

AMA/CME ARTICLE

Ethics in Managed Care: The Obligation of Administration to Attending to Consequences

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This activity is designed for physicians, medical directors, and healthcare policy makers.

GOAL

To provide the reader with an overview of the ethical perplexities facing healthcare providers today and how those issues are being shaped by the growth of managed care organizations (MCOs).

OBJECTIVES

1. Identify ways in which managed care has impacted the ethics of healthcare decision making.
2. Describe the new responsibilities MCOs have in the ethical terrain of healthcare delivery.
3. Ascertain primal patient concerns and questions.
4. Consider ways in which healthcare access for the indigent and working poor can be ensured.

Managed care has vaulted to the center stage of American medicine. In the two-and-a-half years since the failure of President Clinton's healthcare reform, the organizational paradigms publicized by that effort have driven a massive reengineering of the national healthcare system. A recent report (*New York Times*, March 17, 1996:D8) indicated that the percentage of employees in managed care was 71% in 1995, up from 48% in 1992.¹ It is ironic that this process of change may eventually produce a system much like the one proposed by the National Healthcare Reform Task Force—minus the protections for patients and physicians and without a plan for universal access.

Managed Care and Moral Choices

Managed care presents ethical problems that are different from the sorts of moral choices faced by physi-

cians in the past. Physicians are suddenly confronted with a series of ethically problematic situations that look suspiciously like questions of dual loyalty. They are being challenged by patients and families to demonstrate that their commitment to patient good is the prime factor motivating their judgment and advice. Patients and family members no longer assume that suggestions for care derive exclusively from expertise and experience focused on the best possible patient outcome.

Patients are aware that physicians operate under plans that provide incentives and disincentives for certain sorts of referrals. Because of this, they fear that treatment advice may be colored by a physician who is anxious about overspending the budget for expensive diagnostic tests and specialist referrals. They fear that guidelines and restrictions on orders for diagnostic tests and consultation may compromise care. They are concerned that the focus on profit, rather than on the best outcome for patients, will deprive them of the beneficial techniques and procedures that American medicine has developed over the past decades.

These patient worries are not without foundation. Reports in the news media and in academic journals describe how physicians are barred from disclosing to patients the restrictions on their practice options.² Professional and popular journals describe the anguish of patients and family members forced to travel to distant locations where they have no medical, family, or community supports in order to gain access to tertiary care.³ Patients' fears are grounded in reality. Given the new demands of care, the restrictions on the freedom of physicians to practice, and the fears of patients that they will be sacrificed to budget priorities, MCOs must face the fact that they are at the center of the new ethical thicket.

The Shift in Decision Making Power

The language and analysis of medical ethics since its inception in the 1960s has focused largely on the rights of patients and the obligations of individual care

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providers, primarily physicians and nurses. Scholarly commentaries by philosophers, physicians, theologians, and lawyers, as well as opinions by state and federal judges, have emphasized the autonomy of patients, the role of the family in surrogate decision making, and the place of the virtuous, honest, and caring physician. In the past, ethical commentaries hardly ever considered the obligations and responsibilities of healthcare organizations and their administrators. Decisions were made by the doctor, the patient and, when requested or required, family members. The universe of decision making was small and confined.

This picture has been radically altered in recent years. Decisions about patient care must be made with deference to the policies and procedures of the organization. There are no longer administrators who arrange logistics for the convenience of the practicing physicians. Instead, there are managers who establish patterns of practice to accommodate the priorities of the MCO. Often the physician must receive permission to proceed along routes that involve expenditures. Management, or its designees in quality assurance, play an active role in decisions about individual patient care. Whether directly involved or not, the rules that establish the decision making process affect the choices that are offered to the patient.

Given this shift in power and the integration of management decisions into the structure of patient care options, MCOs have acquired ethical obligations that previously accrued to physicians and other hands-on care providers. Administrators have acquired ethical obligations to scrutinize directives to and demands on physicians to ensure that the financial bottom line does not compromise the care of patients, or the integrity of providers.

Once policies and procedures are established, MCOs have the ethical responsibility to review individual care plans to ensure that undue hardship is not imposed on patients and families. This will require creating systems for mediating differences with patients and family members.^{3,4} It will necessitate an honest evaluation of the impact of a treatment plan on the family and a willingness to substitute a more reasonable set of choices if the plan is clearly detrimental to the overall well-being of the patient and family.

This determination will require that MCOs build in some flexibility in acute and tertiary care contracts to meet the future needs of patients and protect their interests. For example, it would clearly be unethical for a managed care plan with a patient population base located primarily in New York to establish exclusive contracts for acute and tertiary care with facilities in

Ohio. The financial self-interest of the plan cannot require patients to uproot themselves and their families in order to receive care. The compromise of patient interests in such a plan is clearly foreseeable and unquestionably unethical, even though it is not yet contrary to law or regulation.

Patients' Concerns

In addition to worrying about access to care and the disclosure of all treatment options, patients are concerned about more specific aspects of care. Such questions include: Will the physician take the extra time needed to work with the chronically ill or elderly patient who requires more attention to facilitate adequate examination and treatment? What about the hearing- and vision-impaired patient or the disabled patient? These special patients demand extra time and perhaps the attention of a multidisciplinary team.

Patients also wonder if physicians will be affected by their financial arrangements with MCOs. They question if physicians are willing to forthrightly reveal the extent of these arrangements. And what percentage of a dependent salary should be of concern to the patient? Should the patient be uneasy if 40% of the physician's salary is dependent upon the wise and prudent stewardship of expensive consultant resources? What if it is 20% or 10%? When should patients worry that their interests might be sacrificed for the financial well-being of the physician?

In addition to being concerned about the shift in the ethical terrain of the doctor-patient relationship, MCOs must examine the dimension of their commitment to the traditional and uncompensated missions of healthcare...especially care for the poor. In arrangements before the advent of managed care, an informal network of public hospitals and clinics, academic medical centers and public sector reimbursement provided care for many of the poor who were otherwise uninsured. Many of these people were, and remain, the working poor whose employers offer no, or few, healthcare benefits as part of employment compensation.

MCOs and Care for the Poor

Care for the uninsured and underinsured has been financed until now by Medicaid and Medicare, by the funds for Graduate Medical Education, by state plans for cross-subsidization, and in part of the profits from medical institutions. By and large, in a site like New York City, which is supported by a sympathetic city and state government, the poor have been served, albeit by a nonsystem of care. All sources of support for this service are now at risk.

A review of uncompensated care for the poor reveals that academic medical centers contain 5% of the nation's hospital beds, yet provide 50% of uncompensated care. Hospitals, especially academic medical centers, consciously segregated funds for care of the poor. As the process of reevaluation and planning for the future continues, it seems naive to think that this historic mission of medical centers will continue unabated. If this traditional policy is to continue, there must be a conscious determination to enlist, or require MCOs to support, a social agenda.

Many of the previously existing informal supports for poor, undocumented people and the unemployed will be made unworkable by the spread of self-contained managed care arrangements that have no commitment to social responsibility. Managed care plans limit their coverage and obligations to their "covered lives," or to the patient panel for whom they have contracted to provide care. The notion that there are others not within the terms of the contract, for whom MCOs might have responsibility, is foreign to this negotiated patient panel.

As the nation moves toward 42 million uninsured people who have no clear access to care, and as managed care plans acquire an ever larger percentage of employed people, there must be some shift in the responsibility for the general health of the nation's citizens. How will these obligations be identified, and how will managed care, a monolithic term that reflects a myriad of financial and organizational structures, be directed to discharge this responsibilities?

Ethics and Cost Control

Managed care organizations must also evaluate their place in the nation's plan for research and for the training of new physicians. One of the heartening results of the shift to managed care has been the new emphasis on training primary care physicians. Despite the reluctance among specialty training and fellowship programs to acknowledge the oversupply of specialists, it has been clear for some time that the surplus of specialists adds to the cost of care without providing any particular benefit to the aggregate health of the population.

Primary care is cheaper and if it helps to control costs, it might make it more likely that access to care could be extended to the uninsured. But new primary care training programs will need to be established where the focus of care is—in managed care organizations. Training is expensive and requires faculty to teach and supervise trainees. Some proportion of these expenses should be borne by MCOs.

Some issues about the extended responsibility of managed care can be examined on the macro-organ-

ization level rather than through the lens of physician practice patterns. For example, what percentage of profit is fitting for an MCO that operates as a health provider organization? Is there really a difference in care delivered by academic medical centers, physician provider organizations, and for-profit companies? Do physician behaviors differ in meaningful ways in all three? Do the contract relationships and leadership of an MCO make a difference to the patients and families under its care? Do organizational arrangements affect quality of care, access to care, and outcomes of care? And do profits for shareholders siphon off funds needed for patient care?

These are all questions to which there are answers. Health systems researchers are capable of designing protocols that can produce data on these and other questions. These data can be the basis for analysis and discussion. The critical factor will be whether MCOs would be willing to participate in these sorts of studies. Their obligations to the welfare of citizens demands their participation in broad population-based studies on effectiveness of outcomes.

Some data seem to indicate there is no difference in outcomes between patients in MCOs and those in standard fee-for-service indemnity plans. But these conclusions are based on old studies that charted the performance of an HMO world that has long since disappeared.

Access to Care

Managed care could be justified by theories of the just distribution of medical resources and fair rationing if it turns out that society as a whole will benefit from the cost-conscious savings of care plans. Justice may be satisfied if the diminution of service for any particular patient is balanced by the increase in access for all.

This extension of access was certainly the basic strategy of the Clinton managed care health reform program. However, managed care is far less likely to increase access in the unbridled market that is now evolving. Under the present conditions it is equally (if not more) likely that savings will be channeled into the pockets of large employers who negotiate the best contracts and to the profits of the managed care owners or stockholders. Given the proposed changes in Medicare and Medicaid, the prospect of block grants to the states, and the recent data demonstrating increases in the number of uninsured people, managed care may signal a new and radical decrease in the access of poor people to medical care.

In the abundant past, medical providers, clinics and hospitals that cared about the poor and underserved

had numerous ways of meeting their self-assessed responsibilities. There was expendable income sufficient to support generous allocations to provide for the needs of the medically indigent. This is no longer the case.

In recent decades money from private and public sources has been used for several social purposes: (1) care for the poor—including free, discounted, or subsidized care and nonreimbursable or enhanced service packages—over and above that which would be supported; (2) education of house staff and fellows; and (3) research. The total dollars spent annually on each of these goals may not yet be known but could, theoretically, be reconstructed to serve as a baseline for the sorts of expenditures that were considered important when funds were easily available. Some proportion of these expenses should be assumed by MCOs.

Conclusion

The social mission of medicine will not retain its traditional appearance. The question is not *if* it will change, but *how* it will change. A conscious and thoughtful process that acknowledges the ethical responsibility of managed care institutions will permit an honest discussion of the role of these organizations in the healthcare plans of the nation.

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1. Woolhandler S, Himmelstein D. Extreme risk: The new corporate proposition for physicians (editorial). *N Engl J Med* 1995;333:1706-1709.
2. Weston B, Lauria M. Occasional notes: Patient Advocacy in the 1990s. *N Engl J Med* 1996;334:543-544.
3. Dubler NN, Marcus LJ. *Mediating Bioethics Disputes: A Practical Guide*. United Hospital Fund of New York, 1994.
4. American Hospital Association. *Managing Conflict in Health Care Organizations: A Handbook*. American Hospital Association, 1995.

CME QUESTIONS: TEST #029604

Instructions

After reading the article "Ethics in Managed Care," select the best answer to each of the following questions. In order to receive 1 CME credit, at least 7 of the 10 answers must be correct. Estimated time for this activity is 1 hour. CME credits are distributed on a yearly basis.

1. Managed care presents ethical problems for physicians because:

- a) they are confronted with problematic situations that look like questions of dual loyalty
- b) they are challenged to demonstrate that commitment to patient good is their prime motivation
- c) patients no longer assume that suggestions for care focus exclusively on the best possible outcome
- d) patients are aware that physicians operate under plans that provide incentives and disincentives for levels of usage
- e) all of the above

2. Since its inception in the 1960s, medical ethics has focused largely on:

- a) physicians' rights and privileges
- b) the role of hospital administrators
- c) the rights of patients and the obligations of individual care providers
- d) the role and responsibility of federal and state government
- e) the legal responsibilities of large insurance companies

3. Scholarly commentary on medical ethics has been contributed by all except:

- a) philosophers
- b) physicians
- c) theologians
- d) hospital administrators
- e) lawyers and judges

- 4. In the past, ethical decisions were made only by:**
- a) the doctor, patient, and/or patient's family members
 - b) hospital administrators
 - c) tertiary care providers
 - d) the patient
 - e) ethics committees

5. Managers in managed care organizations (MCOs) exist to:

- a) establish patterns of practice to accommodate the priorities of the MCO
- b) provide the best possible medical care
- c) maintain the priority of the patient at all costs
- d) comply with legislative rulings
- e) ensure quality medical practices

6. Ethical obligations incumbent on MCOs include all except:

- a) scrutinizing demands on physicians to ensure the financial bottom line does not compromise patient care
- b) reviewing individual care plans to ensure undue hardship is not imposed on patients and families
- c) instituting a system for mediating differences with patients and family members
- d) building in flexibility in acute and tertiary care contracts to protect the interests of patients
- e) maintaining quality medical practice

7. In addition to worrying about access to care and disclosure of treatment options, patients are anxious about more narrow concerns such as:

- a) their right to privacy
- b) if their preferred physician is in their HMO network
- c) the medical qualifications of participating physicians
- d) if the physician will take the extra time needed to work with chronically ill, elderly, or disabled patients
- e) how benefits change from year to year

(CME QUESTIONS CONTINUED ON PAGE 450)

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| <p>AMA/CME TEST FORM AJMC Test #029604</p> <p>Ethics in Managed Care</p> <p><i>Application for 1 Credit Hour of AMA Category I</i></p> <p>(Test valid through April 15, 1997 No credit will be given after this date.)</p> | <p>Please circle your answers:</p> <p>1. a b c d e</p> <p>2. a b c d e</p> <p>3. a b c d e</p> <p>4. a b c d e</p> <p>5. a b c d e</p> <p>6. a b c d e</p> <p>7. a b c d e</p> <p>8. a b c d e</p> <p>9. a b c d e</p> <p>10. a b c d e</p> | <p>(PLEASE PRINT CLEARLY)</p> <p>Name _____</p> <p>Address _____</p> <p>City _____</p> <p>State/Zip _____</p> <p>Phone # _____</p> <p>Please enclose a check for \$10, payable to American Medical Publishing, LLC, and mail with this form to:</p> <p style="text-align: center;">The AJMC CME Test American Medical Publishing 322-D Englishtown Road, Suite 101 Old Bridge, NJ 08857</p> |
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CME QUESTIONS: TEST #029604

(continued from page 448)

8. Before the advent of managed care, healthcare for indigent patients was delivered by:

- a) academic medical centers only
- b) informal networks of public and private hospitals and academic medical centers
- c) public hospitals, primarily
- d) volunteer physicians
- e) privately financed clinics

9. Care for the uninsured and underinsured has been financed until now by all except:

- a) Medicaid and Medicare
- b) funds for graduate medical education
- c) state plans for cross-subsidization
- d) federally run clinics
- e) profits from medical institutions

10. Questions about the extended responsibility of managed care on a macro organization level include all except:

- a) are physicians being properly trained?
- b) what percentage of profit is fitting for an MCO?
- c) is there a difference in care delivered by academic medical centers, physician organizations and for-profit companies?
- d) do contract relationships and the leadership of an MCO make a difference to patients?
- e) do organizational arrangements affect the quality, access, or outcomes of care?

PROGRAM EVALUATION

Albert Einstein College of Medicine & Montefiore Medical Center would like to have your opinion. Would you please fill out the questionnaire below, tear off along the dotted line, and mail to Albert Einstein College of Medicine & Montefiore Medical Center, Office of Continuing Medical Education, 3301 Bainbridge Avenue, Bronx, NY 10467. We thank you for your evaluation, which is most helpful.

On the whole, how do you rate the information presented in the article?

___ excellent ___ good ___ fair ___ poor

Is the information presented useful in your practice?

___ yes ___ no

Comments: _____

Do you have recommendations to improve this program?

___ yes ___ no

Comments: _____

Were any portions of this program unsatisfactory or inappropriate?

___ yes ___ no

If so, which? _____

Do you find the information presented in these articles to be fair, objective, and balanced?

___ yes ___ no

Is there subject matter you would like included in the future?

___ yes ___ no

Comments: _____

In your opinion, were the authors biased in their discussion of any commercial product or service?

___ yes ___ no

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Program Evaluation _____

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