"DOC, JUST ONE MORE THING…"

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During much of the 20th century, physicians were regarded as the most trusted of all professionals. The image of the doctor suggested integrity, loyalty, and compassion—key aspects of the physician's professional identity. However, the managed care movement and other recent evolutions in health care delivery have greatly altered the face of medicine.

In current clinical practice, the traditional one doctor, one patient relationship is no longer commonplace. Instead, physicians tend to practice in groups or complex organizations, with the care of patients divided among many specialists. Doctors often are employed by insurers or are under capitated or other contractual agreements that lead them to heed many masters. Frequent switches in health plan affiliations by physicians and in health insurance by patients make it difficult to have long-standing physician-patient relationships. Consequently, patients feel estranged from their doctors and no longer assume undivided loyalty to their concerns [1].

Physicians today are challenged to be effective, caring providers while navigating a progressively more complex and technical health care system that demands efficiency and cost-effectiveness [2]. At times, competing demands may make it difficult to always place patients' interests above all else [3]. The result is a growing sense of frustration among physicians who struggle to uphold traditional values of honesty, integrity, altruism, and duty to the patient [4]. As patients increasingly question whether they can trust physicians to do what is best for them, there is growing doubt about the integrity of the medical profession and its commitment to serve the needs of patients and society.

Concern for the loss of medicine's respected position has led to several organized efforts to reaffirm traditional values of the profession and to define further principles needed to guide clinical practice in a modern era [5–8]. These efforts and the work of individual scholars have produced a robust fund of literature examining the many ethical and professional challenges of the changing practice environment [9]. Earlier this year, a landmark document was published simultaneously in the *Annals of Internal Medicine* [10] and *The Lancet* [11] to raise awareness about medical professionalism. The Charter on Medical Professionalism is the result of work by the Medical Professionalism Project—a collaboration of the American Board of Internal Medicine Foundation, the American College of Physicians–American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine. The Charter consists of three principles and 10 professional responsibilities (**Table**) that, if upheld, would help to "ensure that the health care systems and the physicians working within them remain committed both to patient welfare and to the basic tenets of social justice" [10,11].

Demonstration of professional behavior has been a core competency for residency training and a requirement for physician certification. There is strong consensus, however, that new physicians are not prepared to address the professional challenges and difficult decisions of modern practice. As a result of concern for continued erosion of professional standards, governing and accrediting bodies for graduate medical education are placing greater emphasis on evaluating professionalism as an essential component of clinical competence [7,12].

This issue of *Seminars in Medical Practice* initiates a new journal feature devoted to examining dilemmas physicians may face in trying to live up to the Charter (Table). The feature uses fictionalized versions of real events to explore difficult decisions that may arise in the course of patient care, as individual patient rights are juxtaposed with organizational or even societal demands. Each case is presented in a progressive disclosure format allowing discussion of the inherent dilemmas and the relevant principles and professional responsibilities that might serve to guide the physician's course of action. At times, these principles are in conflict or are confounded by other factors that can make simple application to actual clinical examples difficult [13]. These factors relate to patient preferences, clinical judgment as to what is best for the patient, and other valid concerns that may have bearing on the clinician's action. Wherever possible, such conflicts are highlighted in the case discussion. The goal of these discussions is not to make prescriptions for physician behavior but to

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Table. Principles and Professional Commitments of the Charter on Medical Professionalism

Guiding principles
Patient welfare
Patient autonomy
Social justice
Professional responsibilities
Commitment to:
Professional competence
Honesty with patients
Patient confidentiality
Maintaining appropriate relations with patients
Improving quality of care
Improving access to care
Just distribution of finite resources
Scientific knowledge
Maintaining trust by managing conflicts of interest
Professional responsibilities

NOTE. This charter was written by the Medical Professionalism Project, a joint effort of the American Board of Internal Medicine Foundation, the American College of Physicians–American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine. (Data from [10,11].)

provide realistic guidance for physicians who may confront similar professional dilemmas.

The first article explores issues that may arise when the physician-patient relationship is affected by the diverse set of insurance plans that make up the health care landscape. Patients either choose to or are forced to navigate between multiple physician practices. In the following case, a physician faces difficult decisions when a patient of 10 years makes a series of requests after joining a Medicare managed care plan in which the physician does not participate. A professional response demands careful consideration of the physician's varied responsibilities, ethical principles, and the law.

Mr. Dalrymple's First Request

Mr. Dalrymple—a 69-year-old man with hypertension, type 2 diabetes, and hypercholesterolemia—had been treated by Dr. Richards for nearly 10 years when he suddenly stopped coming. After 9 months, Mr. Dalrymple returns. His face lights up as Dr. Richards enters the exam room.

"Well, well, look who it is," says Dr. Richards, reaching to shake Mr. Dalrymple's outstretched hand.

"Dr. Richards, it's so good to see you! How have you been, and how are your daughters?"

Dr. Richards spends a few moments catching up and learns that Mr. Dalrymple recently enrolled in Senior Star, a Medicare managed care plan in which Dr. Richards does not participate. The growth of Senior Star has been a hardship for him, as his practice is heavily dependent on Medicare patients.

"You know, I still think of you as my doctor," says Mr. Dalrymple. "Would it be OK if I still see you occasionally? Not for everything, like tests and all. But I liked the pills you were giving me. I'm not so keen on how that new doctor does things."

"What exactly do you mean?" asks Dr. Richards.

Mr. Dalrymple looks down at his lap and then up again. He appears uneasy.

"When I first signed up for that new insurance I didn't know I was going to have to pay so much for my pills. I get charged every time I fill a prescription, and it's costing me more money than I've got. You know my situation. My pension only goes so far, and with my wife's health problems money is real tight."

Mr. Dalrymple pauses and then admits the main reason for his visit today.

"You were always able to give me samples of the pills I was taking before. Can I still get some of those? They worked better for me than the ones the new doctor put me on."

Indeed, Dr. Richards notes that Mr. Dalrymple's records of home blood glucose and blood pressure monitoring show elevated levels of both over the last several months. He also sees that the pill bottles Mr. Dalrymple brought indicate a switch in the medication regimen from the one that he had prescribed.

Dr. Richards pauses to consider how he should respond to Mr. Dalrymple's request.

The Dilemma

In this visit, Mr. Dalrymple returns to Dr. Richards to ask for help with his medical care, but the request is complicated by the fact that he is under the care of a new doctor. Dr. Richards wonders:

- What are my obligations to Mr. Dalrymple now that he joined Senior Star and is seeing a new doctor? I want to help him, but how?
- If I agree to help, what are the limits of care I can offer?

Discussion

Dr. Richards faces a difficult decision between doing what his patient wants and doing what he believes is best

for his patient. This dilemma arises because two essential principles of the physician-patient relationship are in conflict: a duty to serve the needs and interests of the patient and an obligation to respect patient autonomy.

Obligations of the Physician-Patient Relationship

The physician-patient relationship is a voluntary partnership that confers obligations on both parties and that persists until one party terminates it. A patient can end a therapeutic relationship by simply never returning to see a doctor. However, the relationship can always be resurrected when the patient calls for and is given a new appointment.

Dr. Richards and Mr. Dalrymple clearly have had a long-standing relationship. The 9-month delay between visits does not change the nature of this relationship, even though Mr. Dalrymple has seen another doctor in the interim. Now that Mr. Dalrymple is in Dr. Richards's office seeking medical care, all physician obligations to the physician-patient relationship apply. These obligations have been the source of extensive exploration in the medical, ethical, and legal literature. However, certain principles are widely agreed upon [14,15] and relevant to the dilemma Dr. Richards faces in deciding how to respond to Mr. Dalrymple's request.

Patient welfare. Despite dramatic evolutions in the practice of medicine through the ages, one principle has held true: the physician must be committed to the good of the patient; otherwise, there is no trust and thus no relationship between doctor and patient. Dedication to patient welfare is the first guiding principle of medical professionalism defined in the Charter on Medical Professionalism (Table). Several distinct ethical principles of the physician-patient relationship are embodied in the physician's obligation to patient welfare and are relevant to this case. The first is *nonmaleficence*—the principle that the physician should avoid doing harm. Similarly pervasive is the principle that the physician should strive to help the patient in any way possible, called *beneficence*. Finally, philosophically and legally, the physician has a *fiduciary duty* to the patient, meaning he must place the patient's interest above all other concerns. The fiduciary duty reflects, in part, the ethical principle of paternalism, which demands that the physician act in the patient's best interest and has overtones that the physician knows what the patient needs and is able to make decisions on how best to meet those needs. The scope of paternalism in the therapeutic relationship is controversial for physicians, patients, ethicists, and the legal community [16]. However, dedication to serving the good of the patient is universally accepted.

Patient autonomy. Also central to this dilemma is the physician's obligation to respect patient autonomy, the Charter's second fundamental principle of medical professionalism. Over the past century there has been increasing recognition that patient care decisions should take into consideration the values, needs, desires, and preferences of the patient. The physician's role, then, is to provide complete and honest counsel regarding appropriate care options to empower the patient to participate in decisions regarding his or her care. Several newer paradigms for the physician-patient relationship have been advanced in recent decades—patient-centered care, relationship-centered care, patient empowerment, shared-decision making—all of which emphasize the importance of understanding the patient's point of view and respecting patient autonomy. Patient preferences and informed consent have become mainstays of the physician-patient relationship [17,18]. Importantly, patient health outcomes are improved when physicians adopt a care approach that respects patient autonomy [19].

Patient Welfare versus Patient Autonomy

Like all patient care decisions, Dr. Richards's response to Mr. Dalrymple's request should be guided by the principles and obligations embodied in the physician-patient relationship. However, this specific request places Dr. Richards's commitment to patient welfare in conflict with his obligation to respect patient autonomy. Respect for patient autonomy suggests that Dr. Richards should agree to Mr. Dalrymple's request to define the scope of services Dr. Richards provides so Mr. Dalrymple can control his own medical care. However, patient autonomy requires that Dr. Richards fully inform Mr. Dalrymple about care options that are safe and appropriate. Two of the professional responsibilities in the Charter are relevant here: 1) a commitment to ensure that patients are honestly and completely informed regarding treatment options and 2) a commitment to improve the quality of care by taking steps to minimize risks to patient safety [10,11]. The importance of contributing to health care quality improvement is underscored by recent Institute of Medicine (IOM) reports citing significant deficiencies in patient safety [20] as well problems with effectiveness, patient-focus, timeliness, efficiency, and equity [21].

Mr. Dalrymple is asking Dr. Richards to provide concurrent care with another physician. Specialists and primary care physicians often co-manage patients, but they do so with specific limits on the scope of each physician's involvement and with an express agreement to communicate regarding care. The specialist is involved as a

partner with the primary care physician, and the two physicians have distinct responsibilities. In this case, Dr. Richards and the Senior Star physician would have the same primary care responsibilities but without an obligation to communicate or an established means to do so. The proposed situation is not a partnership, but two physicians acting in parallel to each other.

Dr. Richards's responsibility to prevent harm must dictate the scope of care he can offer. In keeping with IOM recommendations, Dr. Richards should provide only care and services that are medically indicated, safe, and consistent with evidence-based best practices [20,21]. With two physicians making independent treatment decisions, the potential for harm is great. Each may assume that Mr. Dalrymple is fully compliant with a prescribed regimen when, in fact, he is using a combination of regimens that may not be safe or effective. Similarly, the principle of beneficence demands that each physician aim to maximize the benefit Mr. Dalrymple receives from his care. Each will decide on a treatment plan in cooperation with Mr. Dalrymple, after a discussion of risks, benefits, and options. Unless Mr. Dalrymple adheres to the mutually agreed upon plan, the potential benefit may be limited or negated. Finally, as a fiduciary of Mr. Dalrymple, each physician has a duty to act in his best interest and to meet the standard of care. This includes responsibility for regular monitoring of his medications and his existing disease as well as routine screening to detect new health problems. If Mr. Dalrymple wishes to receive his medications from Dr. Richards, he must allow Dr. Richards to perform any tests needed to check for medication toxicity and to ensure adequate disease control. Limiting the scope of Dr. Richards's services to medication prescription without monitoring is unsafe and a request for inappropriate care.

In summary, with two physicians having identical responsibilities for managing Mr. Dalrymple's care, it would be impossible for either to ensure that the care Mr. Dalrymple ultimately receives is safe and effective. Physicians make decisions in context, and the context of each patient's health and specific needs drives the physician's clinical judgment. Unless each physician knows what the other is doing and both are acting in concert, neither will have adequate information for safe and effective decision-making. There is a good chance that one or the other will initiate a treatment that is at best of no value and at worst dangerous. Thus, respecting patient autonomy by agreeing to concurrent care would be acting at the expense of patient welfare. This action would contradict ethical principles and the Charter, which limits the application of the principle of patient autonomy to exclude demands for unethical or inappropriate care [10,11]. Provision of concurrent care further contradicts the principles and commitments of the Charter because it gives the patient inappropriate control over the scope of the medical care he receives, perpetuates problems of health care quality, and compromises the physician's professional responsibilities to the patient and to other physicians.

Responding to the Request

Dr. Richards should speak candidly with Mr. Dalrymple and make certain he understands that it would be inappropriate to agree to provide concurrent care with the Senior Star physician because of the potential harm it could cause him. With this understanding, Mr. Dalrymple would ideally be open to discussing appropriate options for primary care. By refusing to provide concurrent care, Dr. Richards would not be terminating care or abandoning a patient—independent ethical and legal concerns—because Mr. Dalrymple has care established with another physician. These issues are not raised when a patient and a physician mutually agree that the patient will be best cared for in another setting.

Assuming Dr. Richards follows through with this course of action, he should carefully document this visit. He should note that Mr. Dalrymple has been in the care of a Senior Star physician and that Mr. Dalrymple wishes to continue seeing that physician while also seeing Dr. Richards for medications. It is important for Dr. Richards to include that he discussed with Mr. Dalrymple the potential dangers of his providing concurrent care with the Senior Star physician and that he informed the patient it would be inappropriate for him to agree to do so. Any advice he offered also should be carefully documented. Finally, assuming he discusses the option of Mr. Dalrymple returning to his care, he should document that he told Mr. Dalrymple he is willing to continue to be Mr. Dalrymple's sole primary care physician.

In the event that Dr. Richards and Mr. Dalrymple decide to proceed with concurrent care, Dr. Richards must set clear ground rules. He must insist on accurate information regarding what medications Mr. Dalrymple is taking, and Mr. Dalrymple must be responsible for ensuring that Dr. Richards has this information. Optimally, Dr. Richards will have the time and the opportunity to communicate directly with the Senior Star physician on a regular basis. Absent this, Mr. Dalrymple must take full responsibility for providing Dr. Richards with official reports of all tests and results. Even with good communication and free exchange of information, Dr. Richards would be exposing his patient to potentially unsafe care and himself to

potential liability if anything goes wrong. Clearly, this would not be the better course of action.

Dr. Richards's Response

Realizing the potential dangers involved in providing concurrent care with another physician, Dr. Richards is not inclined to agree to Mr. Dalrymple's request. He sits next to the patient and tries to explain why.

"Mr. Dalrymple, I'm really uncomfortable with what you're asking me to do. It's not at all the best thing for you to have two doctors taking care of the same problems. For example, if I went ahead and changed your medications without talking with your new doctor, I could be making a big mistake. He may have had a good reason for switching you from the drugs you were taking before. Without knowing anything about that, I could possibly cause you more harm than good by switching you back, and that would be the last thing I'd want to do. Please understand that I want to help you and I'm truly concerned about how you are doing. Do you understand?"

"Well, I guess so. I just don't trust him the way I trust you."

"I can appreciate that you're more comfortable with me, since you know me better and I've taken care of you a long time. And I'd be happy to continue being your doctor. But in that case, it would be best for you to end your relationship with the Senior Star doctor. Again, I believe it's best for you to see only one doctor."

Dr. Richards then adds, "You know, if you decide to stay with your new Senior Star doctor, you owe it to yourself to give him a chance. For example, if you're unhappy about something or don't feel as well as you did before, you should tell him. I'm sure he'd listen and want to help you."

"Oh, I don't know. Maybe."

Dr. Richards stands and moves toward the door, signaling an end to the visit. Mr. Dalrymple slowly stands as well and Dr. Richards opens the door, offering a closing comment.

"It was really nice to see you again. Please think about what you want to do and come back in 2 weeks so we can talk about it. If you decide for whatever reason that you don't want to go back to the Senior Star doctor, I'd be happy to continue being your doctor."

"Thanks, Doc."

Mr. Dalrymple's Second Request

Two weeks later Mr. Dalrymple returns. As Dr. Richards enters the exam room, Mr. Dalrymple looks sheepishly at the floor.

"Doc, I can't continue to see you. My wife and I looked at the costs and with our fixed income we can't afford the extra bills. So I'm going to have to go back to Senior Star."

Dr. Richards felt a curious mixture of relief and disappointment. He was glad Mr. Dalrymple didn't try to press the issue of providing care concurrently with another doctor, but he was sorry to see Mr. Dalrymple leave his care.

"Thanks for coming to tell me."

Mr. Dalrymple again looks at the floor and asks, "Can you do something for me?"

"What's that?"

"You remember when I told you all about my wild days, using drugs and stuff? Well, you know I haven't done anything like that for 25 years. I know Senior Star and others may be asking for records. Could you leave off that information? I'm worried that stuff will haunt me—even though it's done and gone."

Dr. Richards had certainly had previous requests from patients to not report information he had obtained, but he always wondered how far he was entitled to go.

"Mr. Dalrymple, I understand your request, I just need to check on some things. I'll call you in a week and let you know if there's any problem with what you've asked me to do."

"Hey, thanks a lot, Doc. I really appreciate it."

The Dilemma

In his second visit, Mr. Dalrymple initiates an end to his 10-year relationship with Dr. Richards but makes a final request that leaves Dr. Richards wondering:

- Is it reasonable for Mr. Dalrymple to ask me to withhold specific information from his medical record? Am I ethically obligated do this for him?
- Are there legal risks if I do what he is asking?

Discussion

The Limits of Patient Advocacy

The limits of acceptable physician behavior on behalf of patients are hotly debated [22]. Certainly, the fiduciary responsibilities to patients are at the heart of the physician's professional identity. However, recent changes in the practice of medicine have created additional physician obligations—to employers, to contractual obligations, and to society. Many ethical dilemmas for physicians may arise from these conflicting responsibilities [23,24].

Several recent articles have focused on physician behavior in the new financial landscape. Questionnaires

to physicians have shown that a sizable percentage of physicians exaggerate and even misstate clinical data in order to assist patients with reimbursement [25,26]. The cost-containment pressures of managed care have often pushed physicians to be strong patient advocates with their insurers, but distinguishing between aggressive patient advocacy and unethical activities may be difficult [22]. The physician's ethical and legal responsibility is to vigorously assist patients while not violating the principle of contractual justice, which holds that patients receive only those benefits due to them [23].

Patient Confidentiality

Mr. Dalrymple is asking Dr. Richards to maintain confidentiality about particular details of his medical record. Maintaining patient confidentiality is an ethical duty and one of the professional commitments in the Charter (Table). It also is a legal duty. A considerable body of legal opinion has supported and codified patient confidentiality rules for current or former patients [28].

Although Mr. Dalrymple has announced he is leaving Dr. Richards's care, Dr. Richards is still obligated to comply with reasonable requests for form completion and other data transfer. In fact, the medical records of former patients must be kept for a substantial period of time, as defined by both federal and state law. For example, the retention period in Illinois is 10 years—12 years if litigation is pending. Destruction of medical records should be done only according to applicable laws and to recommendations by accrediting agencies.

Mr. Dalrymple speaks of a specific piece of information in his medical file. A patient may not have any true information "deleted" from his medical record, but he may request to amend personal medical information if he believes it is incorrect or incomplete. Corrections are made in such a manner as to leave the original entry clearly readable and the new entry clearly identifiable as a corrected entry.

The new Health Insurance Portability and Accountability Act (HIPAA) privacy regulations govern the use and disclosure of protected health information and the rights of patients to understand and *restrict* the use of their health information (*see sidebar on page 19 for further information about these regulations*). According to HIPAA regulations, Mr. Dalrymple is entitled to request that specific information, such as his past history of drug abuse, be restricted from release to others, whether it be disclosure to another health care provider or to an insurance company. At face value, Mr. Dalrymple's request appears understandable, in that information about his past abuse of drugs could have adverse effects on him in regard to insurance and possibly employment.

Dr. Richards is not legally compelled to comply with Mr. Dalrymple's request in all circumstances. He is entitled to use information from Mr. Dalrymple's record for the purposes of payments, treatment, and health care operations without the specific authorization of Mr. Dalrymple. "Health care operations" cover, for example, the use of medical information for accreditation purposes and for teaching activities. Any other use of the medical record would require Mr. Dalrymple's approval. Mr. Dalrymple can request a list of all entities to whom his medical records have been sent.

Patient Welfare versus Patient Autonomy

At times, the patient's wishes may conflict with what the doctor perceives to be the best possible health care. If Mr. Dalrymple had requested information withheld that had a direct bearing on the quality of care that could be delivered, Dr. Richards would likely feel ambivalent about the request and be hesitant to honor it. For example, if Mr. Dalrymple needed further medical care for hepatitis C but had requested his seropositive status be withheld from his record, Dr. Richards would understandably want to try to persuade Mr. Dalrymple to withdraw his request if the records were for his next provider.

In the case of restricting information about past drug abuse, Mr. Dalrymple's request is legal and reasonable and does not affect his current medical treatment. In light of Dr. Richards's concern for Mr. Dalrymple's welfare, it would be proper to comply as fully as possible. It would be reasonable for Dr. Richards to request that Mr. Dalrymple make his request in writing. Clearly, Mr. Dalrymple should be fully informed about any potential problems that would result from an incomplete medical record being communicated to other providers. Dr. Richards could explain why the information about past drug use may be pertinent to his future medical care.

Dr. Richards must understand that if he agrees to restrict the information, he may not use or disclose this protected health information unless Mr. Dalrymple is in need of emergency treatment and that information is essential to provide the treatment. Other reasons to disclose a patient's medical information may be required by law. Such instances include disclosing a patient's medical information to 1) a government authority if it is believed that the patient is a victim of abuse, neglect, or domestic violence; 2) a public health official to prevent or control disease or to report reactions to drugs or problems with products or devices; or

HIPAA Privacy Regulations

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, was intended to be the centerpiece of several major reforms to protect the privacy of patients' health care information. The 1996 law provided the authority for a series of federal rules addressing issues such as insurance reform, fraud, and security of health information. Recently released HIPAA regulations (*see* www.cms.gov/hipaa) will have a tremendous impact on the handling of medical records, and all health care providers (hospitals, health systems, physician practices) must be in compliance with them. The regulations affecting the privacy of medical records bear directly on this case.

Several HIPAA rules govern use and disclosure of a patient's health care information by a provider. A patient has the right to request that the provider *restrict* use or disclosure of protected health information about the patient to carry out treatment, payment, or health care operations. All other uses of patient information must be specifically authorized by the patient. A patient also has the right to request that the provider limit the disclosure of the patient's medical information to only those individuals involved in the patient's care or in its payment, such as family members and friends. Finally, a patient has the right to ask the provider to communicate by alternative means than through office appointments, to inspect and copy his or her personal health records, and to request amendment or correction of inaccurate information.

While the new HIPAA privacy rules govern the use and disclosure of protected health information and the rights of patients to understand and restrict the use of their health information, it is important to also consider the effect of state confidentiality laws. State law generally is preempted to the extent that it conflicts with the federal privacy standards. Neither HIPAA nor the final privacy regulation, however, preempts contrary state laws that are "more stringent" (ie, provide greater privacy protections) than the federal requirements (*see* www.ahla.org *for an ongoing listing of these state rules*). Thus, HIPAA sets a national "floor" of privacy standards designed to protect all health consumers, but states may establish privacy safeguards that go above and beyond those in the privacy rule under HIPAA.

Several organizations have undertaken educational campaigns concerning the HIPAA privacy regulations, including the American College of Physicians–American Society of Internal Medicine (www.acponline.org/pmc), the American Medical Association (www.ama-assn.org), and Georgetown University's Health Care Research and Policy Center (www.healthprivacy.org). It is important to be aware of these new and wide-reaching privacy guidelines, as they will affect the operations and finances of virtually all health care providers. Further regulations under HIPAA are still forthcoming.

3) an employer, under limited circumstances related primarily to workplace injury or illness or for medical surveillance. State laws govern disclosure in these situations and must be considered.

Carrying Out the Request

Although Mr. Dalrymple's request seems straightforward, carrying it out may be problematic. Protecting patient confidentiality is both ethical and legal, but providing false information to others is both unethical and illegal. How should Dr. Richards answer a request for medical information about Mr. Dalrymple? The best strategy would be to submit all other requested information except the past history of drug use, but this could easily raise a flag for the requesting party and result in a follow-up inquiry. He also could state that Mr. Dalrymple does not want specific information provided, but this would likely lead to the same follow-up inquiry.

What if Dr. Richards stated that no information was available or wrote that there was no past history of drug use? This would be a grave error. At no time should a physician falsify a record, bill, or claim on behalf of a patient. Federal and state laws impose substantial monetary and criminal penalties when a health care provider submits claims that contain false information. Several federal statutes also impose criminal and/or civil penalties for submission of false claims to the government or others. Arguably the most well-known of these federal laws is the civil False Claims Act (FCA) [29]. The penalties under the FCA can be quite substantial. If a physician presents or causes someone else to present a false claim, whether or not the physician has a personal financial interest, the physician can be liable under the FCA.

What if Mr. Dalrymple had previously consented in writing to allow Dr. Richards to provide full medical information? To which request must Dr. Richards respond: the prior written agreement or the verbal request to exclude specific information? There is no easy answer here. Each relationship would be considered a separate contractual agreement. The contract the patient has with his insurance company is separate from the relationship he has with his physician. A third distinct contractual relationship may exist between the insurance company (eg, a managed health care plan) and the participating physician, whereby the physician has agreed to provide specific patient information in regard to payment for services. In this case, as noted above, HIPAA allows for the physician to use or disclose patient health information for purposes of treatment, payment, and health care operations. State insurance laws may provide for other permitted uses and also must be taken into account.

Epilogue

One week later, Dr. Richards calls Mr. Dalrymple.

"Mr. Dalrymple, I would be happy to comply with your request about your past history of drug use. But there are some things you need to know about what I can say and what I can't say. Let's schedule a meeting for next Wednesday at 2 to go over both of our concerns, and I'll also let you know more about your rights concerning your medical record."

"Thanks for helping me, Doc. I'll see you next week."

Summary

In this case, a patient returns to ask for help from a trusted physician while in the active care of a new primary doctor. Although the physician wants to help, he realizes that honoring the patient's specific requests is problematic. The physician's response challenges him to carefully reflect on his ethical, professional, and legal obligations.

In considering the request to provide concurrent care, the physician must wrestle with a conflict between serving the welfare of his patient and respecting patient autonomy. His response is ultimately guided by the most traditional of medical ethical principles: avoiding harm. Although the patient's request is essentially denied, the physician takes great care to explain that his concern for the patient's safety and well-being is the reason. Furthermore, the physician leaves the door open for the patient to return to his sole care, should he wish to.

When asked to withhold specific information from the patient's medical record, the physician must consider not only ethical principles of confidentiality but also recent laws that protect the privacy of patient health care information. Here, the physician seems to be able to agree to most of what the patient is asking, and the patient seems satisfied that his trusted former physician is doing all that he can.

The dilemmas raised by this case are not perfectly resolved. However, by reflecting on relevant principles and responsibilities of medical professionalism (ie, dedication to patient welfare; respect for patient autonomy; commitment to honesty with patients, patient confidentiality, and improving the quality of care), the physician is able to proceed with a course of action that upholds the Charter.

Acknowledgment: The authors thank Lynn S. McGivern, JD, of Lebow and Malecki, LLC, Chicago, IL, for her assistance in researching the legal issues in this case.

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