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Honesty Is an Internal Norm of Medical Practice and the Best Policy

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Honesty Is an Internal Norm of Medical Practice and the Best Policy

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In the past 30 years third parties, whether government or business, have played an ever larger role in industrialized countries, not only in paying for medical care but in managing it. Physicians and others have chafed against the constraints on physician action that have accompanied such management, and some physicians have been persuaded enough of the evil of these constraints to seek their circumvention through the deception of responsible third parties. Until recently, at least, only a small (albeit nontrivial) minority of physicians have been willing to take a pro-deception stance in published surveys (Werner et al. 2004; Wynia et al. 2000). In response to one such survey (Werner et al. 2000), many of those who commented in the pages of the *American Journal of Bioethics* were unwilling to condemn such deception, or did so only half-heartedly, suggesting instead that we seek to address its “root causes” in our flawed health care system.¹ Now, in a natural step forward from that position, Tavaglione and Hurst offer a principled case for the coordinated deception (or “gaming”) of third-party payers by physicians.

Tavaglione and Hurst (2012) develop a positive case for gaming from the priority physicians should place on the internal norms of medical practice. They supplement this positive case with a refutation of common arguments against gaming, considering both deontological and consequentialist anti-gaming views. In what follows I suggest that the premise underlying the entire multifaceted argument, the injustice of third-party payment denials (considered in the aggregate), is not established. I then focus on the likely consequences of systematic gaming and on the argument that gaming is justified by the internal norms of medical practice.

MEDICAL “NEED” AND THE CONSEQUENCES OF GAMING

Tavaglione and Hurst take it as given that third-party denials of payment that contravene “the physician’s judgment of what constitutes adequate care” are tantamount to leaving health care needs unmet and, hence, to injustice. There are certainly notorious instances of third-party payers renegeing on obligations to provide care covered by their

health insurance policies; such denials of care are indefensible, and, so far as I know, are undefended. Third-party payment denials grounded in a questioning of physician judgment are another matter; such denials may certainly be mistaken, but they may also be entirely defensible. “Need” in the case of medical care is a function of what the medical profession comes to regard as optimal care in the ongoing interplay between societal interest in (and willingness to pay for) health care, technological evolution, and third-party payer decisions about what to cover. In the United States the evolution toward more sophisticated and expensive care as the norm has been accelerated by numerous forces unique to our society and health care “system”: ability to pay, market power on the supply side, reimbursement mechanisms emphasizing first-dollar coverage, and, in the case of Medicare, coverage for effective care regardless of cost (Reinhardt et al. 2004). There is good reason to believe that health care in the United States is presently both more expensive than we can afford as a nation (Department of the Treasury 2010) and, in many localities, wasteful (Dartmouth Atlas Project 2007). That being so, the contention that the unwillingness of some health care payers to pay for whatever level of health care is demanded by given physicians is inappropriate, let alone “unjust,” is deeply suspect.

Even if Tavaglione and Hurst were able to establish that third-party payers were collectively behaving badly, it would not follow that gaming would improve matters for patients. If physicians were to systematically and successfully game private insurers in the current American environment, health care costs for those insurers would rise, and rising insurance premiums would inevitably follow. Most patients paying premiums would presumably absorb the increased costs—and some at the margins would be unable to. Those latter patients would likely end up on cheaper health care plans, offering less expensive care, until those health care plans also succumbed to gaming and raised their prices accordingly. In the end, patients struggling to pay for health insurance would be pushed out of private insurance onto Medicaid or, perhaps, into the ranks of the uninsured. In either case, the end result would be a net decrease in



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1. See open peer commentaries in response to Werner et al. (2004), *passim*

85 patients getting needed health care. Similarly unpleasant
 results would follow the systematic gaming of government-
 provided health care. The likely outcomes, in the form
 of unsustainable government expenditures followed by
 the eventual curtailment of provided care or by the more
 90 general catastrophe of government default on its obliga-
 tions, might not be immediate, but they would be no less
 prejudicial to patients receiving needed care in the long run.

THE NORMS OF MEDICAL PRACTICE

85 Systematic gaming by physicians of health insurance enti-
 ties, to whatever extent it occurs, is likely to worsen rather
 than improve health care access and quality in the long
 run, contra Tavaglione and Hurst. Their analysis of con-
 sequentialist objections to gaming does not acknowledge
 gaming’s likely consequences. On their terms, this should
 100 be enough to condemn it, as more rather than fewer unmet
 health care needs seems an unacceptable outcome for any
 policy measured against the rights-based consequentialism
 that Tavaglione and Hurst appear to favor. The positive case
 for gaming they offer transcends such terms, however, as it
 105 appeals simply to the imperative force of the norms of med-
 ical practice. Those who practice medicine are presumed to
 owe allegiance to the practice’s internal norms. And these
 demand, we are told, action on their behalf even if other
 norms, such as that of truth-telling, are violated.

110 Medicine is, as Tavaglione and Hurst contend, a norm-
 driven practice, of which patient welfare is an important
 internal good. The difficulty with their positive argument
 for gaming is in the suggestion that the medical norm of
 beneficence can or should overrule other norms of medical
 115 practice such as truth-telling. Tavaglione and Hurst contend
 that beneficence is a norm important both for medicine and
 for common morality, whereas truth-telling “is not a spe-
 cific principle of medical ethics.” Physicians therefore may
 or should prefer beneficence to truth-telling when these two
 120 norms conflict in medical practice (*ceteris paribus*, presu-
 mably), by virtue of their identity as physicians. But, con-
 tra Tavaglione and Hurst, the distinction between norms
 of beneficence and truth-telling in medicine does not track
 MacIntyre’s distinction between internal and external goods
 125 in relation to a practice. Per MacIntyre, internal goods of a
 practice are those goods attained through competent en-
 gagement in the practice and, hence, through governance
 by the norms and standards that characterize the prac-
 tice. External goods are goods associated with a practice
 130 only contingently—such as status and money in the case of
 medicine (MacIntyre, 1984, 187–189).

135 As MacIntyre’s example of internal goods in relation to
 chess playing makes clear, the internal goods of a practice
 are not merely the outcomes of successful practice—victory
 in chess or patient health in medicine—but successful
 outcomes attained through adherence to the norms and
 standards of the practice. And truth-telling is an essential
 standard rather than a merely contingent accompaniment
 of medical practice. A form of medicine practiced without a
 140 strong and systematic preference for truth-telling over lying

and deception would not be recognizable by physicians
 as the practice in which they were engaged—at least, that
 is, by physicians adhering to the norms of the practice
 into which they were initiated during medical training.
 Tavaglione and Hurst appear to conclude that truth-telling
 145 is not “a specific principle of medical ethics” on the grounds
 of the absence of its mention in codes of medical ethics or in
 much bioethics discussion. Yet enumerations of the norms
 of medical ethics omit many norms that are clearly essential
 to medical practice. Codes of medical ethics typically do
 150 not contain adjurations against theft. We cannot conclude
 on that ground that medical ethics or the norms of medical
 practice are indifferent as to stealing.

The distinction between norms explicitly emphasized in
 medical ethics, such as beneficence, and other norms impor-
 155 tant to medical practice that are less discussed, is captured
 not by MacIntyre’s distinction between internal and exter-
 nal goods but by a distinction drawn by Frederick Will,
 between “manifest” and “latent” norms. As Will suggests,
 acting in accordance with a norm (such as beneficence in
 160 medicine) requires being able both to identify occasions for
 action and to choose the proper action. But in any practice
 such norm-guided action is determined not by the given
 norm alone, but also by a complex background of social
 practice that affects the manner in which the norm is brought
 165 to bear (Will, 1997). Thus, the bearing of the “manifest” med-
 ical norm of beneficence on medical contexts is conditioned
 by the many “latent” norms of medical practice, including
 truth-telling.

To recognize the importance of the latent norms of
 170 a practice is simply to recognize that medical practice,
 as physicians and patients experience it, is entwined
 with our other practices and with the norms that govern
 these—including the norms of our common morality such
 as truth-telling. When trainees join the medical profession,
 175 they do not experience it as a separation from the fam-
 ilar norms that govern their nonmedical lives. Medicine is
 instead a context and an activity in which those familiar
 norms assume a new mode of governance, new emphases,
 and meaning specific to the demands of medical practice.
 180 Sometimes familiar norms undergo some contextual revi-
 sion in medical practice. More often they retain most or all
 of their more general force when they bear in the medical
 sphere.

In the case of truth-telling, medicine has in the past
 185 sometimes subordinated the norm to patient welfare. That
 is, physicians have sometimes taken patient welfare to
 demand deception of patients as regards diagnosis or
 prognosis in the terminally ill. The traditional justification
 for such deception is the perceived need to sometimes
 190 protect vulnerable patients from the truth. Physicians
 have in recent years moved away from such arguably
 beneficial deception, being less willing, as it were, to judge
 on a patient’s behalf that she cannot handle something as
 important as the truth about her condition. This shift in our
 195 practice is no doubt closely connected to the reassertion
 of norms of patient self-determination and autonomy in
 the past 40 years in our larger society—an assertion to

200 which our medical profession has been notably receptive (Jotkowitz et al., 2006) and that reinforces the importance of truth-telling in contemporary medicine.

205 While patient vulnerability has seemed reason enough to adjust the norm of truth-telling for affected patients, it has not generally been otherwise questioned or diluted by physicians. This is unsurprising. In the course of medical training, truth-telling is seldom discussed, not because it is unimportant but because it is both critically important and uncontroversial among academic physicians and trainees, for whom the value of truth in academic work, in research, and in communication about and with patients is utterly taken for granted. And the priority of truth-telling in medicine certainly extends to financial matters, including interactions with payers for medical care.

215 Tavaglione and Hurst's argument for gaming presumes that truth-telling is less critical to medical practice than patient welfare when the latter might be improved through deception of a third party payer. As a description of contemporary medical practice, this is plainly false. While the minorities of physicians willing to advocate the deception of third-party payers as an ethical strategy in published surveys have been nontrivial, they have not amounted to more than 10–15% of respondents (Werner et al. 2004; Wynia et al. 2000). We cannot conclude from such data that physicians, in general, find their obligations to patients to warrant such deception. Were physicians to embrace the deception of third-party payers as suggested by Tavaglione and Hurst, that embrace would not be an assertion of medical norms as against norms that have no specific bearing on medicine. It would be instead the tearing of a fabric, a major disruption in ways of doing and thinking that have hitherto hung together in the practice of the medical profession.

230 The internal norms of medical practice cannot warrant the deception of third-party payers, as these norms, as they are presently constituted, forbid such deception. Shorn of support from the norms of medical practice, Tavaglione and Hurst's case for gaming resolves itself into a highly conventional attack on third-party management of health care provision on grounds of its putative injustice, allied to an

240 equally conventional consequentialist justification of deception. While this argumentative tack may persuade those already inclined both to consequentialism and to a distaste for payer-imposed constraints on physician care of patients, it is unlikely to gain much purchase among those physicians who have embraced their practice and its norms in spite of those worldly imperfections that permit the existence of unmet health care needs in our society. We ought, of course, to work toward the elimination of such needs. We can do so without deceiving those who pay for medical care and sacrificing, as we do so, both future patient access to care and our own integrity. ■ 250

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