Responsible Leadership of Accountable Care Organizations

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Objectives

• Define key concepts
  – Accountable care organizations (ACOs)
  – Quality
  – Professional integrity in relationship to quality
  – Preventive ethics
  – Organizational culture
Objectives

- Identify the ethical concept of physicians and healthcare organizations as co-fiduciaries of patients
- Identify origins of the concept of ACOs in the medical ethics of Drs. John Gregory (1724-1773) and Thomas Percival (1740-1804)
- Identify the implications of the ethical concept of co-fiduciary responsibility and eighteenth-century medical ethics for physician leaders of ACOs
  - Especially for the proper relationship between managing quality and managing cost
Accountable Care Organizations

• “…ACOs are best understood as affiliations of health care providers that are held jointly accountable for achieving improvements in the quality of care and reductions in spending.”
  • Greaney TL 2011
Quality

• Key concepts from the work of W. Edwards Deming (1900-1993)
  – Uncontrolled variation in a production or service process results in widely varying outcomes and therefore unmanageable costs
  – QUALITY = progressively and responsibly minimize variation in a production or service process, which should reduce variation in outcomes and thereby manage costs
    • Improving quality is the means to manage costs responsibly
  – QUALITY IN HEALTHCARE: progressively and responsibly minimize the variation in the processes of patient care so that they vary (as much as possible) as a function of the natural histories of diseases and injuries and the responses of diseases and injuries to clinical management of them
  – PROFESSIONAL INTEGRITY requires healthcare professionals to continuously improve the quality of healthcare = progressively and responsibly reduce uncontrolled and poorly controlled variation in the processes of patient care for which healthcare professionals are responsible
Quality

• Four parties shape the processes of patient care
  – Physicians and other healthcare professionals
  – Healthcare organizations
  – Patients (and their families)
  – Payers
Preventive Ethics

- Mastery of concepts and skills from the discipline of ethics that are designed to anticipate and prevent conflicts among ethical obligations before these conflicts arise and to manage ethical conflicts effectively when they nonetheless occur (with lower frequency)
- Anticipate the potential for ethical conflict in professional roles, in organizational policies and practices, between healthcare professionals and payers, and between healthcare professionals and patients (and their families)
  - Unexamined organizational policies and practices can be a chronic source of preventable ethical conflicts
- Devise and evaluate clinical and pedagogic strategies to prevent potential conflicts from becoming actual conflicts
- Respond rapidly and effectively to ethical conflicts when they do occur
Organizational Culture

- Organization culture shapes the work environment through
  - Values expressed in mission statement
  - Organizational policies and practices
  - Incentives and disincentives
  - Allocation of resources
  - Expectations of organizational leaders
  - How organizational leaders exercise power (the ability to make decisions and then execute them oneself or through others)
    - What organizational leaders encourage and reward
    - What organizational leaders discourage and punish
    - What organizational leaders tolerate
    - What organizational leaders tolerate that should not be tolerated
The Ethical Concept of Physician as Moral Fiduciary of the Patient

• This ethical concept was introduced into the history of medical ethics by Dr. John Gregory (1724-1773) and by Dr. Thomas Percival (1740-1804)
  – Gregory was Professor of Medicine, University of Edinburgh and First Physician to His Majesty the King, in Scotland, author of the first modern, English-language text on medical ethics
    • Gregory J. *Lectures on the Duties and Qualifications of a Physician* 1772
  – Percival was an accomplished physician, scientist, ethicist, and author of the first book entitled *Medical Ethics* in any language
    • Percival T. *Medical Ethics* … 1803
  – Both had enormous influence on the subsequent history of medical ethics through the nineteenth century
Gregory’s Problem List

- **New Medical Institution: The Royal Infirmary**
  - Forerunner of voluntary, not-for-profit private hospital in the United States, funded by “trustees”
  - For the worthy, sick poor (defined population)
  - Patrons/trustees controlled access by patients (payers control access and limit patient autonomy)
Gregory’s Problem List

• **New Medical Institution: The Royal Infirmary**
  – Lay managers screened patients at admission to keep mortality rates down and thus please patrons/trustees (market segmentation out of institutional self-interest)
  – Lay managers strictly controlled access to resources (regulate clinical judgment and autonomy of physicians and restrict patient autonomy)
  – Trustees appointed physicians who worked without pay (use of conflicts-of-interest to influence physician behavior)
Gregory’s Problem List

• Physicians gained power over patients as a function of the hierarchy of a healthcare organization
  – Patients came from lower social classes than physicians

• Infirmary’s lay leadership was given considerable power over physicians and surgeons, by trustees, to control access and manage resources
  – “… money doesn’t talk, it swears”
    • Bob Dylan. It’s Alright Ma (I’m Only Bleeding) 1965

• Gregory was concerned that there was no ethics to guide these new forms of power
Percival’s Problem List

- Disputes among physicians, surgeons, and apothecaries at the Manchester Infirmary
- Competition among practitioners came into the new health care institution of the Manchester Infirmary and threatened to paralyze it, as each group sought to protect its powers and privileges, acting from guild interest, having lost focus on the “good of the patient”
Being a Patient in this Environment

- Infirmary patients engaged in the perilous task of identifying the trustworthy physician
  - Intellectually trustworthy -- knew what he was talking about and doing to and for patients
  - Morally trustworthy -- put the interests of patients ahead of self-interest
Gregory’s and Percival’s Response to this Crisis of Distrust

- Gregory and Percival invented the concept of the physician as a professional in its true moral sense, as the moral fiduciary of the patient
  - Physicians then called themselves “professionals” but they meant usually only someone who had attended the university for medical studies
  - The use of “professional” was largely from individual self-interest, to differentiate oneself from surgeons, apothecaries, female midwives, and irregulars (quacks)
  - The use of “professional” was also to protect and promote guild self-interest
The Ethical Concept of Physician as Moral Fiduciary of the Patient

• The physician should become and remain scientifically and clinically competent
  – Based on scientific method of Francis Bacon (1561-1626), a nascent form of evidence-based reasoning in medicine

• The physician should commit to the protection and promotion of the health-related interests of the patient as the physician’s primary concern and motivation
  – The physician’s self-interests and obligations to others than patients are blunted by professional virtues and obligations to the patient

• Physicians should maintain, strengthen, and pass on medicine to future physicians and patients as a public trust, not merchant guild
Ethical Concept of Co-Fiduciary Responsibility

• Any person or organization that influences the processes of patient care for which physicians and other healthcare professionals are responsible incurs co-fiduciary responsibility
  – All of us are responsible for the consequences of our decisions and actions
  – When those consequences affect patients, fiduciary responsibility is incurred

• Co-fiduciary responsibility of physicians and healthcare organization that influences the processes of patient care for the population of patients for which the organization are responsible
  – “My patient comes first” is no longer an adequate ethical principle and should be discarded
Ethical Concept of Co-Fiduciary Responsibility

• Co-fiduciary responsibility of physicians and payers that influence processes of patient care for patients for which the physician is responsible
• Co-fiduciary responsibility of physicians and family members who influence processes of patient care for the patient for whom the physician is responsible
Historical Origins of ACOs

• Gregory called for medical practice to be based on the professional virtue of candor:
  – “I may reckon among the moral duties incumbent on a physician, that candor, which makes him open to conviction, and ready to acknowledge and rectify his mistakes. An obstinate adherence to an unsuccessful method of treating a disease, must be owing to a high degree of self-conceit, and a belief of the infallibility of a system. This error is the more difficult to cure, as it generally proceeds from ignorance. True knowledge and clear discernment may lead one into the extreme of diffidence and humility; but are inconsistent with self-conceit. It sometimes happens too, that this obstinacy proceeds from a defect in the heart. Such physicians see that they are wrong; but are too proud to acknowledge their error, especially if it be pointed out to them by one of the profession. To this species of pride, a pride incompatible with true dignity and elevation of mind, have the lives of thousands been sacrificed.”
  • Gregory J 1772, Lectures, pp. 28-29
Historical Origins of ACOs

• Gregory was concerned that candor was difficult to achieve for physicians who had to earn their living by practicing medicine
  – Poorly managed economic and guild conflicts of interest result in candor being compromised or undermined by bias

• Called for physicians to become accountable to scientifically sophisticated lay persons: “laying medicine open”
  – “I have thus endeavoured to shew that, by laying medicine open, and encouraging men of science and abilities, who do not belong to the profession, to study it, the interests of humanity would be promoted, the science would be advanced, its dignity more effectually supported, and success more certainly secured to every individual, in proportion to his real merit.”
  • Gregory J 1772, Lectures, p. 236
Historical Origins of ACOs

• Percival made the ethics of hospital practice paradigmatic for professional medical ethics
  – Infirmaries: free hospitals for the working sick poor, funded by “trustees” = wealthy industrialists who employed the sick poor

• Created a system of accountability of physicians to each other in the hospital
  – The work of infirmaries should be constantly improved, thus improving medicine, scientifically and ethically, and the health of the community
Historical Origins of ACOs

• Create data bases
  – “To advance professional improvement, a friendly and unreserved intercourse should subsist between the gentlemen of the faculty, with a free communication of whatever is extraordinary or interesting in the course of their hospital practice. And an account of every case or operation which is rare, curious, or instructive, should be drawn up by the physician or surgeon, to whose charge it devolves, and entered in a register kept for the purpose, but open only to the physicians and surgeons of the charity.”
  
• Percival T 1803, Medical Ethics, pp. 76-77
Historical Origins of ACOs

• Formalize accountability of physicians and organizational leaders
  – “By the adoption of the register, recommended in the foregoing article, physicians and surgeons would obtain a clearer insight into the comparative success of their hospital and private practice, and would be incited to a diligent investigation of the causes of such difference.”
    • Percival T 1803, *Medical Ethics*, p. 78
  – “The establishment of a committee of the gentlemen of the faculty, to be held monthly, would tend to facilitate this interesting investigation, and to accomplish the most important objects of it. By the free communication of remarks, various improvements would be suggested; by the regular discussion of them, they would be reduced to a definite and consistent form, and by the authority of united suffrages, they would have full influence over the governors of the charity.”
    • Percival T 1803, *Medical Ethics*, p. 79-80
Historical Origins of ACOs

• Carry habit of accountability into private practice
  – “At the close of every interesting and important case, especially when it hath terminated fatally, a physician should trace back, in calm reflection, all the steps which he had taken in the treatment of it. This review of the origin, progress, and conclusion of the malady; of the whole curative plan pursued; and of the particular operation of the several remedies employed, as well as of the doses and periods of time in which they were administered, will furnish the most authentic documents, on which individual experience can be formed. But it is in a moral view that the practice is here recommended; and it should be performed with the most scrupulous impartiality. Let no self-deception be permitted in the retrospect; and if errors, either of omission or commission, are discovered, it behooves that they should be brought fairly and fully to the mental view. Regrets may follow, but criminality will thus be obviated. For good intentions, and the imperfections of human skill which cannot anticipate the knowledge that events alone disclose, will sufficiently justify what is past, provided the failure be made conscientiously subservient to future wisdom and rectitude in professional conduct.”

• Percival T 1803, Medical Ethics, pp. 106-107
Preventive Ethics Responses

• Create an ethics of ACOs based on updated candor
  – Combine “committee of gentlemen of the faculty,” “calm reflection,” and “laying medicine open”
• Healthcare professionals should take candor-based leadership role to continuously improve the quality of the processes of patient care for which they are responsible, to create accountable care organizations
• Healthcare organizations should encourage and support healthcare professionals to take leadership role in continuously improving the quality of the processes of patient care for which they are responsible
• Healthcare professionals and organizations should encourage and support patients (and family members) to take a leadership role in continuously improving the quality of the processes of care for which patients (and family members) are responsible
Preventive Ethics Responses

• Healthcare professionals should assert their proper legal and ethical authority in the informed consent process
  – Present to the decision maker only medically reasonable alternatives, i.e., those reliably expected to be clinically beneficial in evidence-based reasoning
  – School decision makers in the discipline of evidence-based reasoning, as called for by concept of shared decision making
  – Not implement requests for clinical management that lack evidence base of expected net clinical benefit

• Healthcare organizations should encourage and support healthcare professionals to take this leadership role in the informed consent process
Preventive Ethics Responses

• Healthcare organizations should continuously improve the quality of the processes of patient care for which healthcare organizations are responsible
  – By submitting to the discipline of evidence-based reasoning
Preventive Ethics Responses

- Patients are intellectually obligated to accept that a right to healthcare, as a positive right, comes with limits
  - From evidence-based reasoning
- Patients are intellectually obligated to accept that poorly controlled and uncontrolled variation in the processes of patient care, including the processes for which they are responsible, does not protect and promote their health-related interests, may increase risk of mortality and morbidity, and wastes resources needed for them and for other patients
  - The patient version of Gregorian candor
- Patients have a right to effective healthcare
- Payers have an obligation to provide payment only for effective healthcare
- Patients should be incentivized to make and implement responsible and prudent decisions
  - Prudence is a virtue that schools us in the discipline of identifying our legitimate self-interests and then acting to protect them
  - Patient autonomy unconstrained by prudence is an ethical problem
ACOs and Co-Fiduciary Responsibility

- Create accountability for professional integrity and thereby an organizational culture of co-fiduciary responsibility
  - Physicians should give up autonomy to practice medicine in ways that are inconsistent with scientific and clinical excellence
    - Physicians should accept discipline of evidence-based reasoning, in order to achieve excellence in patient care, research, and teaching
    - Organizational leaders should not permit exercises of autonomy by physicians that are undisciplined by evidence-based reasoning
ACOs and Co-Fiduciary Responsibility

• Accountable healthcare organizations create a culture that supports healthcare professionals in becoming and remaining scientifically and clinically competent, by submitting to the discipline of evidence-based reasoning with updated candor-based accountability for the processes of care for which clinicians and organization are responsible.

• Accountable healthcare organizations create a culture that supports patients (and their families) in submitting to the discipline of evidence-based reasoning with accountability for the processes of care for which patients are responsible and incentivizing prudence.

• Accountable healthcare organizations create a culture that requires payers to submit to the discipline of evidence-based reasoning with accountability for their influence on the processes of care for which clinicians, organizations, and patients (and their families) are responsible.
References


- Percival T. Medical Ethics, or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons. London: Johnson & Bickerstaff, 1803.
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