AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Opinion on Ethics and Professionalism

Care and Treatment of the Medically Underserved

An AAOS Opinion on Ethics and Professionalism is an official AAOS statement dealing with an ethical issue, which offers aspirational advice on how an orthopaedic surgeon can best deal with a particular situation or circumstance. Developed through a consensus process by the AAOS Ethics Committee, an Opinion on Ethics and Professionalism is not a product of a systematic review. An AAOS Opinion on Ethics and Professionalism is adopted by a two-thirds vote of the AAOS Board of Directors present and voting.

Issue raised

What are the orthopaedic surgeon's obligations to care and/or treat the medically underserved, i.e., patients who do not have insurance and who are unable to pay for such services?

Applicable provision of the *Principles of Medical Ethics and Professionalism in Orthopaedic Surgery*

"X. **Societal Responsibility.** The orthopaedic surgeon has a responsibility not only to the individual patient, to colleagues and orthopaedic surgeons-in-training, but also to society as a whole. Activities that have the purpose of improving the health and well-being of the patient and/or the community in a cost-effective way deserve the interest, support and participation of the orthopaedic surgeon."

Applicable provisions of the *Code of Medical Ethics and Professionalism for Orthopaedic Surgeons*

"I. B. The physician-patient relationship has a contractual basis and is based on confidentiality, trust and honesty. Both the patient and the orthopaedic surgeon are free to enter or discontinue the relationship within any existing constraints of a contract with a third party. An orthopaedist has an obligation to render care only for those conditions that he or she is competent to treat.

"I. D. The orthopaedic surgeon may choose whom he or she will serve. An orthopaedic surgeon should render services to the best of his or her ability. Having undertaken the care of a patient, the orthopaedic surgeon may not neglect that person. Unless discharged by the patient, the orthopaedic surgeon may discontinue services only after giving adequate notice to the patient so that the patient can secure alternative care. Both orthopaedic surgeons and patients may have contracts with managed care organizations, and these agreements may contain provisions which alter the method by which patients are discharged. If the enrollment of a physician or patient is discontinued in a managed care plan, the physician will have an ethical responsibility to assist the patient in obtaining follow-up care. In this instance, the orthopaedic surgeon will be responsible to provide medically necessary care for the patient until appropriate referrals can be arranged."

"VI. C. Physicians should be encouraged to devote some time and work to provide care for individuals who have no means of paying."

"IX. A. The honored ideals of the medical profession imply that the responsibility of the orthopaedic surgeon extends not only to the individual but also to society as a whole. Activities that have the purpose of improving the health and well-being of the patient and/or the community in a cost-effective way deserve the interest, support, and participation of the orthopaedic surgeon."

Other references

American Academy of Orthopaedic Surgeons, Position Statement on Health Care Coverage for Children at Risk, September, 1997.

American Medical Association, *Current Opinions* of the Council on Ethical and Judicial Affairs,

Section 2.095 ("The Provision of Adequate Health Care")
Section 9.065 ("Caring for the Poor")

American Medical Association Council on Ethical and Judicial Affairs, "Caring for the Poor," JAMA, 269: 2533-2537 (1992).

Background

A significant portion of the citizens in the United States have inadequate access to medical care.[1] According to a 1992 study, 17 percent of Americans had inadequate access to physicians, reflected in such factors as premature death and disability caused by controllable illnesses and high rates of infant and child mortality.[2] A 1996 study by researchers in the Harvard School of Public Health found that 37 million Americans (31 percent) were without health insurance or had difficulty getting or paying for medical care at some time during 1995.

Since 1988, the number of *uninsured* persons in the United States has increased steadily each year. The non-elderly uninsured population grew from 33.5 million in 1988 to nearly 40 million in 1994, the year of the most recent national estimate.[4]

The number of American under age 65 with private insurance who are *underinsured* is estimated to be between 25 to 48 million, or ten to twenty percent of the population. These figures are 50% larger than analogous figures for 1987 and may be growing, since employers are offering less generous health insurance policies than in the past.[5] In addition, the percentage of Americans with employer-sponsored health insurance is decreasing; nearly 6% fewer American under age 65 had such insurance in 1995 than in 1988.[5]

While a lack of insurance or underinsurance do not necessarily result in reduced access to medical care, it clearly has an impact. People who are uninsured report up to 47% fewer visits to physicians and fewer hospitalizations than those who have insurance, even though they are in worse health.[6]

The lack of access to health care in the United States is disproportionately distributed throughout the population. Well over half of U.S. population living under the poverty level are women and children. One in seven children in the United States is without health insurance. This is nearly one-fourth of the total uninsured population. When compared to the insured, they are four times more likely to report needing, but not receiving health care.[7] In addition, strong differences in access to and utilization of health care persist for various racial and ethnic groups.[8] The lack of access to health care, particularly primary and preventative health care, has pronounced consequences both for the health care system and for society in general.

In addition, as the health care environment changes, there has been tendency by many Managed Care Organization (MCOs) not to cover those without insurance or those who are underinsured.

Ethical Considerations

I. Obligation of Individual Physicians To Treat the Medically Underserved

Organized medicine has long recognized that the individual physician has an ethical obligation to treat the medically underserved. For example, the first *Code of Ethics* of the American Medical Association (AMA) in 1847 provided that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded."[9] More recently, in 1993, the AMA Council on Ethical and Judicial Affairs stated that medical professionals should reaffirm their responsibility for making health care available to the needy.[6]

Each physician has a moral and ethical obligation to care for the medically underserved. The objective of the medical professional is to care for the sick, to treat the ill without regard for who they may be, what their diseases are or whether they can pay. While reimbursement may follow, the pursuit of material gain is not the primary end of the medical profession.

The obligation of individual physicians to help care for the medically underserved is based in the concept of professionalism, including its pursuit of moral ideals such as justice and beneficence. By drawing on the physician's mercy, compassion and empathy, charity care strengthens the bond between physician and patient that have often been weakened by increased commercialization of medicine. Providing care to patients without expectation of payment reaffirms the primacy of medicine as a helping profession.

Although physicians provide considerable charity care, improvements can and should occur. For example, in 1996, the AMA House of Delegates recognized a growing need for voluntary physician efforts to care for the uninsured in an era of increased fiscal constraint in both public and private sector programs.[10] While most physicians provide free or reduced fee care within their practices, in 1993 as many as one-quarter to one-third failed to provide services to the medically underserved.[6]

What Care Individual Physicians and Orthopaedic Surgeons Are Providing

In 1994, the AMA reported that 68% of all practicing physicians provided some free or reduced fee care, and devoted an average of 12% of their work time, 7.2 hours per week, to caring for the medically underserved, up from 6.5 hours per week in 1990.[10]

According to *Orthopaedic Practice in the United States: 1996/7,* approximately ten percent of the care provided by orthopaedic surgeons is uncompensated or is paid by the Medicaid program. Four percent of the care is entirely uncompensated.[11] In the most recent Orthopaedic Census Survey that specifically dealt with the issue of orthopaedic surgeon's providing uncompensated care, the Academy found:

- Eighty-one percent of orthopaedic surgeons regularly provide care for patient from whom they neither expect nor receive compensation (including charity care clinics);

- Orthopaedic surgeons provide, on average, 37 professional hours per month on uncompensated care or where compensation is Medicaid or other reduced payment. This includes 9.1 hours where compensation is neither expected nor received; 13.3

hours where compensation is expected but not received; and 14.8 hours where compensation is Medicaid or similar reduced payment; and

- Sixty percent of orthopaedic surgeons indicate they are providing more uncompensated or reduced compensated care than they were five years ago. The average increase in hours per month indicated was 31 percent.[12]

Recommendation of the AMA Council on Ethical and Judicial Affairs

In 1993, the Council on Ethical and Judicial Affairs of the AMA adopted a guideline regarding the individual physician's obligation to treat the medically underserved. The Academy generally endorses this guideline and has revised it as appears below:

> ***Caring for the medically underserved should be a normal part of each physician's overall service to patients. Although the measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics and geographical location, orthopaedic surgeons should work to ensure that the needs of the medically underserved in their communities are met. Since a large number of the medically underserved are children, the orthopaedic surgeon has a special obligation to treat them without discrimination based on the ability to pay.***
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> ***Orthopaedic surgeons should devote their energy, knowledge, and prestige to designing and lobbying at all levels to better programs to provide care for the medically underserved.***

II. Obligation of Society and the Medical Profession To Treat the Medically Underserved

The duty to care for the medically underserved rests not only with individual physicians, but also with society and the medical profession as a whole. The policies of the Academy make improved access to medical care a clear priority. Since 1992, the Academy has publicly supported universal, affordable health care available to all. In its response to health care reform, the Academy stated that this country "must provide an essential and universally accepted health package for all Americans, regardless of ability to pay. This health care package must include a basic level of high quality health services, including musculoskeletal services.[5] In 1992, the Academy also stated that the medically underserved should be covered through "an expansion of the federal-state health care financing system.[13]

What Services the AMA and Medical Societies Are Providing?

A survey conducted by the AMA in 1997 found that 29 state or metropolitan medical societies conducted programs to arrange for the provision of free care by participating physicians in the state or area. In addition, 36 state or metropolitan medical societies sponsored or participated in free clinics to serve the medically underserved.[10]

Recommendation of the AMA Council on Ethical and Judicial Affairs

In 1993, the Council of Ethical and Judicial Affairs of the AMA adopted a guideline regarding the obligation of society and the medical profession to treat the medically underserved. The Academy generally endorses the guideline and has revised it as appears below:

The American Academy of Orthopaedic Surgeons and state and local medical societies should help society meet its obligations to provide health care services to the medically underserved. By working together in providing care for little or no compensation, by volunteering at local free

clinics and/or by participating in active professional organizations and their affiliated alliances, orthopaedic surgeons and other physicians can be directly involved in and can encourage the provision of coordinated quality care for the medically underserved.

References:

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4. Employee Benefits Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured Analysis of March 1995 Current Population Survey,* Washington, DC: Employee Benefits Research Institute, (1996). Issue Brief No. 170
5. Short PF and Banthin JS, *New estimates of the underinsured younger than 65 years,* JAMA, 174: 1302-1306 (1995)
6. American Medical Association, Council on Ethical and Judicial Affairs, Section 9.065, *Caring for the Poor,* found in JAMA, 263 (19): 2533-2537 (1993)
7. Donelan K, Biendon RJ, Hill CA, Hoffman C, Rowland D, Frankel M, and Altman D, *Whatever Happened to the Health Insurance Crisis in the United States?* JAMA, 276 (16): 1346-1350 (1996)
8. American Medical Association, *Report #50 of the Board of Trustees: Racial and Ethnic Disparities in Health Care* (December 1995)
9. Lundberg GD, *National Health Care Reform; Answers of Inevitability is Upon Us,* JAMA, 265: 2565-2567 (1991)
10. American Medical Association, Council on Medical Service, *Report #14*: *Physician Initiatives for Care of the Low-Income Uninsured* (June 1997)
11. American Academy of Orthopaedic Surgery, *Orthopaedic Practice in the United States, 1996-97,* 13
12. American Academy of Orthopaedic Surgeons, *AAOS Orthopaedic Physician Census,* Supplemental Form A, 1992, 25
13. American Academy of Orthopaedic Surgeons, *Position Statement on Principles of Health Care Reform* (1992)

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