THE INFLUENCE OF A PROFESSIONAL ORGANIZATION ON PHYSICIAN BEHAVIOR

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INTRODUCTION

As many commentators have observed, our society often operates on the basis of the technological imperative: advances in medicine and in other fields are used because they are available, for their own sake, rather than for the overall good of the public.¹ For example, cardiopulmonary resuscitation ("CPR") is sometimes administered to patients for whom there is virtually no possibility of restoring cardiac function, simply on the presumption that CPR should be applied to any patient whose heart has ceased beating.²

Medical innovations may also be misused on account of invidious biases. Tests for genetic abnormalities have been used in the past as a basis to unfairly discriminate against individuals who carry the abnormalities.³ Other inappropriate biases may also drive the use of innovations. For example, excessive resources have been devoted to certain technologies because of a societal bias in favor of treatment rather than prevention.⁴

To ensure that medical innovations are used in an ethically responsible fashion, a variety of approaches have been used. Professional societies establish guidelines,⁵ insurers employ utilization

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² See Rhoden, supra note 1, at 423; see also Paul C. Sorum, Limiting Cardiopulmonary Resuscitation, 57 ALB. L. REV. 617, 618 (1994) (arguing that "limiting [CPR's] use must depend on patient choice").


review, and governments adopt legal rules. My purpose is not to determine which of these approaches is most valuable. There is undoubtedly a role for all of them, with their importance depending upon the specific innovation and the specific use of the innovation in question. Indeed, a combination of approaches will often make the most sense.

I would like to make three points in this Article. First, professional societies can play, and indeed have played, an important role in establishing guidelines for ethical physician practices. Second, merely setting standards alone is insufficient to shape physician behavior; the standards generally need to be supplemented by other measures or incentives. Third, professional societies are much more successful at setting standards than they are at ensuring physician acceptance and implementation of the standards. The kinds of incentives or mandates that are necessary for the adoption of ethical standards generally have come from outside the profession.

In developing these points, I will refer to empirical studies of efforts to regulate physician behavior, as well as my own experiences in trying to shape physician behavior through the issuance of ethical guidelines by the American Medical Association (“AMA”). But before getting into the specific examples, I will discuss why it is important for the medical profession to have some responsibility for establishing guidelines on ethical matters.

I. PROFESSIONAL RESPONSIBILITY

There are several reasons why the medical profession ought to have an important role in the setting of guidelines on ethical questions.

A. Professional Autonomy

In the past two or three decades, patient autonomy has become the dominant ethical principle in medicine. Patient self-determination has replaced beneficence by the physician as the fun-

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6 See Theodore R. Marmor & Michael S. Barr, Making Sense of the National Health Insurance Reform Debate, 10 YALE L. & POL'Y REV. 228, 232 (1992) ("Private insurance firms spend large and increasing sums on utilization reviews, marketing, and billing.").

7 For example, Medicare denies reimbursement for cellular therapy because it "is without scientific or statistical evidence to document its therapeutic efficacy and, in fact, is considered a potentially dangerous practice." 5 Medicare & Medicaid Guide (CCH) ¶ 27,201, at 29,215 (1993).

8 See Beauchamp & Childress, supra note 4, at 67-113.
damental value in medical decision making. Indeed, as David Blake has observed, when courts are faced with a patient’s request to discontinue life-sustaining treatment, they almost uniformly give lip service to the state’s interests in continuing treatment, and ultimately defer to the patient’s preferences. In the liberal state, in which there is no universal consensus on what is good, individuals must be given considerable freedom from externally imposed moral values. It is incumbent upon the state to maintain moral neutrality and permit individuals to define their own sense of morality, as long as there is no infringement on the freedom of fellow citizens.

Physicians also have a strong need for personal autonomy. Society respects individual dignity by permitting people to have control over essential aspects of their lives, and for most people, professional expression is a critical element of personhood. As Robert Gordon observed, control over the working environment is a basic “precondition to the realization of [a] free, authentic personality.”

To be sure, within the liberal state there may be subcommunities of persons who share a common moral view, and physicians may each therefore agree to be bound by a professional code of ethics. Nevertheless, principles of personal self-expression indicate that it is still for the profession, rather than the state, to develop a professional code.

Patients also benefit from physician autonomy. Medicine will not attract talented individuals if physicians are not given the opportunity for self-regulation. Currently, in explaining an increasing disenchanted with their professional lives, physicians identify loss of autonomy as one of the most important problems. Doctors express grave concern about mounting paperwork, heavyhanded utilization review, and greater government regulations—the so-called “hassle factor.” Such a reaction is predictable. As studies have demonstrated, when individuals exercise more control over decision mak-

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9 See id. at 210 ("So influential is this autonomy model at the present time that it has become difficult to find clear commitments to the traditional beneficence model in contemporary biomedical ethics.").
13 Engelhardt, supra note 11, at 49-56.
15 Id.
ing in their workplace, they experience greater satisfaction and are more productive in their employment.\(^{16}\)

\[\text{B. Moral Responsibility}\]

Professional autonomy enhances the physician's sense of moral responsibility. "By collectively engaging in the process of enacting and enforcing" guidelines on ethical questions, physicians, like other professionals, "develop and reinforce [a] disposition for moral decision-making."\(^ {17}\) Society has a profound interest in "cultivating a moral personality" in physicians, as with all of its citizens.\(^ {18}\)

If physicians are responsible for establishing their own ethical code, they are much more likely to view ethics as an integral part of the practice of medicine. For decades, the public has called on the profession to integrate ethics more fully into medical training and practice.\(^ {19}\) While ethics instruction is now offered in all medical schools, it generally is treated as a supplemental rather than core element of the curriculum;\(^ {20}\) there is still a need for greater emphasis on the incorporation of ethics into medicine. If we say that ethical standards are not really the responsibility of the profession, but of other groups, then we are essentially divorcing ethics from the practice of medicine.

\[\text{C. Independence from Political Processes}\]

While professional self-regulation has inherent conflicts of interest and may be compromised by political pressures, too great a reliance on government regulation risks even greater politicization of the standard-setting process. Examples from the past twelve years are illustrative. Political considerations prevented the Reagan and Bush Administrations from even convening a federal ethics commiss-


\(^{18}\) See id.

\(^{19}\) In fact, in 1985 it was noted that "[i]n scarcely more than a decade, the teaching of medical ethics has become a regular feature of medical school curricula in the United States." Edmund D. Pellegrino et al., Relevance and Utility of Courses in Medical Ethics: A Survey of Physicians' Perceptions, 253 JAMA 49, 49 (1985).

\(^{20}\) See id. Additionally, "the majority of residency training programs in internal medicine are just beginning to try to accommodate the need for training in the ethical aspects of patient care." Daniel P. Sulmasy et al., Medical House Officers' Knowledge, Attitudes, and Confidence Regarding Medical Ethics, 150 Archives Internal Med. 2509, 2509 (1990).
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sion, despite congressional authorization, and delayed for more than four years the implementation of recommendations by a federal advisory panel on fetal tissue transplantation. Even today it is highly unlikely that the U.S. Congress would reach the same position that the AMA’s Council on Ethical and Judicial Affairs did when it concluded that parental involvement should not be mandatory when minors have abortions.

In some cases, independent government commissions can be used to insulate standard setters from political influences. Difficult political questions, like the closing of military bases, are often resolved by the establishment of “blue-ribbon” panels that make recommendations to Congress after careful study. However, the recent politicization of Supreme Court appointments reflects how difficult it is to maintain the independence and integrity of government bodies that have a continuing responsibility.

There is a real danger of overreaching when the government establishes guidelines on ethical issues; the government may be easily tempted to use its ethics pronouncements to serve other policy goals. Indeed, last year, when it issued its proposed regulations for executions, the federal government planned to have physicians participate in capital punishment. As a result of objection from the medical profession, however, the final rules excluded any requirement that physicians be involved.

As the government is becoming both increasingly involved in the provision of health care and increasingly concerned about rising health care costs, intense pressure will develop to sacrifice ethical values for economic reasons. There is already evidence that the federal government is insufficiently concerned about financial incentives by health care plans that discourage physicians from using diagnostic and therapeutic procedures. For example, health mainte-

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22 Id. at 9.
ance organizations and other managed care plans typically use fee
withholds and bonuses to reward physicians more when their pa-
tients consume fewer health care resources. Accordingly, physi-
cians recognize that every time they order a test or a procedure,
their income will be reduced. The Health Care Financing Admin-
istration has proposed rules to limit the amount of a physician’s in-
come that can be placed at risk, but the rules would still allow fee
withholds and bonuses to account for up to 30% of a physician’s in-
come. When 30% of a physician’s income is at risk, health care
costs may be contained, but the possibility that necessary treatment
will be withheld becomes very problematic. In short, governmental
bodies that establish and enforce ethics guidelines may have a ten-
dency to sacrifice important ethical principles to achieve political
goals.

Professional standard-setting bodies can also become politicized.
In the case of the AMA’s Council on Ethical and Judicial Affairs,
however, several steps have been taken to minimize that risk. First,
except for the medical student and the resident, members of the
Council serve a single seven-year term (the student and resident
members generally serve a single term of two or three years, respec-
tively). Accordingly, the decisions of Council members are not in-
fluenced by their concerns about reappointment. Second, Council
members are nominated by the President of the AMA and approved
by the House of Delegates. Because the members do not run for
office, they are not under the pressure of an election campaign to
pander to sentiments that are popular but not ethically meritorious.
Third, while on the Council, members may not hold any other posi-
tions in the AMA. If a person has a position in the House of Dele-
gates or on the Board of Trustees when appointed to the Council, the
position must be relinquished. Consequently, individuals with
strong political ambitions do not seek positions on the Council; a

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29 A fee withhold refers to the practice of health care plans withholding a percentage of the
physician's compensation at each pay period and giving all or part of the withheld payments to
the physician at a later date, depending on the amount of services used by patients in the plan.
Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid
30 See id. at 59,025 to 26.
31 Id. at 59,032.
32 COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, 1992 CODE
OF MEDICAL ETHICS—ANNOTATED CURRENT OPINIONS 86-88 (1992) [hereinafter CODE OF
ETHICS].
33 Id. at 87.
34 Id.
seven-year hiatus from the political process generally would preclude future opportunities for political leadership in the AMA. Because Council members have few political aspirations, they are not as likely to temper their opinions with political concerns. Fourth, the Council has the authority to issue positions on ethical issues either with or without approval of the House of Delegates. While House approval is often sought to avoid a sense that the Council is ramming positions through in an authoritarian fashion, the Council routinely issues guidelines without House approval and even over House objection, if necessary. For example, after the House twice rejected a Council report that called for specific informed consent as a prerequisite to HIV testing, the Council, without seeking House approval, issued an opinion that imposed the requirement of specific consent.

D. Acceptability

Ethical guidelines will be more readily accepted by physicians if they are developed internally rather than if they are imposed by external bodies, particularly external bodies with a poor record of self-regulation. For example, it is easy for physicians to dismiss calls by Congress for stricter rules on conflicts of interest in medicine when members of Congress routinely accept contributions, invitations to visit resorts, and other gifts from businesses that are affected by potential legislation.

The public also appears to hold more trust in the medical profession than in other bodies when it comes to setting ethical standards. In polls taken over the past fifteen years, 50-60% of those surveyed gave a “high” or “very high” rating to physicians on both honesty and ethical standards. In contrast, only 10-25% of the respondents rated United States Senators as having “high” or “very high” ethical standards. The comparable figures for United States Congressmen were 10-20%. Similarly, on the question of who the public

36 CODE OF ETHICS, supra note 32, at 26. The House preferred the view that consent to HIV testing be implied in a patient's general consent to necessary blood tests. AMERICAN MEDICAL ASSOCIATION, POLICY COMPENDIUM § 20.945 (1993).
38 Id.
39 Id.
trusts for proposing fair and workable health policies, 71% of those surveyed trust organized medicine "some" or "a great deal" while only 40% trust the Federal Government "some" or "a great deal."  

E. Reliability

In discussions about self-regulation in medicine, it is commonly argued that lay people do not have sufficient expertise to set standards for medical practice while physicians are much better equipped to establish practice guidelines. For example, the medical profession establishes standards for determining whether a physician has practiced competently. While it is true that ethical guidelines may not require the same degree of professional expertise as technical guidelines, physicians do have unique perspectives on the patient-physician relationship that are critically relevant in determining what guidelines are appropriate. Similarly, physicians are often in a better position than lay persons to make ethical judgments because of the importance of medical facts to ethical conclusions. For example, when deciding whether a child should serve as a donor in a kidney transplantation, it is necessary to understand the risks to the donor and the benefits to the recipient. In addition, because the ethics community has yet to develop its own body of standards, it is not clear that ethicists are in any better position to develop guidelines for the profession.

F. Due Process

According to principles of due process, the medical profession ought to have the opportunity to resolve ethical problems itself before other groups jump in with externally developed mandates. Due process recognizes that in ensuring a just outcome the mechanism for achieving a result is as important as the result itself. Indeed, the tradition of oral argument in appellate litigation is important not so much because it affects the court's decision but because oral argument assures the litigants that they themselves have been heard. Consider also that courts generally do not review ad-

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42 Id. at 186-89.
43 See John E. Nowak & Ronald D. Rotunda, Constitutional Law § 13.1, at 487 (4th ed. 1991) ("The due process clauses also have a procedural aspect in that they guarantee that each person shall be accorded a certain 'process' if they are deprived of life, liberty, or property.").
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ministrative agency decisions until challenges have been taken through administrative appeal (i.e., administrative remedies have been exhausted). Requiring the exhaustion of administrative remedies provides administrative agencies the opportunity to correct their mistakes before courts step in. Just as administrative agencies are given a chance to internally correct errors, so should the medical profession be permitted to correct ethical problems through self-regulation before others step in with their own approaches.

II. Case Studies

Giving theoretical arguments to justify professional self-regulation of ethics is only part of the story. We still need to know whether professional self-regulation actually works. Can the profession engage in meaningful self-regulation, or is this just a matter of letting foxes guard the chicken coop? The medical profession's experience with standard-setting suggests the following conclusion: professional regulation can have a substantial impact on physician behavior, but professional guidelines alone are generally insufficient to change physician behavior. The guidelines must be combined with other measures to ensure compliance.

I will discuss two sources of data that can inform us on the effectiveness of professional standards on ethical issues: the impact of the AMA's guidelines on ethical questions and the impact of professional guidelines for therapeutic procedures such as guidelines that indicate when cesarean sections and coronary artery bypass surgery should be performed. The experience with the AMA's ethical guidelines is directly relevant. However, an assessment of their impact must rely in part on anecdotal data; well-controlled studies of their impact do not exist. Professional guidelines on therapeutic procedures are less relevant because they involve decisions that are both technical and ethical in nature. On the other hand, there have been many studies examining the impact of these guidelines, and we can safely assume that some of the lessons learned apply to the implementation of ethical guidelines.

45 See, e.g., Myers v. Bethlehem Shipbuilding Corp., 303 U.S. 41, 50-51 (1938) (noting "the long settled rule of judicial administration that no one is entitled to judicial relief ... until the prescribed administrative remedy has been exhausted").

A. The AMA's Ethical Guidelines

The AMA's Council on Ethical and Judicial Affairs issues a Code of Ethics\textsuperscript{47} for physicians that is analogous to the ABA's Model Code of Professional Responsibility.\textsuperscript{48} Physicians who violate the AMA's code are subject to discipline by the AMA, and by their county and state medical societies.\textsuperscript{49} A number of specialty societies, including the American Academy of Family Physicians and the American Psychiatric Association, have adopted the AMA's code and hold their members accountable for violations.\textsuperscript{50} In some states, the medical licensing statute expressly considers violations of the AMA's code as grounds for discipline.\textsuperscript{51} Apparently, state licensing boards generally view the AMA's code as probative, though not dispositive, evidence of the expected standard of conduct when deciding whether a physician has committed professional misconduct.\textsuperscript{52}

From my five years as Secretary to the Council on Ethical and Judicial Affairs, I will discuss an example of successful self-regulation and an example of unsuccessful self-regulation and suggest why the two efforts had different results.

1. Gifts to Physicians from Industry

During the 1980s, there was increasing concern in the medical profession about gifts to physicians from pharmaceutical and other companies.\textsuperscript{53} Commentators were troubled both by the magnitude and kinds of industry gift-giving.\textsuperscript{54} Data on magnitude was develop-

\textsuperscript{47} See Code of Ethics, supra note 32. Revised versions of the code are issued every two to three years. The 1994 edition is scheduled for publication in May 1994.

\textsuperscript{48} Model Code of Professional Responsibility (1980).

\textsuperscript{49} See Code of Ethics, supra note 32, at 1, 78-79, 94-98 (§§ 1.01, 1.02, and 9.04 of the Code of Ethics and describing disciplinary procedures).

\textsuperscript{50} See, e.g., American Academy of Family Physicians, Bylaws 6-7 (1993); American Psychiatric Association, The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry (1989).


\textsuperscript{52} Telephone interview with Dorothy Harwood, Assistant Vice President for Administrative and Legislative Affairs, Federation of State Medical Boards of the United States (Feb. 3, 1994).


\textsuperscript{54} See, e.g., Council on Ethical and Judicial Affairs, American Medical Association, Gifts to Physicians from Industry, 265 JAMA 501 (1991) (noting that "there has been growing concern about certain gifts from industry to physicians"); John Graves, Frequent-flyer Programs for Drug Prescribing, 317 New Eng. J. Med. 252 (1987) (letter to the editor); Teri Randall, Kennedy Hearings Say No More Free Lunch—or Much Else—From Drug Firms, 265 JAMA 440 (1991) (noting Senator Kennedy's remark: "Doctors who accept lavish industry gifts are jeopardizing their objectivity and compromising the trust of their patients").
oped by the Senate Labor and Human Resources Committee, which tracked expenditures by eighteen large pharmaceutical companies on gifts to physicians between 1975 and 1988. Over that period, after taking inflation into account, gift expenditures nearly quintupled. There also appeared to be a greater tendency for companies to give gifts particularly likely to influence the treatment decisions of physicians. Gift-giving extended well beyond pens, mugs, and grants for educational programs to all-expense paid weekend trips at lavish resorts for physicians and their spouses, frequent prescriber programs offering free airline tickets for every fifty prescriptions, and "studies" which paid physicians hundreds of dollars if they prescribed expensive antibiotics and collected data that was essentially demographic in nature.

By 1990, guidelines on gift-giving had been issued by a number of professional societies, including England's Royal College of Physicians, the American College of Physicians, and the American College of Cardiology. However, there was little evidence of change in industry gift-giving practices. While praiseworthy, the guidelines lacked specificity. For example, physicians were admonished to decline gifts that they were not willing to have "generally known" to others. This vagueness made it difficult to charge anyone with violations of these guidelines.

Following nearly a year of deliberations, the AMA issued its own guidelines on gift-giving in December 1990. The guidelines explicitly prohibit cash payments, subsidies for the travel expenses of physicians attending conferences, gifts tied to prescribing practices, and any gift not related to patient care. In addition, the guidelines limit the magnitude of individual gifts and require that grants to

55 Randall, supra note 54, at 440, 442.
56 Id. at 442.
58 See Graves, supra note 54.
59 Randall, supra note 54, at 440.
63 See American College of Physicians, supra note 61, at 624; C. Richard Conti et al., supra note 62, at 32; Royal College of Physicians, supra note 60, at 238.
64 Council on Ethical and Judicial Affairs, American Medical Association, supra note 54.
65 See CODE OF ETHICS, supra note 32, at 68-69; Council on Ethical and Judicial Affairs, American Medical Association, supra note 54.
defray registration fees for educational conferences be given directly
to conference sponsors and not to physicians.\textsuperscript{66}

Ordinarily, it is difficult to measure the impact of ethical guidelines. It is not always certain whether ethical guidelines result in behavioral changes. Even when changes are detected, it is often not clear whether the changes reflect the ethical guideline or other contemporaneous influences. For example, if there is an increase in services provided to the poor after the issuance of a guideline calling on physicians to care for the indigent, the increase may be the result of the ethical guideline or perhaps, the result of a coincidental rise in Medicaid reimbursement rates.

With the AMA gift-giving guidelines, however, the impact was immediate and substantial. Companies canceled educational and promotional conferences that were not strong enough to attract physicians willing to pay their own travel expenses, and promotional dinners where physicians received a free meal and a $100 payment were also abandoned.\textsuperscript{67} At the Council on Ethical and Judicial Affairs, we received calls from travel agencies complaining about the impact of the gift-giving guidelines on their businesses, and physicians reported that lavish evening receptions were disappearing at major medical meetings. In this case, the ethical guidelines changed physician behavior dramatically and meaningfully.

Why were these guidelines so successful? First, the pharmaceutical industry incorporated the guidelines into its ethics code for marketing practices.\textsuperscript{68} As a result, the success of the guidelines was not solely dependant on the willingness of physicians to adhere to their ethical responsibilities. After implementation, drug companies generally stopped offering inappropriate gifts; thus physicians were not in a position to accept them. In fact, the industry probably did not fight the guidelines too vigorously because in some ways, companies welcomed the restrictions. To a certain extent, gifts are given because of physician demand,\textsuperscript{69} and once one company accedes to such demands, other companies must follow in order to remain competitive. Similarly, one company may initiate gift-giving as a marketing strategy and other companies, for competitive reasons, feel compelled to match the strategy. A prohibition on gift-giving levels the


\textsuperscript{67} Teri Randall, \textit{AMA, Pharmaceutical Association Form ‘Solid Front’ on Gift-Giving Guidelines, 265 JAMA 2304 (1991).}

\textsuperscript{68} \textit{Id.}

\textsuperscript{69} Royal College of Physicians, \textit{supra} note 60, at 237.
Influence of a Professional Organization playing field for members of the industry, having the same effect as an agreement by the companies that they would not try to compete with each other through gift-giving.\(^7\)

Second, while there are more than one hundred drug companies, a small number of large companies dominate the market.\(^7\) Consequently, in order to ensure that the guidelines achieved their purpose, it was necessary to achieve compliance from only a few major companies. Moreover, with the focus on just the dominant players in the industry, policing the guidelines became much easier as well.

Third, detection of violations is relatively easy. Gift-giving occurs openly, and companies usually offer the same gift to hundreds, if not thousands of physicians. Physicians who support the guidelines as well as competitors of the gift-giving company are likely to be aware of violations and report them to the AMA. Indeed, in the months following the implementation of the guidelines, our attention was drawn to a number of apparent violations.\(^7\)

Fourth, concern about government regulation gave both physicians and industry a strong incentive to follow the AMA’s guidelines. Immediately following the issuance of the guidelines, Senator Edward Kennedy convened hearings on the pharmaceutical industry’s gift-giving practices.\(^7\) After the hearings, he indicated that he would refrain from taking any legislative or regulatory efforts if the AMA’s guidelines eliminated abusive gift-giving practices.\(^7\) Thus, even though there was not a strong enforcement mechanism in place,\(^7\) there was a strong threat of enforcement by means of legislative action looming over both the pharmaceutical industry and the medical profession.

Fifth, the guidelines draw a number of “bright line” rules, establishing clear distinctions between permissible and impermissible conduct.\(^7\) The pharmaceutical industry had previously adopted the American College of Physician’s guidelines on gift-giving practices,

\(^7\) Such an agreement would, of course, be unlawful under antitrust law. See 15 U.S.C. § 1 (1988). Agreeing to the AMA’s code could also constitute a violation of antitrust law, but the risk of prosecution is very low.


\(^7\) Randall, supra note 67.

\(^7\) Randall, supra note 54.

\(^7\) Randall, supra note 67, at 2305.

\(^7\) Randall, supra note 54, at 442.

\(^7\) Code of Ethics, supra note 32, at 68-69 (setting forth the provision relating to “Gifts to Physicians from Industry”).
but, because those guidelines essentially enunciated general principles, industry had a good deal of freedom in interpreting them.\footnote{77 See Randall, supra note 54, at 442.}

In short, the AMA gift-giving guidelines probably succeeded because the rules were clear,\footnote{78 Clear guidelines were also a key factor in the success of a federal government regulation limiting the use of antipsychotic drugs in nursing homes. Robert L. Kane & Judith Garrard, Changing Physician Prescribing Practices: Regulation vs. Education, 271 JAMA 393, 393 (1994).} because they actually served the interests of one of the parties effected, because there was a credible threat of enforcement in the form of greater government oversight, and because violations could be detected with relative ease.

2. Treatment of HIV-Infected Patients

There has apparently been less success with the AMA's ethical guideline on the duty of physicians to treat patients with HIV infection. In December 1987, the Council on Ethical and Judicial Affairs issued a guideline stating that physicians may not refuse to treat patients on account of their HIV infection.\footnote{79 CODE OF ETHICS, supra note 32, at 85; Council on Ethical and Judicial Affairs, American Medical Association, Ethical Issues Involved in the Growing AIDS Crisis, 259 JAMA 1360 (1988).} Since then, however, studies suggest that a substantial number of physicians have not followed the guideline.\footnote{80 See, e.g., ACLU AIDS PROJECT, EPIDEMIC OF FEAR: A SURVEY OF AIDS DISCRIMINATION IN THE 1980s AND POLICY RECOMMENDATIONS FOR THE 1990s 78-80 (1990).} In an August 1990 random national sample of primary care physicians, 50% of the physicians surveyed stated that, if given a choice, they would not work with AIDS patients, and 48% stated that they preferred to refer patients with HIV infection to other physicians.\footnote{81 Barbara Gerbert et al., Primary Care Physicians and AIDS: Attitudinal and Structural Barriers to Care, 266 JAMA 2837, 2839 (1991).} Similarly, in a survey of one thousand surgeons, more than 90% expressed support for a policy of refusing to operate on patients with HIV infection.\footnote{82 ACLU AIDS PROJECT, supra note 80, at 80.} Since these surveys report attitudes rather than actual practices, it is possible that the surveyed physicians overcame their unwillingness to treat patients with HIV infection and hewed to their ethical responsibilities. Indeed, a 1986 survey of orthopedic surgeons suggested that while more than two-thirds of orthopedists believed that a surgeon could ethically refuse to operate on a patient with HIV infection, 90% of the orthopedists who had an opportunity to operate on infected patients had done so on at least one patient with HIV infection.\footnote{83 Paul M. Arnow et al., Orthopedic Surgeons' Attitudes and Practices Concerning Treatment of Patients with HIV Infection, 104 PUB. HEALTH REP. 121, 124, 127 (1989).}
Several other studies, however, indicate that actual practices deviate from the ethical duty to treat. In a survey of Los Angeles County primary care physicians in late 1990, researchers found that 48% of the physicians surveyed had either refused or would refuse to accept HIV infected patients into their practice. Similarly, in a June 1990 survey of North Carolina physicians, 40% reported that they either refused to treat HIV-infected patients or referred the patients elsewhere. In a 1989 survey of resident physicians, 39% of those surveyed in the United States reported that at least one of their HIV-infected patients had been refused care by a surgeon. Finally, a 1989 national survey of 560 randomly selected hospitals found that 20% of these hospitals had experienced at least one case of a staff member refusing to treat a patient with HIV infection; similarly, 25% of these hospitals immediately transferred HIV-infected patients to other hospitals.

Why has there been less success with the guideline on the duty to treat patients with HIV infection than with the guideline on gifts from industry? A number of possible explanations come to mind. First, there are strong personal incentives to ignore the obligation to provide treatment. Physicians, particularly surgeons, are concerned that they will become infected from HIV patients while treating them. While the perceived risk may be greater than the actual risk, it is perceptions that drive behavior. Physicians may also be discouraged from treating HIV-infected patients because of the psychological burdens of providing care. That is, because of the difficult clinical course, caring for HIV-infected patients is often time-consuming and emotionally draining.

Second, it is easy to camouflage violations of the obligation to treat. Physicians who do not want to treat a patient with HIV infection can simply tell the patient that they are not taking any new course, it is possible that many of the 90% refused to treat the majority of HIV-infected patients who sought care from them.

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84 Charles E. Lewis & Kathleen Montgomery, Primary Care Physicians' Refusal to Care for Patients Infected with the Human Immunodeficiency Virus, 156 W. J. Med. 36, 37 (1992).
88 Weinberger et al., supra note 85, at 684.
patients, or that they accept patients only through a referral. Moreover, even when violations are detected, there may not be a credible threat of enforcement. Currently, the Americans with Disabilities Act ("ADA") prohibits physicians from denying care to patients on account of their HIV infection. However, until the ADA went into effect in July of 1992, state anti-discrimination laws provided weak protection for patients with HIV infection.

From these two examples of ethics guidelines, we can take away two important points. First, the medical profession is perfectly capable of devising meaningful and responsible guidelines on ethical matters, even when guidelines require conduct that might not be in the physician's own personal interest. Second, the profession is less successful when it comes to ensuring that guidelines are followed. Consequently, guidelines will probably not be adopted in practice unless there is some credible method of enforcement from outside the profession. As discussed in the next section, these two lessons can also be derived from the medical profession's experience with practice guidelines.

B. Practice Guidelines

To ensure that physician practices are consistent with quality medical care, professional societies have developed standards of practice for a wide range of clinical situations. The American Academy of Pediatrics has published schedules for childhood vaccinations, the American College of Cardiology has issued guidelines for exercise testing, coronary artery bypass surgery, and pacemaker implantation, and the American Society of Anesthesiologists has

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91 Jackson & Hunter, supra note 89, at 130.

92 ACLU AIDS PROJECT, supra note 80, at 64-66.

93 AMERICAN ACADEMY OF PEDIATRICS, REPORT OF THE COMMITTEE ON INFECTIOUS DISEASES 5-60 (21st ed. 1988).


96 Committee on Pacemaker Implantation, American College of Cardiology/American Heart Association Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular
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established standards for anesthetic monitoring during surgery. These guidelines were developed by panels of experts, based on published data and their own clinical experience.

In general, studies have shown that simply developing and disseminating practice guidelines is not sufficient to change physician behavior, even when there is widespread knowledge among physicians about the guidelines. For example, despite the efforts of professional societies to reduce the rate of cesarean sections, the rate has remained high in both the United States and Canada. After Canada's Society of Obstetricians and Gynecologists issued its practice guidelines for cesarean sections, roughly 90% of obstetricians surveyed reported that they knew about the guidelines, and more than 80% reported that they agreed with the guidelines. Yet two years after the release of the guidelines, there was only a small decrease in the cesarean section rate. Indeed, if that small a decline were multiplied over time, it would take more than thirty years for Canada's cesarean section rate to reach the medically desirable level.

Similar results were found in a study of practice guidelines issued by the National Institutes of Health (“NIH”). Between 1977 and 1986, the NIH developed guidelines on sixty different practice questions. In a study of the impact of four of those guidelines (two that applied to treatment of breast cancer, one that applied to cesarean sections, and one that applied to coronary artery bypass surgery), researchers found that the guidelines were largely unsuccessful in changing physician behavior.

The failure of information alone to change physician behavior is not surprising. Sociological studies on the diffusion of innovation in medicine, in agriculture, and in other settings have come to the same conclusion: knowledge about and availability of an innovation


100 Id. at 1310.

101 Id.


103 Id. at 2712.
are almost never adequate by themselves to cause adoption of the innovation.\textsuperscript{104}

There are a number of reasons why physician behavior does not change by the mere dissemination of practice guidelines. Some studies suggest that the judgment of physicians may be shaped more by their own clinical experiences than by nationally developed guidelines.\textsuperscript{105} Physicians may also resist practice guidelines as an unwarranted intrusion on their decision-making authority.\textsuperscript{106} Indeed, some theoretical inquiries suggest that personal independence is a fundamental element of professionalism in the United States. Burton Bledstein has described a "culture of professionalism" that developed in the 19th century and that rested on the idea of "self-governing individual[s] exercising [their] trained judgment."\textsuperscript{107} By permitting professionals to be truly autonomous individuals, society could fully realize the benefits of the professionals' creative energies.\textsuperscript{108}

Other factors underlying the resistance to change include personal interests and patient preferences. For example, in the case of cesarean sections, physicians may continue performing the procedure unnecessarily because they believe doing so will reduce their risk of malpractice liability—a jury might mistakenly attribute a newborn's pre-labor injury to the use of vaginal delivery. Physicians may also be responding to other financial and personal incentives to perform cesarean sections, primarily that cesarean sections are more remunerative and require less time than vaginal deliveries. Finally, physicians may be acceding to their patients’ requests for cesarean sections (which may stem from the patient's wish to avoid a painful and prolonged delivery).\textsuperscript{109}

The failure of practice guidelines to change behavior cannot be attributed simply to the inability of physicians to modify well-entrenched practices. There are a number of cases in which the medical profession has rapidly adapted to medical innovations, even without the issuance of practice guidelines. For example, within five years of its introduction in the United States, laparoscopic cholecys-

\textsuperscript{104} James S. Coleman et al., Medical Innovation: A Diffusion Study 55 (1966).


\textsuperscript{106} See Greco & Eisenberg, supra note 105, at 1273.


\textsuperscript{108} Id. at 91-92.

\textsuperscript{109} See Lomas et al., supra note 99, at 1310.
tectomy has replaced more traditional surgical methods in roughly 80% of operations to remove the gallbladder. This rapid adoption of a new procedure is particularly striking given the unavailability of any rigorous studies comparing the two procedures, and the fact that laparoscopic surgery involves techniques very different from those used in more traditional forms of surgery.

In some cases, practice guidelines have been successful in changing physician behavior, and the successes can be attributed to a number of different factors. The successful implementation of standards for anesthetic monitoring was a result of a combination of mandates from both hospitals and licensing boards for their use, and reductions in malpractice premiums that were conditioned on their use.

Reimbursement policies of health care insurers can also be important. Before the issuance of guidelines on cardiac pacemaker implantation, data suggested that at least 20% of pacemakers were not warranted. Following the issuance of the guidelines, there was a 28% decline in the use of pacemakers in Medicare patients. The decline probably reflected the use of the pacemaker guidelines by the Medicare system in deciding when to cover pacemaker implantations. Tying reimbursement to adherence to practice guidelines is an obvious method for achieving physician adoption of practice guidelines. Physicians are not very likely to perform procedures for which they are not compensated.

Indeed, the interesting question is why reimbursement has not been predicated more frequently on physician adherence to practice guidelines. For the most part, the answer probably lies in the fact that most practice guidelines have been developed relatively recently and are available for only a small percentage of medical decisions. In addition, as indicated above, there is a good deal of

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111 Id.
114 Eichhorn, *Prevention*, supra note 113; Pierce, supra note 97, at 63.
117 Kelly & Swartwout, * supra* note 98, at 54.
resistance by the medical profession to the imposition of practice guidelines. When Blue Cross and Blue Shield of Illinois disclosed its plan to require physicians in its managed care networks to follow practice guidelines, the AMA criticized the plan as an unwarranted intrusion on professional judgment by an insurance company.\textsuperscript{118} Health care insurers may have resisted using their reimbursement policies to impose practice guidelines in the belief that the benefits of using practice guidelines did not outweigh the costs of antagonizing physicians.

Strict regulatory oversight has also been cited as a mechanism for ensuring adherence to practice guidelines. In a study of coronary artery bypass surgery in New York State, researchers found a very low rate of inappropriate operations.\textsuperscript{119} The authors of the study attributed the findings to the state government's careful regulation of bypass surgery, including the requirement that hospitals satisfy high standards of quality before they are certified or recertified as centers for open heart surgery.\textsuperscript{120} Similar results have been achieved by federal regulatory oversight. After the federal government imposed strict guidelines for the use of antipsychotic drugs in nursing homes, researchers found that there was a substantial decrease in antipsychotic drug use in Tennessee nursing homes.\textsuperscript{121}

In several cases, such as the use of antibiotics or cesarean sections, practice guidelines have been adopted by physicians when local "opinion leaders" (physicians whose opinions tend to be followed by other physicians in their community) have adopted the guidelines and encouraged their colleagues to do so as well.\textsuperscript{122} The phenomenon of opinion leadership is widely recognized and studied in the marketing and sociological literature.\textsuperscript{123} Purveyors of consumer products have long known that while media advertising is useful for

\begin{footnotes}
\footnote{118} Michael L. Millenson, \textit{Blue Cross to Enforce Treatment Guidelines}, Chi. Trib., Nov. 10, 1993, at Al.
\footnote{119} Lucian L. Leape et al., \textit{The Appropriateness of Use of Coronary Artery Bypass Graft Surgery in New York State}, 269 JAMA 753, 758 (1993).
\footnote{120} Id. at 760.
\footnote{121} Ronald I. Shorr et al., \textit{Changes in Antipsychotic Drug Use in Nursing Homes During Implementation of the OBRA-87 Regulations}, 271 JAMA 358 (1994).
\end{footnotes}
Influence of a Professional Organization

making people aware of a new item, consumers often turn to influential friends and acquaintances for guidance when deciding whether to try the item. The importance of opinion leadership for physicians was illustrated in a major study dealing with the adoption of a new prescription drug in four Midwestern towns in the 1950s. Researchers found that the most important factor in explaining how rapidly a physician adopted the drug was whether the physician was well-integrated into professional and social networks with other physicians. Physicians who were professionally and socially isolated tended to be much slower to incorporate the drug into their practice.

Opinion leadership reflects a number of factors. There will often be a good deal of uncertainty about the appropriate use of a test or treatment, and the greater the degree of their uncertainty, physicians, like other people, are more likely to turn to respected friends or acquaintances for guidance. While the existence of nationally developed consensus guidelines suggests that the uncertainty has been resolved and therefore there is little need to validate the guidelines through local opinion leaders, it is also the case that consensus panels are convened precisely because of a need to overcome major differences of opinion among people in the field. The issuance of the guidelines does not mean that the differences have been resolved. In addition, there appears to be a common distrust of researchers by practicing physicians. In one study, practicing physicians reported that they viewed researchers as biased by their personal interest in having their theories validated and their work published. As a result, the practitioners believed that scientific studies tend to exaggerate the value of a new therapy, and that the initial promise of an innovation often does not hold up when the innovation is more widely used. Finally, on matters of ethics, where there are often widely divergent views on what constitutes proper conduct, individual physicians are especially likely to trust their own judgment over that of national experts.

In short, the mere issuance of guidelines by professional societies rarely suffices to change physician behavior. Physicians often have countervailing incentives to maintain their existing practices. Consequently, additional measures are needed, such as acceptance and

124 Chan & Misra, supra note 123, at 53.
125 COLEMAN ET AL., supra note 104, at 79-112.
126 Id.
128 See id. In many cases, of course, innovations do not live up to their initial promise.
encouragement by local opinion leaders, financial incentives, and/or credible threats or methods of enforcement.

As indicated, for both the AMA's ethics guidelines and professional practice guidelines, the additional measures needed to ensure adoption tend to come from outside, rather than from within the profession. Why has this been the case? First, there is a natural reluctance to engage in enforcement when the discipline is meted out to colleagues. Members of a commission investigating police corruption in New York City came to a similar conclusion: police corruption exists, despite such periodic investigatory commissions, because police are reluctant to clamp down when they discover corruption in the ranks.129 Physicians, like other professionals engaged in self-regulation, can readily sympathize with ethical lapses of their peers because it is easy to imagine themselves making similar errors. Moreover, medicine has always been an unusually collegial profession. The Hippocratic oath130 instructs physicians to give special preference to the sons of their colleagues, and fealty to the profession is considered as important in the oath as devotion to patients.

Self-enforcement is also weak because it is poorly funded. Physicians who serve on the disciplinary boards of their professional bodies do so without compensation. In addition, there is little money available for staff, and the boards have no subpoena authority. Consequently, few cases can be pursued, and rigorous investigations are not possible. Moreover, even when cases are prosecuted, there are substantial financial risks to the professional society. Physicians who are disciplined often challenge their sanction through time-consuming and costly litigation. Indeed, the legal fees for defending a case can deplete much of a small medical society's annual budget. Antitrust liability is of particular concern with its potential for treble damage and attorneys' fee awards.131 As the U.S. Congress found when it enacted the Health Care Quality Improvement Act of 1986132 to provide physicians some protection against retaliatory lawsuits, the threat of liability "unreasonably discourages physicians from participating in effective professional peer review."133

CONCLUSION

As policymakers consider how to regulate the use of medical innovations by physicians, they should recognize the important differences between establishing and enforcing professional guidelines. The medical profession's experience with ethics guidelines and practice guidelines indicates that society can rely on the profession to develop responsible standards. In addition, principles of change theory suggest that physicians will be more receptive to restrictions on their autonomy if they are involved in the process of developing the restrictions. However, on the issue of enforcement, reliable mechanisms have come from outside the profession, generally in the form of regulatory mandates or reimbursement policies.

An important caveat is in order. It is likely that the establishment and enforcement of guidelines are related rather than independent endeavors. Specifically, the willingness of the medical profession to enact responsible guidelines might diminish if robust enforcement mechanisms were in place. It may be that tough guidelines can be adopted precisely because there often is little risk that they will be enforced. On the other hand, the alternative of having outside groups establish the guidelines might provide sufficient incentive for the profession to continue developing rigorous ethical standards even under a system of regular, reliable enforcement. How all this would play out is indeterminate; whether enhanced enforcement would diminish the zeal of professional standard-setting is an empirical question that can be resolved only by monitoring the regulatory process and measuring the impact of greater enforcement activities.

134 Greco & Eisenberg, supra note 105, at 1272.