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John A. Sbarbaro

Edmund Casper

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A CASE FOR INDEPENDENT JUDGMENT: THE MEDICAL SOCIETY IN PERSPECTIVE FOR THE 1990s

JOHN A. SBARBARO, M.D., M.P.H.*
AND EDMUND CASPER, M.D.**

I. INTRODUCTION

As members of one of the three "learned professions" (law, medicine, and theology), physicians have been able to retain a unique and often honored position in society. Undoubtedly, part of the strength of this role lies in the mystery of disease process, the lack of understanding of metabolic functions, and man's fear of mortality. But equally contributory has been the skill of the intuitive physician who brought compassion and the anticipation of intervention to the bedside. This human relationship is best captured by a 19th century phrase by Marian Evans Cross:

> Many of us looking back through life would say that the kindest man we have ever known has been a medical man or perhaps that surgeon whose fine tact *directed by deeply-informed perception*, has come to us in our need with more sublime beneficence than that of miracle-workers.

It is now clear that both health and disease are directly related to an individual's unique blend of physical, mental, and emotional characteristics. True, in recent years, we have developed tests for measuring some of our human metabolic and physical functions thereby providing a basis for the "science" of medicine. But we still have no measurements for the mental and emotional components of life. Thus, the physician must continue to rely on his own unique blend of physical senses, mental perception, and emotional attunement to reach an intuitive decision as to what factors underlie the problem adversely affecting his patient — the "art" of medicine.

No two patients are alike, nor are any two physicians identical. It should be no surprise, therefore, that when faced with an individual patient two physicians may come to a different conclusion as to the underlying problem and recommend two different treatment approaches. One or even both of these approaches may be successful, however, failure will cause the patient to seek a third or even fourth physician and on

* President of the Denver Medical Society and the Vice President for Medical Affairs, St. Anthony Hospital Systems, Denver, Colorado.

** Member of the Board of Directors, Denver Medical Society, and the Deputy Manager for Medical Affairs and Chief of Psychiatry, Denver Department of Health and Hospitals, Denver, Colorado.

until the patient finds a physician with a reciprocal spirit with whom there is symbiotic communication both spoken and unspoken.

Recognizing the importance of this one-to-one human relationship, physicians are trained for seven to eleven years to become comfortable and confident in relying upon their own senses and intuitiveness (the "art") when making vital decisions concerning their patients' care. Physicians must be able to understand and evaluate the opinions of others, yet have the strength of character to remain true to the course of action they feel best for the patient. It is this aspect of medicine that makes the physician susceptible to criticism by members of the legal profession. And it is from this area that much of the misunderstanding and conflict between the legal and medical professions is forthcoming. There can be no national standards for intrapersonal symbiosis — "the art." Therefore, the physician is all too often judged primarily by adherence to measurable "scientific" standards.

Independent judgment and action is central to the physician's role and to the medical profession. Unquestionably errors in judgment do and will continue to occur, but until we can scientifically measure and quantify all of the physical, mental, and emotional components of a patient's life, the "art" of medicine must continue. Medical societies must protect and nurture this vital essence of the profession in order to assure the existence of the "art." All too often, the medical society finds itself in direct opposition to legislative and judicial actions initiated by members of the legal profession. Clearly it is time for understanding and discussion rather than open conflict.

II. Perception of the Medical Community

There have been, and no doubt will always be, many forms of the healing arts, from witch doctors to physical therapists, some based on scientific knowledge, others directed solely toward the emotional aspects of man's life. In earlier years, medical societies served as gathering places for practitioners of similar training, healing beliefs, and interventional techniques. They sought to differentiate the healing art of medicine from other forms of intervention. To the eyes of some, the societies were exclusive, elitist, and even arrogant. To others, the societies came to represent the highest quality of scientific medical practice, challenging and measuring each new and highly touted healing advance against rigid precepts of successful patient outcome. A few called such actions protectionism and deliberate efforts to retard the entry of new healing techniques. Most, however, recognized that the true goal was to protect all members of the community from fraud, exaggeration, and false hope.

The success of medical societies in establishing their credibility as organizations dedicated to scientific principles and standards of care reached its peak in the early 1960s. Membership in a society denoted that a physician met and continued to meet established patterns of behavior and that he was accepted by his peers as a quality physician.

In the mid-sixties, however, the federal government moved to finance the health care of the elderly population and segments of the economically deprived community (Medicare and Medicaid). History had clearly demonstrated that with federal funding comes federal control, direction, and the power to enforce its will. Fearing encroachment on the independence of physician judgment and action, many medical societies strongly opposed the new programs. Their opposition was quickly attacked as protectionism, but protectionism of financial income, not of independent judgment. Instead of representing the highest of professional standards, medical societies were cast as reactionary unions, peddling political influence and out of touch with the social needs of America. The image and credibility of the physician in the community were suddenly in steep decline.

III. Forces Affecting the Medical Community

The last fifteen years have seen the medical profession buffeted by three tremendous forces. These forces are collectively more potentially destructive to independent judgment than any government controls.

First, technological and pharmaceutical advances of unparalleled number and diversity have required specialization and now, subspecialization by physicians. This has resulted in the potential for both fragmentation of the physicians' judgment and fragmentation of the medical community. Equally significant, the successes arising from these technological advances have led the general public to expect a successful outcome as the "standard of care" — any failure as substandard, unacceptable, and a breach of contract. Perhaps most reflective of this expectation are recent television and newspaper advertisements by members of the legal profession suggesting "a free review of their care" for those who feel this standard was not met.

Second, a marked increase in the numbers of graduating physicians generated through federal capitation funds to medical schools (lump sum payments for each new student slot created by the school) has created the availability of more physician services than demand requires. This has made it possible to establish intense cost competition among physicians. The extreme degree of this competition is reflected by programs which now can successfully require physicians to sign service contracts holding the physician at financial risk for the amount of care provided to patients. Additionally, applications to medical schools have recently dropped to 1.8 applicants for every available position — with onerous implications for the quality of future physicians.

Finally, expansion of federal small business requirements to individual physician's offices have required considerable increases in overhead and staff costs. This led many physicians to abandon private practice and accept salaried positions.

Other forces effecting the medical community include insurance plans which subtly influence a physician's judgment by placing personal financial risk upon the physician. Equally dangerous are the direct limi-

tations on a physician's choice of care options that can arise from a fear of federal sanctions or malpractice claims if a standardized protocol is not followed. Further, physicians who are salaried can be at even greater risk of succumbing to administrative pressure on their clinical decision making.

IV. The Responsibility of the Medical Community to Monitor Physicians' Actions

As a direct consequence, the need for a strong and independent medical society is perhaps greater now than at any other time in the history of medicine. The hallmark of a profession is that it alone has the skill and the training — the capability — to monitor and judge the behavior and actions of its members. The medical society must stand for the highest of professional standards and demand that all physicians adhere to the first principle of medicine: to use their independent judgment to do what is best for the patient, no matter what personal pressures are brought to bear upon the physician. The outcome of a physician's care is not and should not be the standard of good practice; the true measure is the thoroughness of thought, the scientific soundness of the decisions, and individual application of care principles to that unique individual — the patient — by taking into consideration the physician's perception of and symbiosis with the entire physical, mental, and emotional makeup of that patient. The medical society must remain the citadel for uncompromising quality care that is based on this independent and individualistic physician judgment.

It is to the advantage of the legal profession to strongly support the medical society in this goal, because the medical societies can establish a forum in which the "art" can be evaluated, challenged, and understood. The Interprofessional Code, published following this article, is a result of such discussions between our professions.

V. The Colorado Physician Health Program

A. *The Need for a Program*

Unfortunately, in addition to increasing pressures on the professional aspects of physicians' lives, they are facing immense pressures from the financial area of health care delivery, including what appears to be a punitive federal bureaucracy. Severe penalties are now being imposed for even minor billing infractions of federal rules. For example, a $2,000 penalty can be imposed for an error in a bill of less than twenty dollars. In light of the myriad of insurance policies, massive data handling, and office staff turnovers, such errors are inevitable, and therefore the physician's personal risk is great. Add to these pressures the continual loss of physicians' prestige nationwide, the combined result can be an overwhelming stress for physicians as human beings. Without a base of organized support, professional nourishment, and personal reinforce-

ment, even a physician of unusual inner strength can be overcome by personal anxiety.

In recent years, we have already witnessed the impact of this growing pressure on a few physicians, which is seen in the form of severe drug or alcohol abuse. If a medical society is truly the repository of professional values and behavior, then it must, as representative of the entire profession, respond openly and directly to the problems of these impaired physicians.

The American Medical Association's 1973 report on *The Sick Physician* gave impetus to the development of formal assistance or rehabilitation programs for impaired physicians. Specifically, the report called for "accountability to the public through assurance of competent care to patients by physicians and other health professionals . . . [because] [i]t is a physician's ethical responsibility to take cognizance of a colleague's inability to practice medicine adequately by reason of physical or mental illness, including alcoholism or drug dependence."

B. *The Development of the Colorado Physicians Health Program*

In 1978, the Colorado Medical Society and the Denver Medical Society began a series of informal voluntary programs involving special committees to help impaired physicians. The program received sporadic calls for help from physicians, their families, and others. However, the efforts of these special committees were not enough to provide an effective program. These early efforts failed due partly to the resistance of the individual physicians and the resistance of the medical societies, all of whom perceived the potential for liability and the legal barriers arising from the reporting requirements of the Colorado Board of Medical Examiners.

By 1984, the medical community realized that these informal efforts were ineffective. Consequently, a new initiative was launched to establish a formal structured program for impaired physicians that would be sponsored by, but operate independently of, the medical societies. This decision was based on concerns about the long-term viability of a program whose existence would be dependent upon a medical society's ability to provide ongoing funding. Further, it was agreed that confidentiality could be better maintained outside of the societies' organizations. The proposed structure called for a nonprofit corporation to be funded through a surcharge on physicians' state licensure fees. Paid staff persons would report to the independent governing board of the corporation. Functionally, the program was to operate on the employee assistance program model (i.e. the program provides intervention, referral, and monitoring, but not direct treatment). The purpose of this new Colorado Physician Health Program (CPHP) was the early detection of problems, intervention, evaluation and then referral to treatment before a serious impairment developed which might affect a physician's ability to practice medicine.

The Colorado Board of Medical Examiners is required by statute to

protect the public health, safety, and welfare by regulating and controlling the practice of medicine. Since the Board of Medical Examiners address "unprofessional conduct" issues, as defined in the State's Medical Practice Act in terms of "impairment," there was fear by some that the CPHP might serve as a shelter for a physician whose judgment was actually impaired, and thus a threat to the public. The Denver and Colorado medical societies addressed this concern from the perspective of "intervention prior to impairment," and, although the two points of view were at first exceedingly difficult to reconcile, the CPHP became a reality in 1986.

The Board of Medical Examiners agreed to allow the CPHP to accept referrals from all sources including patients, fellow physicians, and institutions. The Board also provided assurances of both confidentiality and anonymity. Crucial elements in the negotiations were: (1) assurances to the Board of Medical Examiners that all program participants who required treatment and monitoring would sign a Participation Agreement; (2) in instances of potential "unprofessional conduct" by a referred physician, a practice review would be conducted; and (3) the program would report to the Board all physicians whose ability to practice medicine with reasonable skill and safety was in question.

Meanwhile, a permanent funding mechanism was proposed — an increase in physician licensure fees to be collected by the State at the time of license application or renewal. The Colorado Medical Society and all component societies supported a bill, which was passed by the legislature. The new law created a "Physician's Peer Health Assistance Fund" from a licensure surcharge not to exceed $15 per year. Under the law, the Board of Medical Examiners would award grants annually from the fund to "one or more peer health assistance programs" assisting physicians in dealing with physical, emotional, or psychological problems which could become detrimental to their ability to practice medicine. Specific functions to be performed by the programs would include education, assistance in problem identification, evaluation, referral, monitoring, counseling, and support. The cost of individual treatment, however, would not be paid by this fund, but would be the responsibility of the physician.

C. *The Operational Elements of the Colorado Physician Health Program*

The operational program elements adopted by the CPHP are:

1. REFERRALS to the CPHP would be accepted from anyone, and for any reason including perceived or potential physical, psychological, or emotional problems whether or not related to substance abuse. Both confidentiality and anonymity would be assured.
2. FORMAL INTERVENTION would be initiated if or when a referred physician refused to cooperate.
3. EVALUATION would be provided, with screening for substance abuse, medical and psychiatric disorders.
4. PARTICIPATION AGREEMENTS would be signed by the Pro-

gram's Medical Director and each physician participant. The Agreement would outline the treatment and monitoring plan, the necessity for a practice review, and would clearly reference the Colorado Physician Health Agreement's responsibility to notify the Board of Medical Examiners when evidence existed of an inability to practice medicine with reasonable skill and safety or in the event of non-compliance of the agreed upon treatment and monitoring program by the physician.

5. PRACTICE COMPETENCY REVIEWS would be conducted by independent objective reviewers mutually acceptable to the Board and to the CPHP.

6. REFERRALS would be made for treatment, maintaining an employee assistance management model.

7. MONITORING of treatment progress would be provided.

The CPHP remains unique as a formal, nonprofit corporation designed by the state's organized medical community to address health related issues of Colorado physicians. As an organization independent from its sponsoring state and local medical societies, the program is able to offer its services to all licensed Colorado physicians whether or not members of the societies.

D. *Other Aspects of the Colorado Physicians Health Program*

CPHP policy decisions are the responsibility of a physician dominated Board of Directors who have direct oversight of the program, thereby allowing the program to function without the multi-level decision making process inherent in a medical society structure. The structure also allays the fear that confidentiality might be lost through a fellow member of the society who is a competitor. Equally important is the fact that the responsibility for funding a peer assistance program is placed on every physician licensed to practice in the state. This assures the program's long term existence without dependence on the state and local medical societies to guarantee long term financial support.

As noted, the program was intentionally designed to avoid the problems which would have undoubtedly arose from providing treatment. A program which provided treatment for physicians might be viewed as (1) in competition with the private sector programs, and (2) in conflict with the CPHP's role of assisting the Board of Medical Examiners in protecting the public welfare, the concern for "its patients." The clear absence of either kind of potential conflict of interest unquestionably smoothed the process of the program development and legislative support. The requirement for signed Participation Agreements (contingency contracts) provides a clear understanding of expectations for both the program and the participant. Risk of exposure to the licensing Board provides a strong incentive to comply with CPHP recommendations throughout the course of treatment and recovery. The incorporation of practice review into the Participation Agreements has allowed the CPHP to move forward in forming a working alliance with the Colorado Board of Medical Examiners. The results of its first fifteen months

of operation have been most encouraging with over one-hundred referrals already received and acted upon.

IV. Conclusion

This formal program is perhaps the best example of a professional organization fulfilling its mission to be individually responsible and to collectively uphold professional standards. It is directed at insuring that a physician's independent professional judgment is not adversely affected by drugs, alcohol, or mental deterioration. Equally important will be the medical society's future ability to defend physicians' judgment against financial, organizational, and even legal encroachments. As members of the human community who may have an individual need for a physician's skill and knowledge, it behooves the Bar Association to support the Medical Society in this effort.