1997)
	*	CO	Colo. Rev. Stat. § 12-36-106 (1997), as amended by S. 36 and H.R. 1015, 61st Leg., 2d Reg. Sess. (enacted, 1998))
+	*	CT	Conn. Gen Stat. § 20-9 (1997)
	*	DE	Del. Code Ann. Tit. 24 § 1703 (1997)
		DC	D.C. Code Ann. § 2-3301.2 (1998)
		FL	Fla. Stat. Ch. 458.305 (1997)
	*	GA	Ga. Code Ann. 43-34-20 (1997)
		HI	Haw. Rev. Stat. § 453-1 (1997)
	*	ID	Idaho Code § 54-1803 (1997)
+	*	IL	225 Ill. Comp. Stat. 60/3, 60/49, 60/50 (West 1997)
	*	IN	Ind. Code § 25-22.5-1-1.1 (1998)
	*	IA	Iowa Code § 148.1 (1997)
+		KS	Kan. Stat. Ann. § 65-2802, 65-2837 (1997); (see also, Kan. Stat. Ann. § 65-1005 (repealed 1957))
		KY	Ky. Rev. Stat. Ann. § 311.550 (Michie 1996)
	*	LA	La. Rev. Stat. Ann. § 37:1262 (West 1998)
+		ME	Me. Rev. Stat. Ann. Tit. 32, § 3270 (West 1997)
		MD	Md. Code Ann., Health Occ. § 14-101 (1997)
		MA	Mass. Regs. Code tit. 243, § 2.01 (1998) (administrative code)
	*	MI	Mich. Comp. Laws § 333.17001 (1997)
	*	MN	Minn. Stat. § 147.081 (1997)
		MS	Miss. Code Ann. § 73-25-33 (1997)
+		MO	Mo. Rev. Stat. § 334.010 (1997), as amended by H.R. 1601, 89th Leg., 2d Reg. Sess. (enacted, 1998); Mo. Rev. Stat. § 334.021 (1997)
	*	MT	Mont. Code Ann. § 37-3-102 (1997)
	*	NE	Neb. Rev. Stat. § 71-1,102 (1997)
	*	NV	Nev. Rev. Stat. § 630.020 (1997)
	*	NH	N.H. Rev. Stat Ann. § 329:1 (1997)
		NJ	N.J. Rev. Stat. § 45:9-5.1 (1997)
		NM	N.M. Stat. Ann. § 61-6-6 (Michie 1998)
		NY	N.Y. Educ. Law § 6521 (Consol. 1998)

		NC	N.C. Gen. Stat. § 90-18 (1997)
	*	ND	N.D. Cent. Code § 43-17-01 (1997)
	*	OH	Ohio Rev. Code Ann. § 4731.34 (Anderson 1998)
		OK	Okla. Stat. tit. 59, § 492 (1997)
	*	OR	Or. Rev. Stat. § 677.085 (1997)
+		PA	63 Pa. Cons. Stat. §§ 422.2, 422.10 (1997)
	*	RI	R.I. Gen. Laws § 5-37-1 (1997)
	*	SC	S.C. Code Ann. § 40-47-40 (Law. Co-op. 1997)
	*	SD	S.D. Codified Laws § 36-4-9 (Michie 1998)
	*	TN	Tenn. Code Ann. § 63-6-204 (1997)
		TX	Tex. Rev. Civ. Stat. Ann. § 4495b (West 1998)
		UT	Utah Code Ann. § 58-67-102 (1998)
+	*	VT	Vt. Stat. Ann. Tit. 26, §§ 1311, 1313 (1997)
		VA	Va. Code Ann . § 54.1-2900 (Michie 1998)
		WA	Wash. Rev. Code § 18.71.011 (1997)
		WV	W. Va. Code § 30-3-4 (1998)
		WI	Wis. Stat. § 448.01 (1997)
	*	WY	Wyo. Stat. Ann. § 33-26-102 (Michie 1997)

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3. McDonnell at 437.
4. Murphy v. Board of Medical Examiners of the State of Arizona, 949 P.2d 530 (Ariz. Ct. of App. 1997).
5. *Id*.
6. Morris v. District of Columbia Board of Medicine, 701 A.2d 364 (1997)
7. *Id*. at 368
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20. Council on Ethical and Judicial Affairs American Medical Association. Opinion 2.095, "The Provision of Adequate Health Care." *Code of Medical Ethics: Current Opinions with Annotations*. Chicago, IL: American Medical Association. 1998.
21. *Appendix A: Definition of the Practice of Medicine, a state-by-state survey* was obtained from the American Medical Association Division of Health Law. On file with Carla Kinderman, JD, Division of Health Law, American Medical Association.