As I begin this article on ethical guidelines for medical directors, I am faced with several troublesome thoughts which I must share immediately with my reader. With them settled and behind us, we can go on to the topic at hand.

Firstly, where should one begin? Surely it is reasonable to assume that anyone who has taken medical training has been taught about and has thought about many of the ethical considerations which have beset our profession since its infancy in apothecary and barber shops. It is impossible for me to imagine a doctor who has not, consciously or otherwise, arrived at a personal set of reactions to most ethical situations, at a personal code of behavior, and who therefore enjoys a base of ethical thought. I intend to begin by building on this foundation.

Secondly, where does one end? The ramifications of ethical consideration are almost literally endless. Related to this is the third question, “what should one try to cover?” My commission is one brief article on ethics for the insurance company medical director, yet with at least a continent-wide application. For the readers who want more, and of a more general nature, I commend the short (234 pages) and thought provoking book “Principles of Ethics” by Paul W. Taylor, who at the time of writing was professor of philosophy at Brooklyn College, City University of New York; or, if something even more is needed, the Holy Bible, written by many authors, none of whom, to the best of our knowledge, held university appointments. Since the lengthy dissertations are available, I will try to be brief and helpful. In my limited experience with them, too often ethicists believe their role is to provoke thought, to ask questions rather than to suggest answers. I was privileged to have lunch once with Ivan Illich. At the time I was working for our provincial medical association and had no shortage of provocative ethical questions. I came to lunch hungry for food and guidance. Illich apparently believed his role was to question, not to answer. I went away with my appetite for food sated but still hungry for answers to my ethical concerns. I would rather annoy my reader with suggested, albeit personal, answers to some of our mutual concerns than anger him or her with an empty dissertation on theory without substance.

Taylor defines ethics as “philosophical inquiry into the nature and grounds of morality” with “morality” used as “a general name for moral judgements, standards and rules of conduct.” Clearly such an inquiry cuts across one’s national, ethnic, religious and social background. Yet each of these will contribute to the personal morality of the individual medical director.

Furthermore, our ethical behavior will be governed in part by the expectations of the society in which we live. Taylor talks of society expecting from an individual conduct which is “his public acknowledgement of moral responsibility” and points out that “society, generally, holds individuals morally accountable in the same way a person can hold himself accountable.” The companies we work for, our co-workers and the people who buy our product, all are important parts of that society and hold these expectations of our behavior.

Ethical principles specifically related to our profession have been codified for centuries. Some of use have sworn the oath of Hippocrates. We may find comfort in the prayer of Maimonides. State, provincial and national medical societies have developed codes of ethics and specific branches of medicine or hospitals may have their own codes. There is no shortage of ethical guidance for doctors!

When we step into our offices each morning, we face a spectrum of ethical responsibilities. Our employers expect time and expertise in fair measure for the salaries paid. Other employees expect constancy of approach to underwriting and claims assessment. The applicants for our product expect impartiality and expert judgement. And we carry with us the expectations of our profession and finally of ourselves. Polonius says to Laertes in Hamlet:

“This above all,—to thine ownself be true; And it must follow, as the night the day, Thou canst not then be false to any man.”

This sentiment has been called “noble and resonant,” but it is also incomplete and therefore not totally true. We cannot only be true to our own ethical standards. If we are, we indeed may be “false” to many other men. Rather we must meet as well the standards of the others mentioned above or know why we cannot meet them.

First then to the employer and through it, to the industry. Our employers buy our time and our knowledge. They expect us to apply our intellect and experience to the problems they present to us. But they do not buy our souls. We must be free to think and act in good conscience. If management is astute, it will give us the freedom to act responsibly, to make judgements with guidance from company policy, but without absolute limitations. It retains the freedom to override our decisions, for the greater good of the company. So the first principle affecting our ethical behavior as medical directors is that “we must make decisions in keeping with our personal codes of ethics and that of our profession.”

If we are astute, we will present our decisions in a reasoned and logical fashion, with a co-operative and not a confrontational pose, to show the contribution we have to the culture of our companies and to the industry as a whole. It is wrong to talk about the social conscience of the industry as though
it was an impersonal development of a non-human business. The social conscience of our industry is expressed by countless good works, charitable donations and social initiatives which represent the visible, tangible expression of the personal beliefs of hundreds of accountants, actuaries, salesmen, lawyers, business administrators and physicians in the industry. Through our ethical behavior we contribute to this. The second principle of ethical behavior for medical directors then is "we have a responsibility to contribute to the moral climate of our companies."

Our ethical responsibility to our companies has a day to day practical application. During routine underwriting and claims assessment do we see flaws in plan design or policy wording which is misleading? Are we general in selling a principle but specific in applying it? For example, it is common in Canada for our government medicare plans to pay for "necessary" special nursing care for hospitalized patients. Equally it is common for private major medical or health insurance plans to provide for payment for "necessary" nursing care not paid for by the government plans. There should be no problem with this but there is! Payment for essential out-of-hospital nursing care is clearly the responsibility of private plans but many policy holders are left with the impression that, as well, "desirable" private nursing care in-hospital, if it is not paid for by medicare, will be paid for by the private plan. Of course it is not. Necessary out-of-hospital nursing care is a valid and valuable benefit which must be carefully sold. If a medical director sees too many invalid claims for this benefit, he should check on the selling methods being used. The third ethical principle then is that a medical director's concern for ethical behavior in the company may extend to areas of the company in which he may have some influence but over which he has no jurisdiction.

In underwriting, many of the traditional medical ethical principles come into play. An applicant tells us or gives others permission to tell us intimate details of his health and his life style. Actuarial, financial and medical opinion is brought to bear on this application and a decision which may affect the future of his family and his business is made. Indeed information may be developed regarding his present health and his own future may be affected. The similarity between an application for insurance coming to the medical director of the company and a patient coming to his personal physician is real and the ethical considerations of one situation may be applied judiciously to the other.

The consideration of confidentiality of information is the one to which most attention is paid and so should be dealt with first. It is a moral question on which both medical codes and society's codes have spoken often. Maintaining a patient's confidence is a keystone not only of medical ethics but of the doctor-patient relationship. Second only to our teaching of reverence for the human body has been our teaching of protection of the patient's secrets.

Society as a whole, on the other hand, has been somewhat less clear about its feelings in this regard. A colleague visiting a new church on Sunday morning was astounded to hear the minister announce not only the hospital and room number of ill members of the congregation but also give details of the disease including specific diagnoses. My hometown newspaper has a column headed "With the Sick" which frequently gives the diagnosis and/or surgical details of the illnesses of local citizens. While this has been going on, state and provincial parliaments have been approving privacy legislation and guidelines for business.

If society has been sending this mixed message about its concern for confidentiality of information, the insurance industry has not! Industry associations have issued privacy guidelines for their members and the MIB member pledge deals specifically with confidentiality. Obviously AIDS has brought the question of confidentiality to the foreground of our consciousness. Of course we knew that a leak of information about bad heart disease might affect the career of an applicant for group life insurance, but the thought that leaked knowledge of an applicant's positive HIV antibody test might cost him his job, his home, his friends and his family, has brought us all up short and made us review the confidentiality issue with thought and dispatch. The fourth principle of ethical behavior for a medical director hardly needs to be stated: A medical director will promote business practices which protect the confidentiality of all medical information obtained from an applicant.

Underwriting reminds us of several established interrelated ethical principles dealing with personal competence, principles our clinical colleagues must remember every day. We have a moral responsibility to continue our education. Yet we must realize that we do not and cannot know everything. Recognizing the limits of one's knowledge and seeking help appropriate to the patient's needs is a recognized principle of medical ethics. For us it means the ready availability of current text books and underwriting manuals and contacts in the local medical community from whom we can get advice. The fifth ethical principle for medical directors is "continue your education and maintain clear avenues of expert underwriting and medical advice."

Within our companies there is a two-day educational process between us and our colleagues. It is trite to say we are a part of a team but in any well run business, that is true of all employees. The usual confidant relationship we have with our lay underwriters and claims assessors emphasizes this. They teach us, such subtleties as intuition and skepticism. We teach them about widely varying medical topics from murmurs to liver function tests. We must abhor the tendency of an occasional clinical colleague to confuse a lay underwriter with his superior medical knowledge. I feel like sending such a physician an actuarial report or any page of any company's income tax return. Who would be confused then? We must resist the temptation to cover our mistakes with medical double-talk. The ethical point here is simple. In our day to day work with underwriters and claims assessors we have a responsibility to learn from them and to help them understand significant medical information. The code of ethics of the Canadian Medical Association says succinctly "Teach and be taught". Let those four words become our sixth principle.

It is in underwriting that we may meet our own prejudices. Referring again to the AIDS epidemic, because of the association of homosexuality and drug abuse with the spread of the disease, we have become aware of the widespread homophobia we find not only in society generally but in our profession. At its extreme I once heard this expressed "Any disease that is killing queers and drug addicts can't be all bad!" Yet regularly we are called on to insure homosexuals and reformed addicts. We have some data and experience on the recidivism of addicts and we know that a homosexual couple living in a faithful, monogamous relationship are at
no greater risk of getting AIDS than a comparable heterosexual couple. But biases surface. This is not surprising since moral perfection is not a requirement of becoming a medical director. If it were, our ranks across North America would be decimated. What is essential is that we recognize the immorality of prejudice. We must respect the individuality of each applicant, and his inherent worth as a person.

This recognition becomes more important when we find something wrong of which he is unaware—sugar in the urine, hypertension, abnormal liver function tests—these are frequent. In one instance a medical director reviewing a chest X-ray, routinely requested because of the patient’s age and the face amount of the policy, diagnosed a thoracic aneurysm whose presence was unknown to the applicant. The director had a radiologist confirm his diagnosis, notified the attending physician and sent him, by courier, the X-rays and the radiologist’s report and gently urged the attending physician (a rather nervous locum tenens as it turned out) to refer the applicant immediately to a thoracic surgeon. Although the applicant was in a city several thousand miles away, he was in the office of the thoracic surgeon within twenty-four hours of the medical director first seeing the chest X-ray. And that is exactly what the medical director should have done! The seventh ethical principle requires us to respect and protect the inherent worth and health of every applicant.

Health claims assessment, by its nature, always offers the possibility for conflict between the interests of the insurance company and those of the claimant. The claimant says “I am disabled” and the evidence submitted may clearly indicate that is so. Or the evidence may not be so clear. The company says “Here are the circumstances under which we agree you are disabled” and spells out conditions relative to occupational status, education level (and therefore ability to protect disability than deny it) but that is his ethical problem and we leave it to him). Through all of this the medical director must seek truth, knowing he may well end up with just a best guess. We cannot let emotion cloud our judgment nor can we dismiss compassion, surely one of the basis of ethical thought, as a factor in our decision. The intellectual consideration is “weigh all the facts”. The ethical consideration is “be fair to all the interests represented at the decision” and once again we have a simple obvious ethical principle, the eighth to be outlined.

All of us from time to time and some of us regularly, have a role in our companies as an occupational health physician. We may be called on to help with a specific personnel problem. There may be an occupational health hazard to identify. In these circumstances all of traditional and well recognized ethical principles related to private clinical practice and occupational health apply. The confidentiality of the employee’s medical information must be protected. The employee must be protected from undue risks in the workplace and the employer must be protected from frivolous complaints and frankly fraudulent health claims. All of these principles and many others have been reviewed countless times before and this brief mention of them is included for completeness sake only.

To the reader faithful enough to come this far with me, it will be apparent that I have written little that is particularly new. You have been saying “well yes, of course that’s true” and “I do that now”. That does not surprise me nor should it disturb you. It illustrates simply that sound ethical behavior has been recognized for years by our profession as an inseparable component of good medical practice, no matter what branch of specialty of medicine is being practiced. It is taught to us in both direct and subtle ways and it becomes a part of our daily decision making. If I have showed you some new perspective on some part of our work, I am content. But as I write about a “new perspective” I am reminded of a book I came across recently titled The Medical Advisor in Life Assurance by Dr. E. H. Sieveking of London, England. He writes at one point “The duties which the medical officer of an insurance company undertakes to perform are of a very responsible character, as they involve both the happiness of the applicant and the welfare of the company,” and at another “Life insurance involves interest of the greatest importance to the individual and to society; and here, as in many other matters affecting the welfare of humanity, the medical man is one of the chief guardians of social morality and civilization.” The book was written in 1874! In ethical principles, there is not much that’s new, is there?

References

2. William Shakespeare — “Hamlet” — 1600 (?).