PERSPECTIVES

The Practical Utility of Gag Clause Legislation

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State legislatures and the U.S. Congress are currently engaged in efforts to prohibit “gag” clauses in physician contracts.^{1,2} These clauses, promulgated by managed care organizations (MCOs) and other such health plans, prohibit physicians from frankly discussing all treatment options, covered or uncovered, expensive or inexpensive, that could be of benefit to the patient. For example, one clause reads: “Do NOT discuss proposed treatments with [health plan] members prior to receiving authorization. Do NOT discuss the [utilization oversight] process with members. Do NOT give out [plan’s oversight] phone number to members.”³

Because MCOs cover approximately 190 million citizens in the United States,⁴ these gag clauses have a significant impact on the health care of most individuals in this country. As would be expected, organized medicine and consumer groups have applauded state and federal efforts to limit the use of such clauses. However, even with a law against gag clauses in place, there are other modes by which the MCO can enforce desired physician action. Virtually every health services contract signed by physicians includes a termination-without-cause clause. This clause generally allows the MCO to fire the physician for any reason, or for no reason at all.⁴ Challenges to this form of termination (also known as “deselection” because the physician, initially “selected” by the MCO, is “deselected” when fired) have been notably unsuccessful.^{4,5}

The legal conclusion that terminations without cause are acceptable very much colors my review of many MCO contracts and, related to this, my assessment of the effectiveness of gag clause legislation. Two questions invariably arise in my discussions with physicians regarding their contracts: (1) Can they terminate me? and (2) What care am I supposed to give? These questions are actually articulating very much the same concerns and provide insight into how gag clause legislation will affect physicians. “Can they terminate me” means “Can they terminate me at any time for any or no reason at all?” The answer to

this question is “yes” under the termination-without-cause clause. “What care am I supposed to give?” means “What care should I provide so that they won’t terminate me?” The answer to this question is “care that doesn’t make waves for the MCO, doesn’t involve extra administrative costs for patient care appeals, experimental procedures, expensive procedures, nonformulary drugs, resources outside the plan, or requests for uncovered care, and doesn’t make the plan look bad”—the same limitations imposed by an explicit gag clause. And the MCO can still exercise its legal right under the contract and deselect the physician. So even if gag clauses are prohibited, they are effectively maintained by the presence of the standard termination clause in physician contracts.

ETHICAL RESOLUTIONS?

What should physicians do if these limits on communication affect patient care? It would be convenient if we could simply “do the best for the patient, regardless,” i.e., talk to the patient about specialist treatment, experimental procedures, the nonformulary drug, etc., and then be deselected. Unfortunately, in the practical world, things are not so simple. There are negative effects of such a choice that go beyond the specific treatment for the given clinical circumstance. On a basic level, there is the loss of confidence and trust by the patient in his or her treatment after the first physician is deselected. And there are the difficulties faced by the next physician who must attempt to come up to speed on important tangible and intangible patient and treatment factors, taking precious time to merely reinvent the wheel. Hence, both patient and physician have the deck stacked against them in forming an optimal relationship. The new physician must rely on a one-page transfer summary and notes scribbled over a period of perhaps several years or longer without the benefit of knowing the patient as a person, his or her culture, or background. And the patient must rely on the MCO to have within its selected provider list another compassionate and caring physician with whom he or she can quickly establish a trusting relationship similar to the one that took years to build with the previous physician. Thus, doing the “best thing” in the short term by violating the implicit gag clause may result in the worst thing for the patient in the long run.

Even worse, the exigencies of the current health care market place more burden on the patient. A patient

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whose physician has violated the gag clause and been deselected may not be readily able to obtain a new physician. If the patient is “expensive,” e.g., has a terminal or chronic illness or is elderly, he or she carries a high cost profile that is quite undesirable for any new physician to assume. The patient will also have an adverse effect on the new physician’s outcomes profile.⁴ Further, because of the increasing productivity pressures on the physician, taking on new patients presents a financially difficult and undesirable task. Very sick patients and patients who have generally not been well assimilated into the medical care system, such as the poor, are particularly vulnerable to this characterization. These factors and the patient’s steadily increasing disease will make it difficult for both parties to manifest the extended energies necessary to establish an effective therapeutic alliance.

And finally, other, nontraditional ethical issues are raised by physician termination under a gag clause beyond those created by the physician’s medical responsibilities. Doesn’t the physician have an ethical responsibility to support his or her family? To pay his or her bills? To save for retirement? Deselection by ignoring the implicit gag clause will create a failure to fulfill one’s ethical responsibilities in these realms and to these people. Often we and others forget that we have ethical duties to a broad range of individuals other than our patients. Because of the breadth of these responsibilities, there is no simple answer to what is the “right” thing to do when deciding whether to follow implied gag clauses in the face of potential deselection.

A RECOMMENDATION

The prohibition of gag clauses sought by consumer groups, physicians, and others fundamentally rests on the premise that full communication between physicians and patients should be paramount; i.e., only through complete and open discussion can a physician provide the best care for the patient and a patient make an informed decision about his or her care. A method for making this premise, rather than the financial bottom line, the focus for health care delivery is to extend liability for patient injury to MCOs through federal legislation. Federal legislation would subject all MCOs and their patients to its requirements and protections. A federal scheme would also avoid issues involving state laws that may not be applicable to certain MCOs⁶.

Using this approach, all parties involved in providing the patient’s care—the physician and the MCO—will have aligned incentives to manage the care provided to the patient so as to at least minimize the risk of patient injury, rather than deciding the extent and form of that care under the currently divergent incentives of physicians and management. By extending liability to the organization, nondisclosure of pertinent medical information would be theoretically discouraged by the organization itself, which would have a strong incentive to work diligently with the

physician to find medical treatments that effectively address the patient’s disease so as to avoid the costs of patient injury.

Most likely MCOs will respond to these financial incentives; although individual physicians may not respond effectively to potential legal liability,^{7,8} corporate entities generally do.⁹ By acting to limit patient injury and its costs, they will be improving their profitability and potentially creating a new basis for marketing: low patient injury levels. Thus, although perhaps not the optimal quality-improvement tool, potential liability and particularly its accompanying financial cost will give MCOs, which are the typical economic actors, an incentive to provide care that at least minimizes patient injury and at most provides the most efficient and effective patient care.

In addition, the federal statutory scheme should mandate that terminations of physicians by MCOs under termination-without-cause clauses be preceded by a termination hearing, as has been held by one court (*Potvin v Met. Life Ins. Co.*, 63 Cal Rptr 2d 202 [Ct App 1997]), to clarify that the physician is *not* being terminated for quality-of-care reasons.⁴ Because this hearing would be a public forum, MCOs who terminate physicians for discussing treatment options with patients would be exposed for taking these actions. Public accountability for such MCO actions based on costs over quality may also serve as a marketing tool for those MCOs that instead focus on quality over cost.

Thus, refocusing the health care enterprise on patients and increasing public scrutiny of MCO decision making, in combination with federal laws prohibiting gag clauses, would substantively allow these laws to work. By giving all with a hand in providing health care the incentive to think first of the patient, rather than the financial bottom line, when treatment decisions are made will avoid the pitfalls of current proposals to prohibit gag clauses.

SUMMARY

Efforts to limit gag clauses by state legislatures and Congress have received kudos from many quarters. But without attention to other standard aspects of physician contracts, the effects of gag clauses will continue. Some physicians who feel the difficulties of current medical practice are too onerous will leave the profession if they can; the vast majority who stay, with patients, families, and others who rely on them, will simply try to do their best under these constraints. That means dealing with the effects of severing the patient-physician relationship and with conflicting ethical concerns on an ad hoc basis. And that also means heeding the insight that formal rules may not have their desired effect when, in practice, others don’t really need to play by them. Only through refocusing the health delivery system on the patient and public scrutiny of provider terminations and MCO actions can the prohibition of gag clauses truly be effected. Let us

hope that this insight is not lost on lawmakers in their efforts to substantively eliminate the effects of gag clauses on patients and physicians in our health delivery system.

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