Teaching Managed Care Principles: We Need to Do Better

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Most of the public attention paid to managed care is extremely negative. A widely distributed weekly news magazine had a cover story a few months ago with the words "HMO Hell" emblazoned across a picture of a woman in a hospital gown, howling in apparent mental and physical anguish. A common theme in the media is that physicians in managed care systems fail to provide necessary care, either because the organization won't approve it or because of financial incentives to do as little as possible. Indeed, the Supreme Court recently heard a case involving the issue of whether managed care organizations fail in their duty to patients when they offer physicians "bonuses" based on decreased utilization of tests and procedures.

Not surprisingly, given the poor public image of managed care, politicians court voters by promising to protect them from managed care abuse. Congress spent much of last summer debating a "patient's bill of rights," and now the House and the Senate are working on a final bill acceptable to both houses.

Doctors also generally oppose managed care. Physician satisfaction with health maintenance organization (HMO)-affiliated practice is poor,[1] and as managed care becomes more prevalent, physicians become more dissatisfied.[2] Physicians believe that the financial arrangements of managed care compromise care[3] and that managed care hurts the physician-patient relationship and creates serious ethical conflicts.[4]

With the negative coverage of managed care, it would seem particularly urgent for medical students and residents to understand as much about managed care organizations as possible. After all, many if not most trainees will practice in managed care systems upon graduation.

However, medical trainees know very little about managed care. They do not understand the financing arrangements or cost-reduction strategies,[5,6] and do not consider themselves prepared for practice in a managed care system.[5,7] In my personal experience with a residency training program in Southern California, residents are not even aware of the political controversies surrounding managed care. This is particularly surprising given the massive presence of managed care in the area and the heavy coverage given to managed care issues by the local media.

Medical trainees tend to have the same negative views of managed care as do the general public and physicians in practice.[6-8] A number of surveys of medical students and residents show that trainees think that managed care interferes with the patient-physician relationship, impairs physician independence, and is more concerned with making money than providing quality patient care.[6] Only a minority of residents report that they would be satisfied working for an HMO and practicing by its guidelines.[8]

Resident ignorance about managed care persists despite a mandate from the Accreditation Council for Graduate Medical Education that residency programs include training in practice management and healthcare systems. In this issue, Colenda et al describe a curriculum and a curriculum development process that make a valiant attempt to redress this problem.[9] They worked with a consortium of 4 university-affiliated primary care residency training programs, 4 managed care organizations, and 1 large healthcare system. They formed a curriculum committee with representatives from the training programs (including faculty, residents, and medical educators) and representatives from the managed care organizations (including a medical director). They first decided on the most important managed care topics, then decided to present the material in

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clinical case vignettes. The cases were developed by the academic representatives and reviewed and approved by the entire committee. The material was presented to postgraduate-year 1 residents from all 4 training programs in 10 small-group, problem-based learning modules.

The final curriculum was designed to teach general principles and to address the local needs of the participants. Colenda et al do an excellent job of describing both the difficulty and the crucial importance of developing a product acceptable to all the stakeholders, as well as the importance of spending time getting buy-in from participants. They also stress the need for faculty development, although they were able to have only 1 half-day session to present both the rationale for the curriculum and the material itself. The process they describe should serve as a good guideline for any program struggling with how to develop a managed care curriculum.

Unfortunately, the curriculum was not successful. Although the interns were "enthusiastic about the process and content of the seminar series," their knowledge of managed care concepts was poor at the beginning of the year and did not improve after the yearlong course. Resident attitudes were similarly unaffected. At the start of the year, residents thought that managed care negatively affected healthcare quality, physician autonomy, and the patient-physician relationship. The trainees thought that managed care put cost over quality. However, they did not even believe it was an effective method for controlling healthcare costs. At the end of the year, these attitudes had barely budged.

This negative attitude persisted despite conscious efforts to keep the curriculum from portraying managed care in a negative light. Academic physicians generally take a dim view of managed care,[7] and the physicians in the study by Colenda et al were apparently no exception. The managed care representatives on the curriculum committee believed that the academic physicians had a poor understanding of managed care principles and an unfavorable attitude toward the system. Indeed, the managed care representatives thought that the first draft of the curriculum presented a negative view of managed care. The cases were revised accordingly. Although the authors do not state it directly, the implication is that the final curriculum presented managed care in a neutral, or even favorable, light. However, the residents continued to view managed care in a decidedly unfriendly manner.

It is not clear why the curriculum did not work. The residents in this study thought that their colleagues would resist learning about managed care process issues and resent the time taken away from learning clinical medicine. At the same time, many of the faculty knew little about managed care, and it is not likely that they became experts after the 1 half-day orientation to the new curriculum. Therefore, it is possible that the case-based discussions centered on the clinical issues that were more familiar (or perhaps more interesting) to both faculty and residents, rather than on managed care issues. It is also possible that resident resistance to managed care was so high that one course—however well designed and delivered—was not enough to improve knowledge or attitudes. Whatever the reason, the curriculum's lack of success is too bad.

It is important for physicians to know about managed care. Physicians need to know what is really bad about managed care systems—and really offensive to patients—and negotiate contracts that do not include those elements. Physicians also need to know what is good about managed care. The system has been somewhat successful in decreasing the rise in healthcare costs, and for many Americans, health insurance premiums have stabilized in the last few years. Preventive healthcare is generally better in managed care systems, and studies show that it is effective. Cancers for which there are good screening tests are detected at earlier stages in managed care systems than in fee-for-service systems.[10] Physicians do tend to order fewer tests and procedures under managed care systems,[11] and this too can be good for patients. Studies show little correlation between intensity of test ordering and patient outcome, and every procedure is an opportunity for significant iatrogenic injury.[12]

Knowledge also could help doctors educate their patients. Patients are terrified that their doctors have financial incentives to deny care. Patients are less likely to trust that doctors who work under managed care will act in their best interest compared with doctors who work under fee-for-service arrangements.[13] Doctors who understand managed care are in a better position to reassure their patients by explaining how they are reimbursed and how the reimbursement structure can be an incentive to improve care. Physicians who are in a position to answer patient concerns with accurate information are better able to ensure both that their patients get the best quality care and that their patients *believe* they are getting the best quality care.

Colenda et al describe an excellent process for developing a curriculum to teach managed care principles. We need further research to ensure that medical students and residents learn the material the curriculum presented and become effective advocates for a healthcare system that can deliver cost-effective and high quality care.

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