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SCOPE NOTE 31

Managed Health Care: New Ethical Issues for All

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Changes in the way that health care is perceived, delivered, and financed have occurred rapidly in a relatively short time span. The 50-year period since World War II encompasses enormous growth in medical technology, soaring health care costs, and significant fragmentation of the two-party patient-physician relationship. This relationship first grew to include the third-party payer, the health insurance industry, and now "with great speed and relatively little awareness, a significant change has occurred in the way some decisions are made about a patient's medical care" (III, Institute of Medicine 1989).

The new means of providing health care bring an increasing number of parties into clinical decision-making processes. With this change, ethical issues that once concerned only health care professionals, the physician or the nurse, have expanded to include patient and the groups who "manage" care—e.g., health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service groups (POSs), independent practice associations (IPAs), insurance reviewers, hospital institutional managers, and, the most recent purchasers of group health care who base their decisions on competitive pricing.

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The term “managed care” refers to a variety of continually adapting and developing arrangements that involve four groups. These groups, which have been labeled by the world of business, not health, are the “consumer” (once the patient), the “provider” (the physician and other health care professionals), the “insurer” (the reimburer for any care), and the “purchaser of care” or the primary buyer of health services (the large employer organization). Capitation is a common way to pay for health services in managed care systems. A certain dollar amount is negotiated for health services for a specified number of patients whether the care is delivered or not; the provider shares with the insurer any financial risk for the actual cost of care (III, Centers for Disease Control (U.S.) 1995).

When the Clinton administration’s health care reform movement failed to gain support in the U.S. Congress, the use of managed care to control rising health care costs accelerated. The literature on managed care and its effect on the patient-physician relationship reflects this shift. During the era of health care reform, “debate centered on how managed care could control costs, on the use of technology and patient satisfaction, [and] on access and barriers to care” (IV, Emanuel and Dubler 1995). When managed care organizations began contracting with physicians to provide health care services subject to the plans’ provisions, these plans became agents in clinical decision making on a wide-spread basis. HMO enrollment grew to 51 million persons by 1994 (III, Centers for Disease Control (U.S.) 1995). This “corporatization” of health care has sparked a plethora of articles about the effects of the marketplace on the physician’s ability to do what

is best for the patient, and on the patient’s ability to trust the physician to do so.

Many authors make it clear that managed care itself is not the problem, but rather the development of for-profit managed care plans by “corporate conglomerates with billions of dollars in assets that compensate their executives as grandly as basketball players” (V, Kassirer 1995) “in a marketplace that is largely unregulated” (I, Zoloth-Dorfman and Rubin 1995). “Some, mostly older plans that were created when cost containment was an unexpected benefit rather than their central purpose, deliver high-quality care economically. Unfortunately, others cut costs by recruiting the healthiest patients, excluding the sickest, rationing care by making it inconvenient to obtain, and denying care by a variety of mechanisms” (V, Kassirer 1995).

These cost-containment features now play an intimate role in clinical practice. When a managed care plan contracts with a physician, the doctor becomes a “double agent” with contractual obligations to the plan to provide a preset amount of services and professional responsibilities to each patient to authorize necessary treatment (V, Angell 1993). This duality can undermine the physician’s fiduciary responsibility to the patient wherein the physician “has power over the affairs of [the patient] . . . and is required by law to act on that person’s behalf” (I, Rodwin 1995).

Some see the physician as being placed in a vulnerable position by this duality. “The increasing prominence of managed care arrangements has created new opportunities for economic discrimination against physicians . . . Physicians who meet their professional obligations and act as patient advocates risk deselection; failure to actively oppose utilization review denials may result in a malpractice lawsuit from the patient” (V, Fielder 1995). Articles address the issue of physicians who attempt both to fulfill their fiduciary responsibilities and to retain their jobs by “gaming the system” —i.e., presenting clinical data in such a way that the patient’s treatment will be covered. “When careproviders anticipate that an appeal for exceptional care will not succeed, they may consider altering the information that they provide to the MCO [managed care organization]

if this would enable the patient to receive additional care” (V, Howe 1995). This is an uneasy compromise at best. While some see such practices as consistent with nonabandonment of the patient, “gaming can violate the principles of nonmaleficence, of veracity, and of justice” (V, Morreim 1995).

“In the vastly more complex present and future, the physician’s obligations to the patient can no longer be a single-minded, unequivocal commitment, but rather must reflect a balancing. Patients’ interests must be weighed against the legitimate competing claims of other patients, of payers, of society as a whole, and sometimes even the physician himself” (V, Morreim 1995).

An expanded view of the patient-physician relationship is derived from the notion of “shared decision making” for informed consent set forth in the 1982 report *Making Health Care Decisions* by U.S. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. “Shared decision making requires participation of the patient in setting the goals and methods of care and, therefore, in formulating the alternatives to be considered” (IV, Whitbeck 1995).

Patient participation has become a focus in the development of clinical outcome measures (I, Sharpe and Faden 1996; I, Stewart et al. 1995), and some managed care organizations are actively including patients in their reviews of programs and services (III, Jacobs Institute of Women’s Health 1996). Many see these developments as positive aspects of managed care and propose that another, institutional, level of fiduciary responsibility be added so that patient participation in outcome assessment may have the opportunity to grow and flourish at the same time as patients and physicians are protected. “Medical ethics must stop being case oriented and become institutionally oriented . . . we must change our focus from articulating principles and rules that apply to individual cases to devising institutional structures that can ensure ethical behavior” (II, Emanuel 1995).

The move to develop institutional ethics is being addressed on many fronts. Specialty organizations, such as the American College of Obstetricians and

Gynecologists, are issuing position papers on the ethics of managed care (III, ACOG 1996). Bioethics groups are developing guidelines to be used when consulting with managed care organizations (II, Biblo et al. 1995). In addition, the American Medical Association (AMA) continues to develop its position paper “Ethical Issues in Managed Care” and has assured members that it will stand behind any physician who comes into conflict with a managed care organization by advocating for patients.

Well-defined institutional ethics can be seen as supporting the managed care organizations themselves in addition to patients and physicians. “The change to managed care might be less threatening if the decisions of managed care plans are perceived to be rational, fair, and respectful of provider and patient needs . . . managed care organizations without a commitment to ethics will not survive in the marketplace” (II, Biblo et al. 1995) In addition, development of organizational ethics for managed care may help to protect institutions that are in transition themselves. “The conversion to managed care has the potential to squeeze hospitals so badly that they will no longer be able to support research or education adequately, fund the debt service on their capital loans, or provide many community services, such as free care for the uninsured” (V, Kassirer 1995).

It is hoped that this Scope Note will provide an introduction to the ethical issues raised by managed care as these programs grow in importance into the new century—issues that go beyond the pros and cons of managed care itself. “Perhaps the most positive consequence of medicine’s economic revolution is that it forces us not only to reevaluate our economic arrangements, but to examine basic ideas about medical ethics that should have been reconsidered long ago, quite apart from any connection with economics” (V, Morreim 1995).

I. GENERAL LITERATURE

Chervenak, Frank A., and McCullough, Laurence B. **The Threat of the New Managed Practice of Medicine to Patient’s Autonomy.** *Journal of Clinical Ethics* 6(4): 320-23, Winter 1995.

Using the elimination of routine ultrasound

screening for pregnant women as an example of “an assault on the essential exercise of [patient] autonomy,” the authors hold that the physician “should never practice below a standard based on both beneficence and the essential exercise of autonomy.” If a cost-benefit analysis is tied only to beneficence, this combination creates a “resurgent paternalism as a basic, and until now hidden, ethical feature of the new managed practice of medicine.”

Fischer, Josef E. **Ethical Dilemmas in Managed Care.** *Bulletin of the American College of Surgeons* 80(11): 11-25, November 1995.

Fischer thinks that certain assumptions are made when managed care issues are discussed, namely, that quality will be constant, physician assistants will diagnose as competently as physicians, generalists are as competent as specialists, and full-time employees will act as professionals. He says physicians have always acted as patient advocates, but that managed care utilization review is performed by others who have no personal contact with patients. He presents three court cases concerned with the patient-physician relationship and concludes that patient advocacy is a principle that must be constant for physicians.

Harris, Edward. **The Mirage Called Choice.** *Health Care Analysis* 3(3): 185-89, August 1995.

Harris says “the promise of choice is perhaps the most seductive element in the propaganda for commercial medicine.” The patient cannot realistically make an informed choice, nevertheless, business promotes self-interested choice as both rational and virtuous. Harris thinks that to apply commercial principles to the provision of medical care abandons the idea of service—i.e., “the sense of equitable provision of proper care according to need.” He concludes that medical markets do not maximize real choice.

James, Tom, and Nash, David B. **Health Maintenance Organizations: A New Development or the Emperor’s Old Clothes?** In *Readings in American Health Care: Current Issues in Socio-Historical Perspective*, ed. William G. Rothstein, pp. 266-77. Madison: University of Wisconsin Press, 1995.

Reviewing the history of prepaid health plans in the United States from the 1920s to the present, the authors pay particular attention to the effect of the Health Maintenance Organization Act of 1973 on the growth of managed care. The authors also describe various models of managed care plans and conclude that “health care can be provided in an accountable format, giving greater benefits to a larger number of people than under the previous fee-for-service system”.

Managed Care. *Trends in Health Care, Law & Ethics* 10 (1/2) [Special Issue], Winter/Spring 1995. 143 p.

This special issue contains more than 25 articles on ethical issues raised by managed care. Some authors focus on philosophical issues, such as the nonabandonment of patients and the patient-physician relationship, while others examine the effects of managed care on clinical practice in rehabilitative medicine, urology, and geriatrics. Also addressed is the integration of ethics programs into managed care organizations.

Miles, Steven H., and Koepp, Robert. **Comments on the AMA Report “Ethical Issues in Managed Care.”** *Journal of Clinical Ethics* 6(4): 306-11, Winter 1995.

The authors provide an historical overview of the Federal Trade Commission’s allegations in the late 1970s that the AMA conspired “to inhibit the growth of health maintenance organizations (HMOs) in part by the use of its ethics standards.” They claim that the AMA’s Council on Ethical and Judicial Affairs “should have more fully disclosed the constraints and influences [of the FTC order] on its analysis and described how it managed these pressures in writing [its] report” *Ethical Issues in Managed Care*.

Morreim, E. Haavi. **Lifestyles of the Risky and Infamous: From Managed Care to Managed Lives.** *Hastings Center Report* 25(6): 5-12, November-December 1995.

Describing a trend toward a patient’s responsibility for maintaining good health and helping to pay for care costs, Morreim notes that developed managed care programs try to reduce

the health risks of enrollees, thus lowering health care risks for the provider and insurer. Patients will be charged or rewarded with financial incentives directly related to their behavior. The author discusses legal, medical, and economic enforcement of patient responsibilities as a way to ensure that all within the health care system (payers, providers, and patients) “use its resources more wisely”.

Moss, Mae Taylor. **Principles, Values, and Ethics Set the Stage for Managed Care Nursing.** *Nursing Economics* 13(5): 276-84, 294, September-October 1995.

Moss stresses the importance of ethics education in preparing health care professionals for decision making in managed care environments, which intensify existing ethical issues and generate new ones. She predicts that a “massive effort on the part of health care decision makers” will be required to ensure universal coverage and quality care in a capitated system.

Pellegrino, Edmund D. **Interests, Obligations, and Justice: Some Notes Toward an Ethic of Managed Care.** *Journal of Clinical Ethics* 6(4): 312-17, Winter 1995.

Pellegrino comments on both the AMA’s *Ethical Issues in Managed Care* statement and its critique by Miles and Koepf. In the process, Pellegrino clarifies his position on resource allocation quoted in the AMA statement. He reaffirms the primacy of the physician’s responsibility to individual patients (commutative justice), but says that “this cannot exist apart from a more comprehensive ethic of managed care that would include an ethic of the collective, corporate, and societal obligations to the care of the sick as well.” He goes on to enumerate six principles of a “corporate ethic of managed care”.

Pellegrino, Edmund D. **Words Can Hurt You: Some Reflections on the Metaphors of Managed Care.** *Journal of the American Board of Family Practice* 7(6): 505-10, November/December 1995.

Pellegrino decries the use of phrases, such as case managers, fundholders, gatekeepers, or clinical economists, that replace the “honorable title of ‘physician’”. He says that managed care

and managed competition “deliberately set out to change physician behavior by incentives and disincentives.” He urges physicians to remain stewards of the physician-patient relationship and to guarantee quality care.

Petchey, Roland. **General Practitioner Fundholding: Weighing the Evidence.** *Lancet* 346(8983): 1139-42, 28 October 1995.

Britain’s National Health Service has instituted fundholding, a practice that allocates money directly to certain practitioners to purchase services for patients. Petchey raises questions about the impact of fundholding on efficiency, planning, and the doctor-patient relationship, and about its consequences for the organization and culture of primary care.

Plows, Charles W. **A Response to “Comments on the AMA Report ‘Ethical Issues in Managed Care’”.** *Journal of Clinical Ethics* 6(4): 318-19, Winter 1995.

As chairman of the Council of Ethical and Judicial Affairs of the American Medical Association, the author responds to Miles and Koepf’s claim that a Federal Trade Commission (FTC) order in the 1970s limits the scope of the Council’s report *Ethical Issues in Managed Care*. Plows says that “. . . the restrictions of the FTC played no significant role in the Council’s analysis, and did not inhibit the ability of the Council to fulfill its charge of elaborating and upholding the principles of medical ethics.”

Rimler, George W., and Morrison, Richard D. **The Ethical Impacts of Managed Care.** *Journal of Business Ethics* 12(6): 493-501, June 1993.

Reminding readers that the roots of managed care go back to the 1970s, this article provides an overview of the development of managed care plans and reviews the findings of the 1989 Institute of Medicine (IOM) study *Controlling Costs and Changing Patient Care? The Role of Utilization Management*. The authors draw a distinction between the “contractual and managed care issues” that were raised in the IOM report, and they question the efficiency of several cost control mechanisms from a business perspective.

Robinson, James C., and Casalino, Lawrence P.

The Growth of Medical Groups Paid Through Capitation in California. *New England Journal of Medicine* 335(25): 1684-87, 21 December 1995.

Robinson and Casalino studied patient enrollment, capitation and other revenue, and work schedules of six large, independent medical groups. They found these independent physician groups differed from staff-model HMOs in the way that they faced challenges related to continuing rapid growth and financial stability.

Rodwin, Marc A. **Conflicts In Managed Care.** *New England Journal of Medicine* 332(9): 604-7, 2 March 1995.

Rodwin reviews the concept of fiduciary responsibility in health care and calls for the development of public policies to protect the patient-physician relationship by prohibiting managed care organizations from making physicians bear the financial risks of resource allocation. Rodwin also examines the hidden role of the case manager, “nonphysicians who are employed by managed-care organizations to coordinate medical care and benefits,” and suggests several ways in which they could be held accountable for their decisions.

Schreter, Robert K.; Sharfstein, Steven S.; and Schreter, Carol A. **Allies and Adversaries: The Impact of Managed Care on Mental Health Services.** Washington, DC: American Psychiatric Press, 1994. 231 p.

Clinicians and managed care executives express their ideas on providing accessible, effective, and affordable mental health care. Inpatient and outpatient services; the roles of the psychiatrist, psychologist, and social worker; as well as practice guidelines and ethical issues are each discussed from two points of view, that of the clinician and that of managed care.

Schroeder, Steven A. **Cost Containment in U.S. Health Care.** *Academic Medicine* 70(10): 861-66, October 1995.

Schroeder urges that the effects of managed care be watched for possible neglect of those persons who already do not have access to health care and for diminished employment opportunities for all health professionals. He thinks that any

savings will go to the business side of the plans—e.g., to pay shareholder dividends—and will not be used to expand services to the uninsured. Discussing adverse selection, risk adjustment, and outcomes measurement, he opines that such guiding methods in managed care will result in neglect for persons with chronic illness.

Sharpe, Virginia A., and Faden, Alan I. **Appropriateness in Patient Care: A New Conceptual Framework.** *Milbank Quarterly* 74(1): 115-38, 1996.

Following up on the RAND Health Services Utilization Study that looked at geographical variants in surgery utilization, the authors develop a framework for delineating the three sources of value that constitute “appropriateness” in patient care—the clinic, the patient, and society—and suggest that “determinations of the appropriateness of a procedure should not be regarded simply, or even primarily, as an evidentiary problem . . . but rather as a problem of values assessment.” The authors put forth this framework to help providers and plan administrators “maintain a clear distinction between the clinically nonbeneficial [procedure] and one that is simply judged not cost worthy”.

Spear, Scott. **Why There Should Not Be Health System Reform Without Legal Reform. Editorial.** *Plastic and Reconstructive Surgery* 95(4): 742-43, April 1995.

Spear calls attention to problems in the nation’s legal system, claiming that they are the same as those associated with health care: access to care, bureaucratic and administrative waste, and overall costs. He notes that the 12 percent of the gross national product (GNP) spent in 1990 on legal “care” is not too different from the 13.2 percent spent on health care and points out that approximately 2 percent of health costs include liability insurance premiums.

Stewart, Moira; Brown, Judith Belle; Weston, Wayne W.; et al. **Patient-Centered Medicine: Transforming the Clinical Method.** Thousand Oaks, CA: Sage Publications, 1995. 267 p.

The authors explore the concepts involved in patient-centered care, the inclusion of these

concepts in medical education, and research in evaluating patient-centered care. Chapters focus on such topics as the enhancement of physician-patient relationships and qualitative vs. quantitative outcome measures.

Sulmasy, Daniel P. **Managed Care and the New Medical Paternalism.** *Journal of Clinical Ethics* 6(4): 324-26, Winter 1995.

Sulmasy suggests that physicians who are uncomfortable with the current emphasis on patient autonomy experience a renewed sense of control over the clinical environment by accepting the “new role of making decisions about the allocation of funds” given to them by managed care organizations (MCO). Sulmasy calls the denial of “information that might . . . have been valuable to . . . [patients’] own deliberations” the “new medical paternalism” and proposes that “. . . cost-control can be achieved in the private sector if an MCO operates like a ‘medical kibbutz’ in which all members . . . participate actively in any decisions to eliminate tests or treatments”.

Wilder, Daniel. **Privatization and Human Rights in Health Care.** In *Health Care Reform: A Human Rights Approach*, ed. Audrey R. Chapman, pp. 263-73. Washington, DC: Georgetown University Press, 1994. 314 p.

Wilder says that once health care providers are “released from their community mission and encouraged to pursue private ends” some may become more efficient, but others will try to select patients in order to avoid those who need expensive care. He thinks that plans that “wear the clothing of the market place” will generally conflict with human rights.

Zoloth-Dorfman, Laurie, and Rubin, Susan. **The Patient as Commodity: Managed Care and the Question of Ethics.** *Journal of Clinical Ethics* 6(4): 339-57, Winter 1995.

The authors, who serve as ethics consultants to a health maintenance organization and several hospitals, present numerous examples of poor clinical care received by patients under managed care and narratives of frustrated providers who are prevented from giving what they believe to be adequate care due to plan limitations. This article also contains historical anecdotes about

early models of not-for-profit managed care.

II. INSTITUTIONAL ETHICS

Barr, Donald A. **The Effects of Organizational Structure on Primary Care Outcomes Under Managed Care.** *Annals of Internal Medicine* 122(5): 353-59, 1 March 1995.

Barr reviews literature describing the relationship between the organizational structure of managed care systems and the quality of care within them. He finds that large organizations present problems in satisfaction for both patients and physicians and notes that costs increase as the organizations grow larger. He suggests further studies to ascertain the size at which a practice group achieves not only cost effectiveness but also patient and physician satisfaction.

Biblo, Joan D.; Christopher, Myra J.; Johnson, Linda; and Potter, Robert Lyman. **Ethical Issues in Managed Care: Guidelines for Clinicians and Recommendations to Accrediting Organizations.** Kansas City, MO: Midwest Bioethics Group, 1995. 24 p. Also published as a supplement to *Bioethics Forum* 12(1), Spring, 1996.

Noting that “. . . hospitals had been motivated to create internal mechanisms for dealing with ethical issues because of . . . organizational ethics standards promulgated by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO),” the authors have developed guidelines to be used by health care professionals and plan administrators for incorporating ethics into managed care organizations. Using focus groups of managed care administrators, physicians, and consumer groups to determine the issues to be addressed, the guidelines consider the factors involved in the creation of an ethical corporate culture, in the specification of quality-of-life criteria, and in the allocation of resources.

Emanuel, Ezekiel J. **Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases.** *Journal of Clinical Ethics* 6(4): 335-38, Winter 1995.

Since “the physician-patient interaction no longer occurs in a practitioner’s office in which

. . . [the practitioner] has control over the structures that influence the interaction,” the author suggests that “the context of medical ethics can no longer be cases, but institutional structures.” Emanuel calls situations in which there are financial incentives to provide fewer services “conflicts of omission” and discusses the implications of this type of conflict of interest for disclosure of information to patients and for patient autonomy.

Scott, Robert A.; Aiken, Linda H.; Mechanic, David; and Moravcsik, Julius. **Organizational Aspects of Caring**. *Milbank Quarterly* 73(1): 77-95, 1995.

The authors suggest ways in which the administrative organization of medical services might promote or inhibit expressions of caring by physicians and other medical personnel. They discuss issues of productivity and cost constraints and stress the importance of time spent in the relationship between patients and those caring for them. Saying that “medicine is a multifaceted practice” that has “scientific and economic aspects and must be related to societal needs as well,” the authors conclude that medicine is “fundamentally the art of healing,” which “may be the last real ethical frontier”.

Yentis, S. M. **Bad Research Is Not Audit [Letter]**. *Lancet* 347(8997): 330, 3 February 1996.

In a letter to the journal editors, the author observes that clinical outcome measures are being determined by peer-review procedures (audits) rather than by traditional research methods. Yentis fears that data from these inappropriate audits, originally intended for quality assurance, “lack ethical approval, standardization of management, randomisation, [and] blindness” and possibly will be used to change practice parameters. The author advises that “calling a project an audit should not be an excuse for avoiding ethics committee approval and doing research ‘on the cheap’”.

III. ORGANIZATIONAL REPORTS AND STUDIES

ACOG. American College of Obstetricians and Gynecologists, Committee on Ethics. *Physician*

Responsibility Under Managed Care: Patient Advocacy in a Changing Health Care Environment. [Position Paper 170.] Washington, DC: American College of Obstetricians and Gynecologists, April 1996. 5 p.

This paper addresses fiduciary beneficence, patient autonomy, “economic credentialing” of physicians (where the physician is judged not by clinical performance but by the amount of money spent on patients), and disclosure of treatment options to patients in managed care environments. The committee recommends that obstetrician-gynecologists become members of managed care boards in order to influence policy directives and quality assurance procedures.

American Medical Association. *AMA Calls on Managed Care Providers to Cancel Gag Clauses and Submit Contracts for Ethical Review [News Release]*. Chicago: American Medical Association, 23 January 1996.

The AMA Council on Ethical and Judicial Affairs issued a statement calling for an end to “gag” clauses in physician contracts with managed care plans that prevent doctors from telling patients about potential treatment options. The organization offered to review managed care contracts at no charge and also promised to support physicians who provided full disclosure to their patients despite plan provisions. The Council’s statement will be published as part of the *Code of Medical Ethics Reports* in June 1996.

American Medical Association, Council on Ethical and Judicial Affairs. **Ethical Issues in Managed Care**. *Journal of the American Medical Association* 273(4): 330-35, 25 January 1995.

Adopted by the American Medical Association’s House of Delegates in June 1994, and subsequently revised to include peer-review comments, this report broadens the scope of the AMA’s previous report *Financial Incentives to Limit Care: Financial Implications for HMOs and IPAs*. Reaffirming that “physicians must continue to place the interests of their patients first,” the report “recommends measures to preserve the fundamental duty of physicians as patient advocates by reducing the risk of rationing and inappropriate financial incentives.” (See also I, Miles and Koeppe 1995 and I,

Pellegrino 1995.)

American Medical Association, Council on Ethical and Judicial Affairs. **Financial Incentives to Limit Care: Financial Implications for HMOs and IPAs.** In *Reports of the Council (No. 28)*. Chicago: American Medical Association, June 1990. 15 p.

The Council analyses the ways in which the organizational structures of managed care plans are distinct from fee-for-service systems and discusses the potential effects of financial incentives on quality of care and physician autonomy.

American Psychiatric Association. Council on Psychiatry and Law. **The Professional Responsibilities of Psychiatrists in Evolving Health Care Systems.** Washington, DC: American Psychiatric Association, 1995. 14 p.

Although not official policy of the American Psychiatric Association, this resource document was approved by its Board of Trustees in 1995 and outlines the principles of psychiatric practice that the Association deems necessary to preserve in any new health care system. Four principles are discussed: fiduciary obligations to patients, patient participation in health care decisions, access to appropriate psychiatric care, and quality of care. The paper also discusses physicians' responsibilities to their patients, including: the responsibility to disclose information to patients, the need to appeal on the patient's behalf if care is denied, and further responsibilities if coverage is denied.

Centers for Disease Control and Prevention (U.S.). **Prevention and Managed Care: Opportunities for Managed Care Organizations, Purchasers of Health Care, and Public Health Agencies. Recommendations and Reports.** *Morbidity and Mortality Weekly Report* 44(RR-14): 1-12, 17 November 1995.

A Managed Care Working Group set up in 1995 prepared this Centers for Disease Control and Prevention (CDC) report, which presents a summary of the systems for the finance and delivery of health care and looks at ways that preventive health care can be included by managed care organizations in order to improve public health.

Institute of Medicine, Committee on Technological Innovation in Medicine. **Technology and Health Care in An Era of Limits.** Volume 11 in the series *Medical Innovation at the Crossroads*. Ed. Annetine C. Gelijns. Washington, DC: National Academy Press, 1992. 283 p.

The Committee looks at the likely implications of any restructured health care system for practitioners, patients, and the generators of new medical technology. Managed care systems both proposed and in place throughout the world were studied, and cost containment policies reviewed. Speculation about the implications of the systems for patients and providers, as well as for those involved in the development of drugs, medical devices, and surgical techniques, are discussed.

Institute of Medicine, Committee on Utilization Management by Third Parties. **Controlling Costs and Changing Patient Care? The Role of Utilization Management.** Ed. Bradford H. Gray and Marilyn J. Field. Washington, DC: National Academy Press, 1989. 312 p.

The Committee traces the evolution of utilization review and its effect on health care services and clinical decision making. This report includes an appendix on the assessment of quality assurance in health maintenance organizations.

Jacobs Institute of Women's Health. **Proceedings of Women's Health and Managed Care: Balancing Cost, Access, and Quality.** [Special Issue] *Women's Health Issues* 6(1): January/February 1996. 64 p.

Contains summaries of panels and transcripts of discussions from a July 17, 1995, conference on managed care and its potential contributions to women's health held in Washington, DC. Panels included representatives from managed care organizations, federal agencies, physician groups, and private health care foundations. Speakers focused on utilization patterns, quality assurance, and models of care in health maintenance organizations.

National Health Council. **Putting Patients First.** Washington, DC: National Health Council, 1996. 24 p.

The Council proposes ten principles governing the rights and responsibilities of patients enrolled in managed health care programs. Composed of national voluntary health care organizations, it asks the managed care industry to join in endorsing such rights and principles as informed consent, confidentiality, decision making and appeals about coverage, full information about cost, and choice of providers. Patient responsibilities include pursuit of a healthy lifestyle, full knowledge of the health plan, participation in health decisions, and cooperation in acceptable treatments.

U.S. Congress. Congressional Budget Office. *Managed Competition and Its Potential to Reduce Health Spending*. Washington, DC: Government Printing Office, May 1993. 43 p.

Managed competition is described as emphasizing motivation for “consumers, insurers, and providers to be more cost-conscious,” and “imbuing the health care system with the efficiency, flexibility and innovation of competitive markets.” The study presents different proposals to achieve savings in health care spending.

Woodstock Theological Center. *Ethical Considerations in the Business Aspects of Health Care*. Washington, DC: Georgetown University Press, 1995. 39 p.

Through two years of study and four conferences, the Woodstock Seminar in Business Ethics explored the business aspects of health care and the ethical dilemmas faced by health care professionals. This report presents an ethical framework for practice, examines specific instances in which ethical principles conflict, and calls for “. . . institutional and systemic reforms . . . [to] help create a climate that fosters rather than frustrates ethical decision making”.

IV. PATIENT-PROFESSIONAL RELATIONSHIP

Crawshaw, Ralph; Rogers, David E.; Pellegrino, Edmund D.; et al. **Patient-Physician Covenant**. *Journal of the American Medical Association* 273(19): 1553, 17 May 1995.

In this statement, the authors reaffirm the primacy of patient welfare and the physician’s role as patient advocate in the face of threats from “for-profit forces [that] press the physician into the role of commercial agent to enhance the profitability of health care organizations.” The authors call for all health care providers, professional societies, and health care organizations to participate in the “covenant of trust with patients” in order to maintain the integrity of the medical profession.

Emanuel, Ezekiel J., and Dubler, Nancy Neveloff. **Preserving the Physician-Patient Relationship in the Era of Managed Care**. *Journal of the American Medical Association* 273(4): 323-29, 25 January 1995.

To provide a context for discussing the impact of managed care on clinical ethics, the authors propose an ideal physician-patient relationship to be used as a normative standard for assessing medical care. This ideal consists of six C’s: choice, competence, communication, compassion, continuity, and (no) conflict of interest. The authors enumerate potential advantages and disadvantages to maintaining each of these qualities within plan environments, and they suggest some practical steps to eliminate the threatening aspects of managed care.

Glass, Richard M. **The Patient-Physician Relationship: JAMA Focuses on the Center of Medicine**. *Journal of the American Medical Association* 275(2): 147-48, 10 January 1996.

Saying that the patient-physician relationship is “under siege” both from the “tension between the science and the art of medicine” and from the “rapid changes in economics,” Glass urges scientific studies of the communication between patients and doctors and the behavior of the physicians. He fears that trust is threatened by reliance on technology and by economic considerations.

Mehlman, Maxwell J., and Massey, Susan R. **The Patient-Physician Relationship and the Allocation of Scarce Resources: A Law and Economics Approach**. *Kennedy Institute of Ethics Journal* 4(4): 291-308, December 1994.

The authors maintain that legal precedents

support and preserve trust in the patient-physician relationship, and they discuss the relative merits of contract, tort, and fiduciary law in this regard.

Mirvis, David M. **Doctor-Patient and Doctor-Patient-Society Relationships after Health Care Reform.** *Annals of the New York Academy of Sciences* 729: 56-61, 4 December 1994.

Mirvis says there has been a shift from thinking of health care as being within the purview of the individual or the employer to thinking of it as a right that changes both the role of the patient and that of the physician. The patient “assumes a role as an individual member of society at large which has its own goals and objectives.” The physician becomes an “agent of society for meeting these objectives, rather than an individual entrepreneur.” Mirvis concludes, however, that the role of the physician as the patient’s advocate remains critical.

Orentlicher, David. **Health Care Reform and the Patient-Physician Relationship.** *Health Matrix* 5(1): 141-80, Winter 1995.

The author reviews studies of patient outcomes under managed care and finds that “there are not sufficient empirical data to draw definitive conclusions about the effect on patient welfare from incentives to limit care.” Orentlicher observes that individual rationing decisions can be made appropriately when there is continuity in the patient-physician relationship, but the possibility for continuity of care is greatly undermined by managed care arrangements.

Pellegrino, Edmund D. **Allocation of Resources at the Bedside: The Intersection of Economics, Law, and Ethics.** *Kennedy Institute of Ethics Journal* 4(4): 309-17, December 1994.

Responding to Mehlman and Massey’s review of the legal aspects of the patient-physician relationship, Pellegrino provides an ethical analysis of the same issues. The author calls for the primacy of patient welfare within legal constraints and notes that this is balanced by “physicians being advocates for a just system”.

Perry, Clifton B. **Conflicts of Interest and the Physician’s Duty to Inform.** *American Journal of*

Medicine 96: 375-79, April 1994.

The author discusses standard notions of the fiduciary relationship between a physician and a patient and discusses three court cases on this issue.

Thurston, Jeffrey M. **Death of Compassion: The Endangered Doctor-Patient Relationship.** Waco, TX: WRS Publishing, 1996. 189 p.

Deploing the fact that managed care is altering the traditional doctor-patient relationship to a business transaction that usurps the physician’s decision-making power, the author sees a danger for patients when decisions about diagnosis and treatment are dictated by fiscal considerations. He urges the use of medical savings accounts to help solve the problem of rising costs and says all pre-existing conditions must be covered.

Whitbeck, Caroline. **Trust.** In *Encyclopedia of Bioethics*, revised edition, ed. Warren T. Reich, pp. 2499-2504. New York: Simon and Schuster Macmillan, 1995.

The author traces the development of the fiduciary relationship between the patient and the physician into the era of “shared decision making” and recommends institutional safeguards to protect patient-physician relationships.

V. PROFESSIONAL ISSUES

Angell, Marcia. **The Doctor as Double Agent.** *Kennedy Institute of Ethics Journal* 3(3): 279-86, September 1993.

Calling the weighing of patients’ medical needs against monetary costs to society a danger to the patient-centered ethic that is central to medicine, Angell urges restructuring the system to remove inflationary pressures. The commitment to care for individual patients should “not be abridged lightly. And it should not be nullified by a budgetary crunch”.

Arnesen, Trude, and Fredriksen, Stole. **Coping with Obligations Toward Patient and Society: An Empirical Study of Attitudes and Practice Among Norwegian Physicians.** *Journal of Medical Ethics* 21(3): 158-61, June 1995.

Arnesen and Fredriksen questioned 109 Norwegian physicians of whom 96 percent

agreed or partly agreed that setting economic priorities was necessary. Responses indicate that the physicians acted more in the interests of their patients than in the interests of society, but 68 percent had refrained from giving the best treatment because it was too costly. The authors found that 60 percent wanted more public guidelines.

Dunham-Taylor, Janne; Marquette, R. Penny; and Pinczuk, Joseph Z. **Surviving Capitation.** *American Journal of Nursing* 96(3): 26-29, March 1996.

The authors define capitation as “accepting a fixed amount of money per enrolled person per period (usually a year), and agreeing to provide some defined set of health services to all plan members with no additional billing.” They describe the steps leading to the growth of health maintenance organizations and say that nurses are at high risk during any cost cutting measures. Preventive health care is seen as an area that nurses are eminently qualified to enter.

Fielder, John H. **Disposable Doctors: Incentives to Abuse Physician Peer Review.** *Journal of Clinical Ethics* 6(4): 327-32, Winter 1995.

After describing several cases in which competent physicians were disciplined unjustly by peer review, Fielder states that “. . . what we are seeing is not just a few isolated instances of abuse of peer review but a disturbing pattern of reliance on peer review to remove unwanted doctors, frequently for underlying financial reasons.” The author reviews the lack of due process available to physicians who wish to challenge adverse peer-review decisions or deselection by managed care organizations and discusses existing case law and pending legislation aimed at safeguarding physicians who advocate for their patients.

Gold, Marsha R.; Hurley, Robert; Lake, Timothy; et al. **A National Survey of the Arrangements Managed-Care Plans Make with Physicians.** *New England Journal of Medicine* 335(25): 1678-83, 21 December 1995.

The authors surveyed 108 managed care plans, inquiring about how plan physicians were included. They found complex systems for selection, payment, and monitoring of the

chosen physicians. The article includes statistics and the methods used.

Howe, Edmund G. **Managed Care: “New Moves,” Moral Uncertainty, and a Radical Attitude.** *Journal of Clinical Ethics* 6(4): 290-305, Winter 1995.

Howe discusses the conflicts providers and patients face when they challenge a managed care organization’s decision not to provide care. The author gives specific clinical examples of “gaming the system” that simultaneously support the bond of trust between the patient and physician and undermine the physician’s duty to be truthful. The author also describes the ethical quandary involved in “implementing a so-called ‘Robin Hood solution’ by which [providers] would charge some patients more” to fund pro bono services for other clients.

Kassirer, Jerome P. **Managed Care and the Morality of the Marketplace.** *New England Journal of Medicine* 333(1): 50-2, 6 July 1995.

Affirming that “managed care itself is not the enemy,” Kassirer sees “market-driven health care” as a threat to both medical professionalism and to “superb [managed care] plans [that] are being underbid by wealthy investor-owned plans.” The author exhorts us “to persuade our leaders to speak out . . . [to] acknowledge that managing care can limit costs . . . [but] that the enormous profits of megahospital systems and huge insurance conglomerates should be used for medical care,” rather than for investor profit.

Morreim, E. Haavi. **Balancing Act: The New Medical Ethics of Medicine’s New Economics.** Washington, DC: Georgetown University Press, 1995. 184 p.

The focus of Morreim’s book is a redefinition of the physician’s fiduciary responsibility to the patient in an era of economic constraints and a reframing of the patient’s role to include an active sense of responsibility rather than a passive notion of autonomy based on freedom. The author discusses the problems inherent in developing practice parameters, the pros and cons of “gaming the system,” the physician’s obligation to negotiate with plan administrators on behalf of patients, and the physician’s responsibility to discuss with patients the

economic aspects of medical options—i.e., the actual costs to the patient plus plan limitations and physician incentives where applicable.

Pellegrino, Edmund D. **Ethics.** *Journal of the American Medical Association* 271(21): 1668-70, 1 June 1994.

The author reviews the “tangled nexus of moral, legal, economic, and professional obligations” for physicians practicing in managed care environments and holds that, even if laws are passed to protect physicians from litigation for following plan directives, “immunity to liability would not relieve physicians of their ethical obligations to the patient.” Pellegrino lists a new set of questions posed by managed care, including whether physicians are ethically bound to provide pro bono services not covered by the plan and whether plan directives found to be harmful should be met with “collective action by the whole profession to change the system”.

Wasnick, John D. **The Physician Ethic and Managed Care: Reformation Parallels.** *Pharos* 59(1): 27-28, Winter 1996.

Asking if physicians can “reconcile their ethical duty to individual patients to provide care of the highest quality with the demands of managed care trusts to maximize cost effectiveness,” Wasnick says that managed care demands that physicians “work within the limitations demanded by society.” He compares the current situation of physicians with that of the 16th century religious reformation when monastic life lessened, and religious figures entered society to combine a high religious ethic with the demands of commerce and government. Wasnick thinks that now physicians must recognize such a dual ethic.

Wolf, Susan. **Health Care Reform and the Future of Physician Ethics.** *Hastings Center*

Report 24(2): 28-41, March-April 1994.

After analyzing ethical issues relating to the then viable Health Security Act, Wolf notes that existing ethical guidelines from professional organizations focus on serving the patient versus serving social goals, when in fact the “conflict [is] between the patient and organizational goals of profit.” The author calls for clarity in delineating the ground rules as “our society is, in effect, renegotiating a key part of what many call its ‘contract’ with the medical profession.” Wolf suggests levels of physician advocacy within managed care that correspond to standard notions of the physician’s fiduciary responsibility, and she proposes adding a new level of organizational ethics to support the patient-physician relationship.

Woolhandler, Steffie, and Himmelstein, David U. **Extreme Risk—The New Corporate Proposition for Physicians.** *New England Journal of Medicine* 335(25): 1706-8, 21 December 1995.

The authors think that managed care plans that tie physicians’ incomes to curtailing service create pressures to exploit patient trust for physician financial gain. They say that the next step in such businesses will be to avoid sick patients. The authors suggest that “salaried practice in nonprofit, community-controlled regional plans” might achieve better results.

This Scope Note was prepared by Martina Darragh, M.L.S., and Pat Milmoie McCarrick, M.L.S., Reference Librarians at the National Reference Center for Bioethics Literature. The authors would like to acknowledge the assistance of Virginia A. Sharpe, Ph.D., Assistant Professor of Medicine and Ethics, Georgetown University Medical Center, in developing this publication.

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