

Ethical Issues in Managed Care

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Managed care organizations (MCOs), because they are involved in the delivery of medical care, have ethical responsibilities.¹ We believe that an emphasis on managed care's moral mission is essential to the credibility of this system of care.² Steven Miles, MD, has pointed out that ethicists often snipe at managed care as a strategic tactic to preserve market position or ensure institutional survival, rather than engage in an authentic debate about the nature and ethical behavior of MCOs (e-mail, December 1995). As he suggests, much of the criticism of managed care originates from two sources: (1) institutions with a vested interest in loosely monitored fee-for-service insurance; and (2) ethicists in those centers who have constructed an elaborate, idealized conception of the ethics of the doctor-patient relationship, which is based on a position of privilege (with regard to command of resources) on the part of both patients and doctors that may never have existed, even in fee-for-service.

Here, we suggest that the doctor-patient relationship, as it is idealized in medical ethics, actually may be more important to physicians than to patients. As such, an additional basis for ethics in managed care systems must be explored that should include a new emphasis on personal responsibility, by both patients and physicians, for illness and treatment. We outline two key assumptions that underlie managed care, ex-

amine the benefits and burdens of this type of system, and discuss its continuing impact on the doctor-patient relationship.

Managed Care: Ethical Assumptions

Managed care systems that strive to deliver excellent service and to achieve a high degree of patient satisfaction will be the model healthcare systems of the 21st century. Managed care recognizes the dual concepts of appropriateness and scarcity: If all care were of high quality and appropriate,³ and if resources were unlimited, then managed care would be unnecessary. Managed care assumes that physicians will be advocates of both the patient and the MCO, even when these roles seem to conflict. Generalists in the United Kingdom perform both roles implicitly and invoke medical reasons to deny medical treatment to patients deemed "too old, too sick, or too unlikely to benefit."⁴ Patients generally are not told that the resource is relatively scarce.

Managed care organizations make at least two ethical assumptions: (1) the doctor-patient relationship will be fiduciary and nonadversarial; and (2) equality of access is the proper ethical concept for resolving dilemmas about resource allocation. Although one may question both assumptions, they deserve to be examined and understood.

Fiduciary relationships in managed care are assumed to be trusting and covenantal, even though they also are contractually based. Physicians are assumed to act with goodwill as patient advocates; for example, when appropriate, they will appeal unfair economic constraints on the care of an individual patient.

Fiduciary relationships obligate physicians to act as patient advocates in the case of a utilization review decision that is inappropriate for medical reasons. Some limits to the fiduciary relationship exist, however. Patients must recognize that their physicians will work with them within the system, but are not easily permitted to go outside the system—even in their fiduciary role.

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Managed care assumes that equality of access for all MCO members is more important than all-out, expensive treatment for one member. This concept of equality requires that physicians in MCOs become consistent decision makers, and that they make the same decisions for individual patients in face-to-face situations as they would for groups of comparable patients when considered as a patient population.

Benefits and Burdens in Managed Care

The ethical constraints in managed care result in specific benefits and burdens to all parties.

Benefits. The benefits to patients in MCOs are substantial. Managed care organizations integrate the financing and delivery of health services, provide services at a discount, and minimize paperwork. Copayments and deductibles are low or nonexistent. In one study, the quality and quantity of ambulatory care for patients in a health maintenance organization (HMO) was judged equal to or better than that for patients in the fee-for-service sector.⁵

MCOs also provide benefits to physicians. They limit the start-up costs of practices, and many can offer dependable incomes, regular practice hours, and structured practices. Managed care organizations give financial incentives to physicians to deliver care to enrollees in an efficient, cost-effective manner. Physicians are assured a patient population, albeit at volume discount, and a peer group with which individuals can build collegiality and best practices. Many of these advantages are greater in staff-model HMOs than in independent practice associations or group-model HMOs.

Managed care organizations offer equal access for all members, provide financial reimbursement for administrators and others, and allow payers to use developed business principles and to test those principles in new markets. For example, the principles of continuous quality improvement have been used in the automobile industry since the 1970s and have been applied to the administration of healthcare by many MCOs.

Burdens. Given medicine's traditional focus on the individual patient, the emphasis by MCOs on benefiting the group may seem utilitarian and even impersonal. Some patients receive incomplete or incomprehensible information when they are offered an MCO plan, or when it is advertised.⁶ In such situations, restrictions on care are de-emphasized, and curious patients must at least consider scrutinizing both payer and physician. Serious questions arise about the limits of patient autonomy,⁷ and about the inability of patients to access particular uncovered providers and services.

Managed care presents moral and professional challenges to medicine's virtue-based ethics, including the fundamental values of clinical practice.⁸ Managed care's administrative controls threaten to change doctor/patient relationships to businessperson/consumer relationships.⁹ Neither the complexity nor the standardization of MCO processes easily accommodates differences among individual patients, thereby stifling the physician's flexibility.¹⁰ The physician increasingly is caught between the patient's expectations of more and "higher-tech" care and the MCO's expectations of lower cost and higher volume.¹¹

Frequently, MCOs are financially risky enterprises, responsible for providing an enormous array of services. They also suffer from a dearth of outcome data and are often unable to substantiate their protocols and procedures with valid, reliable medical data. Managed care organizations potentially may be at risk for suits in several areas, including breach of contract, breach of warranty, and breach of the implied covenant of good faith and fair dealing.

The Doctor-Patient Relationship in MCOs

The nature of the doctor-patient relationship in the MCO is not intended to be ethically distinct from the doctor-patient relationship in indemnity systems. It continues to be a fiduciary relationship. The physician still treats patients on his or her panel one at a time as unique and valued individuals and acts as a prudent steward, judging wisely the limits of care. Nevertheless, ethical issues in managed care seem to focus on access and cost issues because they are imbedded more explicitly in the organizational structure of the MCO system. They also take into account the relationship of patients to a community of others, including physicians, all linked by an HMO contract.

The doctor-patient-MCO relationship requires that physicians hold the organization to its own ethical responsibilities of facilitating members' access to needed healthcare.¹² Physicians can help to design systems of managed care that permit ethical practice overall; even so, unfair constraints may occur in individual cases.

Professional advocacy means that physicians should assist patients with medical or financial issues that are unreasonable or discriminatory, or that would injure a patient's medical interests. Physicians successfully have appealed constraints on out-of-plan services.¹³ The necessity of making these appeals is a newly explicit burden, which is likely to become more commonplace; whether physicians will continue to help patients appeal these constraints will depend in part on the strength and depth of their relationships,

and on the effect of constraints on the quality of care. Interestingly, many MCOs now include in their provider contracts an obligation for the provider to appeal constraints, if medically warranted.

Economics Have Become Central to Ethics

Physicians have previously tended to view socioeconomic considerations in patient care as external to ethical decision making.¹⁴ This point of view may have arisen for several reasons, including a tradition of self-identification as the patient's primary advocate, fear of becoming an agent of an inequitable distribution of social resources, or a sense of relatively unrestricted access to medical care through third-party payers.

In a recent study of visits to a medical office by 562 consecutive patients, however, 56 ethical problems involving the costs of medical care were identified.¹⁵ Even though cost constraints in the MCO setting have been widely discussed, our experience suggests that the economic motivation underlying requests for ethics consultation may not be apparent, or may even be concealed, during the consultation request.¹⁶

Reconciling individual variability and preferences with managed care's efforts at standardization will be difficult. Practice guidelines primarily can be educational; used unwisely, however, they are a double-edged sword that can readily be used against physicians who do not advocate for care when it is medically necessary but not within the guideline.¹⁸ It is one thing to use practice guidelines to teach, practice, and consult. It is another thing to adopt a particular one among the thousands that exist as the standard of practice.

No two patients have identical backgrounds, values, or even physiologic status. Written practice guidelines do not necessitate much communication between physician and patients. The application of guidelines can rely primarily on physiologic parameters that do not necessarily take into account the wishes, desires, values, or preferences of patients or physicians.

Economic and decision making power already has shifted from those who provide medical care and those who receive medical care to those who pay for that care. The system increasingly is based on institutional and societal efficiency, as well as on cost concerns, which now have emerged as the central elements in medical ethical decision making.

Equality of Access: The Fairest Cut?

Managed care organizations require that physicians provide all members with equal access to the MCO's

medical resources, while continuing to prescribe care on the basis of an individual member's medical needs. Managed care organizations depend on physicians to protect the financial well-being of the organization, and to bear in mind the medical and financial interests of all MCO members when seeing an individual patient. Most MCOs, for example, can ill afford to care for many patients who have great medical and financial needs. For MCOs, equality of access means that providing resources to meet the substantial medical needs of one patient—say, in a persistent vegetative state—makes it hard to meet the basic needs of other patients.

To provide basic care to all members, MCOs may exclude certain highly expensive benefits, such as liver or bone marrow transplantation. However, most HMOs cannot legally exclude such services on the basis of cost alone; in the coverage language, these services may be described as experimental or investigational. This distinction is a critical one, because traditional indemnity insurance, unlike most HMOs, can exclude these services for cost reasons.

The moral basis of this trade-off is fairness—fairness to all members, and to a population of patients, rather than deference to one. Do individual patients know that they are endorsing such a trade-off when they "buy insurance" on open-enrollment day? We believe that they do not. Are physicians ready to accept this trade-off? If their primary obligation is to the health of an individual patient, rather than to the medical and financial well-being of all MCO members, or to the MCO itself, then most physicians can adjust. If their primary obligation is to trade off one patient's need against another's premium, then most physicians are not ready.¹⁸

To meet the expectations of MCOs to contain costs, some physicians may limit the appropriate care given to a specially medically needy patient so that scarce resources will be available to other patients.¹⁹ Indigent MCO patients, for example, receive fewer resources than nonindigent MCO patients and have a higher prevalence of serious symptoms and more hospital bed-days than non-MCO patients.¹⁹ Nevertheless, MCOs care for the chronically ill at the same level as do indemnity plans,²¹ and every type of healthcare organization and plan seeks to contain costs, irrespective of financing and delivery of care. Physicians who treat both managed care and fee-for-service patients may use different rationales for determining whether to refer patients for procedures or desired services: whether MCO patients actually receive fewer services than do patients with indemnity insurance is debated.²²

Profit-driven healthcare organizations recently have been criticized for failing to pay attention to postgraduate training, clinical research, and care of the medically indigent, and for taking money out of the healthcare system.²³ Typically, federal and state payments for Medicare and Medicaid risk programs do not include funds for postgraduate training. But with attention to an educational mission, managed care may be able to resolve policy dilemmas of justice, may improve quality, and may reduce costs in the long run.²⁴

New Ethical Accountability

Patients who enroll in MCOs and physicians who care for MCO patients have several new accountabilities. Ethical incentives for meeting these accountabilities should be offered²⁵ and should include discounts to members who reduce their risks for common, preventable causes of disease and death. The major underlying behavioral causes of death from heart disease, cancer, stroke, accidents, and chronic obstructive pulmonary disease are tobacco (19%), diet and activity patterns (14%), and alcohol (5%).²⁶ Because death rates from tobacco, alcohol, firearms, illicit drugs, poor diet, and sedentary activity levels are much higher in indigent populations than in non-indigent populations, special efforts to understand, educate, and encourage the medically indigent must be a top priority for MCOs.

As individuals, patients must take greater responsibility for their own health, especially to prevent diseases for which they are at special risk. As MCO members, they must acknowledge their decision either to forego some explicitly excluded services or to pay for them out-of-pocket. They also must acknowledge that the MCO will work to minimize expensive treatments, even if these treatments are not explicitly excluded. In addition, patients must be responsible, with their physicians, for appealing unfair economic constraints on their care, beginning with their point of MCO entry (often their place of employment). Finally, as members of society, MCO members have civic responsibilities to participate in public debates on healthcare issues, including debates on access to basic care.

Physicians have several new accountabilities as well. They must be able to do their work as personal advocates, while maintaining good professional relationships with their patients under managed care; if they cannot, managed care ultimately will fail. When necessary, physicians or their case managers, nurses, or staff must become more informed about their patients' MCO policies, to identify areas of interference

or "red tape," and to distinguish between medically indicated care and financially available care. Referrals to specialists, preauthorizations for surgery or hospitalization, and required follow-up visits all are within a gatekeeper's control. Primary physicians can develop this role into one of clinical authority and can wear it as a mantle of advocacy. It may be necessary to develop new terminology, as both patients and physicians dislike the term "gatekeeper," but do not reject the concept or practice.

Conclusion

The ethical and economic aspects of treatment decisions are intimately entwined. The goal of practicing good medicine is best served by acknowledging rather than denying the influence of economic realities on clinical practice, and by warding off distortions of sound judgment.

A simple cost-containment agenda is the preferred course of action of neither physicians nor patients. The promises of managed care depend on equal access, disease prevention, and health promotion, but the economic pressures of the current healthcare environment threaten to distort these concepts and destroy the fidelity of the physician-patient relationship. However, the data do not confirm that managed care harms the quality of care. Rather, they suggest that good managed care systems can, given physician endorsement, outperform fee-for-service in terms of both quality and cost-effectiveness.

A good physician-patient relationship is central to the practice of medicine. We must now broaden that concept by considering populations of patients when seeing an individual as we treat patients.

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