EDITORIAL AND COMMENT

Are ACOs on Uncertain Ethical Ground and a Threat to the Autonomy of Patients and Physicians?

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In this issue of *JGIM*, DeCamp et al. have analyzed the accountable care organization (ACO) literature for the discussion of ethical issues, and come away from their exercise concerned that there has been very little consideration or anticipation of what the ethical concerns of this new platform for healthcare might be. They note, “The structure of healthcare affects the ethical issues arising in the practice of medicine,” and reason, “ACOs will experience ethical challenges.” With their review, they were able to develop a list of nine issues for the attention of clinicians, patients and management. Their list highlights that there will be concerns for patients and clinicians about the potential loss of autonomy when the core doctor-patient dyad moves into an ACO.¹

Elliot Fischer and others launched the concept of the ACO in 2006 and meant ACOs to be tightly connected to the concepts of the Triple Aim.² One healthcare industry information service describes the Triple Aim as the goal of an ACO:

*The goals of ACOs are nicely summarized in something known as “the triple aim,” which was first articulated by Donald Berwick, MD, former acting CMS administrator. The three aims are: (1) improving the experience of care, (2) improving the health of populations and (3) reducing per capita costs of healthcare.*³

The phrase ‘Triple Aim’ is new (2007),⁴ but the concept is more than 40 years old. Dr. Robert Ebert, then Dean of the Harvard Medical School, founded Harvard Community Health Plan in 1969 for reasons highly aligned with today’s concept of an ACO and the core principles of the Triple Aim. He wrote in 1965:

“The existing deficiencies in health care cannot be corrected simply by supplying more personnel, more facilities and more money. These problems can only

*be solved by organizing the personnel, facilities and financing into a conceptual framework and operating system that will provide optimally for the health needs of the population.”*⁵

Some ACOs believe the Triple Aim will be difficult to achieve without recognizing the stress of practice, and have added an additional goal of improving the work experience of healthcare professionals, and refer to the Triple Aim “plus one”.⁶ Unless the Triple Aim is understood as the goal of the ACO, we cannot expect to adequately consider the ethical benefits or liabilities of ACOs.

Everyone understands and applauds the “improving the experience of care” part of the Triple Aim. The part about populations begins to get a little less certain. Some understand that to improve the health of populations, we must continue to push toward universal access and equity in care. The third aim is the hardest to understand and generates controversy. Some people, in and out of healthcare, do not yet accept the necessity of lowering the cost of care, and of those who do, still fewer see cost as an ethical issue rather than a practical concern.

We should consider the distorting reality that the cost of healthcare has on many other issues that we care about, including the cost of the goods we purchase, the quality of education in our community, the deterioration of our community’s infrastructure, the taxes we pay, and the potential that continuously rising healthcare costs may have on our personal finances.⁷ Perhaps the more we enjoy protection from financial concerns related to practice finances or personal healthcare costs, the more we are likely either to ignore costs or see the discussion of cost as someone else’s problem or an unethical attack on our own healthcare or practice.

In the last year, I have been delighted with the progress in the conversation and understanding about the necessity to lower the cost of care while maintaining quality and access. Everywhere I go, physicians are curious about ACOs and value-based reimbursement. These conversations invariably

include the Triple Aim and often concerns about how the ethical basis of practice is affected, especially in the area of practice autonomy. Perhaps the most significant change in the conversation is the realization that to achieve the lofty goals of the Triple Aim, we will need to shift the focus from practicing as individuals to working with other healthcare professionals for the benefit of the patient. This shift from “my responsibility” to “our responsibility” for which we are collectively accountable has been a part of the evolution of group practice, and is accelerated by the move to the ACO structure.⁸ The shift generates the need for a discussion of collective professionalism and its impact on traditional concepts of individual practice autonomy.

The ethical evaluation of ACOs must consider the larger issues of universal coverage, equity and the sustainability of healthcare costs in a complex community economy just as seriously as it considers the impact of the ACO on physician practice autonomy and patient choice and preference. As the chief executive officer (CEO) of a large physician practice that is an ACO, and now as a consultant to physician practices, I have been empathetic to the individual stress experienced by physicians as they attempt to adjust to and comply with the changes in practice associated with the move from volume-based reimbursement to the value-based objectives of the ACO as expressed by the Triple Aim. I have experienced these same stresses myself as a physician.

When ACOs are aligned with the goals of the Triple Aim, they will be using tools of continuous improvement and data from collected experience and well performed clinical trials to implement uniform workflows and accepted best practices, to improve quality and safety, lower costs, and improve work life balance for all members of the care team. These well-intended changes induce stress that can be articulated by some as arising from a loss of autonomy, and can be perceived as unethical attacks on the long-accepted and established values of the individual doctor–patient relationship.

As the authors note, the ethical basis of practice autonomy lies in the concept of professionalism. The American Board of Internal Medicine (ABIM) has given deep consideration to the subject of professionalism⁹ and “best practices,” as have all of the participating Societies that collaborated in the creation of the “Choosing Wisely” recommendations.¹⁰ Autonomy is absolutely required in practice for the professional to customize the care of the individual, but autonomy and professionalism together constitute a complex balance for the individual clinician, because the professional is charged with the responsibility that his or her advice for the patients lies within the bounds of proven efficacy or at a minimum, our collective good judgment.

Proof of efficacy in complex chronic diseases can be elusive despite well-constructed trials. More and more, we are trying to learn how to effectively use large data sets with denominators to augment the process of discovering the best practices. Individual practice is usually a numerator

experience, and we depend upon the reporting and mingling of our own experience with others to find the best practice. ACOs were conceptualized to discover and spread best practices and are on solid ethical ground when they request adherence to proven standards.

Could it be that as the discussion of the ethical issues of ACOs evolves, we will engender an even more insightful discussion of professionalism? Will a discussion of the ethics of ACOs simultaneously advance the discussion of the ethical relationship of the individual patient to all other patients and the community?¹¹ As the economics of healthcare change and more patients see ACOs as institutions that give them more value for their health care dollar and as they realize that the cost of their care is a function of risk shared across a community, could it be that more patients will also see the value of receiving care from a system built on best practices and the avoidance of care with little likelihood of benefit?¹²

Our previous failures to improve quality while expanding access and lowering cost have led us to speculate that healthcare is a different kind of industry where improvement is always associated with higher cost and where the usual laws of economics do not apply. Now organizations like Virginia Mason, ThedaCare, and Geisinger have used Lean and other tools of care improvement to yield advances in quality and safety while lowering cost. The Mayo Clinic and the Cleveland Clinic have long shown that collaborative, evidence-based care produces a better value.

Transformation of long-standing habits and deeply held values and assumptions will be required as we move to practice in ACOs. Some will surely experience a sense of loss and feel that their values are being violated in this transition. We should listen to their concerns even as we press forward toward the Triple Aim and as we continue to explore the ethical challenges that arise as we practice more and more in the structure of ACOs.

Conflict of Interest: The author declares that he does not have a conflict of interest.

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