REFLECTIONS

HMO BLUES

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At 3:00 PM on a Friday afternoon, I received a telephone call from the medical director of a health maintenance organization (HMO) regarding the discharge plans for my patient. He said, "I reviewed your patient's numbers; she doesn't need to be hospitalized any longer! I recommend you continue her workup as an outpatient."

My patient, a 37-year-old public health care worker, was being evaluated for hyperthyroidism, pleural effusion, pericardial effusion, and mediastinal lymphadenopathy. This hospitalization was her third in 2 months. The pulmonologist and cardiologist were treating her acute medical conditions. We both disagreed with the medical director, and the specialists recommended the patient remain in the hospital for chest tube placement and lymph node biopsy. I submitted an appeal to her HMO to reverse its directive because she was not clinically stable for discharge to home.

My patient was furious that her insurance refused to pay for any further hospital care. She was a single mother facing financial hardships and would be left with a hospital bill she could not afford. She continued to complain of chest pain and shortness of breath and refused to leave the hospital until her symptoms were treated. The medical director of the HMO made it clear to all physicians involved in her care that she was financially responsible for her hospital bill.

After 48 hours she became more stable, and her symptoms subsided. She was discharged from the hospital awaiting approval from her HMO to continue with the same specialists for management of her medical problems. Despite the appeal, the HMO refused to pay the additional 48-hour hospital care requested by all physicians involved in her care.

What is my role as an employee of a HMO? Can the physician be an advocate for both the patient and the HMO? What happens when these roles collide? The physician-patient relationship is at great risk when medical decisions are driven by third party HMO business interests. The essence of the physician-patient relationship is based on honesty and trust. Physicians are obligated to keep their patients from harm and injustice. The Hippocratic Oath, however, does not provide any guidelines regarding financial constraints on treatment recommendations, and I believe that HMOs are changing the physician-patient to a corporate-consumer relationship. I felt caught in a tug of war between my patient's expectations of high-quality medical care and the expectation of cost containment by the HMO. It is difficult to be an advocate for the HMO when financial strains are placed on the physician-patient relationship, and the focus becomes cost containment instead of high-quality health care delivery.

Because HMOs hold a prominent, critical place in the recent evolution of health policy, developing a universal code of ethics should be given top priority by the health care policy makers. What are the standards and ethical codes that HMOs use to limit or deny medical services? Ethical violations can cause great harm to patients and potentially death. I believe any incentives offered to physicians for denying health care are unethical. By defining the ethical dilemmas of managed care, physicians, patients, medical directors of HMOs, and policy makers can work together to maintain patients trust.

Submitted 13 December 2002.

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