Managed Care: Some Basic Ethical Issues

Not a few critics utter prophetic indictments against managed care organizations, programs, or plans. However, my ethical concerns are aimed at certain policies and practices in many managed care organizations (hereafter MCOs), rather than at MCOs as such. MCOs are not, I believe, inherently or intrinsically evil and unredeemable. Nevertheless, an ethical audit reveals troubling deficiencies. Many, perhaps all, are correctable, but they must be corrected before we can certify that MCOs are ethically acceptable in practice as well as in

strategy for cost containment, even though many believe that true cost containment will also require other structural changes.[2] In 1993 almost 80 percent of U.S. citizens received health care insurance through their employers, and 51 percent of those were enrolled in managed care programs, a substantial increase over the 29 percent enrolled in such programs in 1988.[3] The percentage in MCOs has continued to increase and reached 70 percent in 1995.

The term "managed care" has been used so widely and so loosely that it is now almost meaningless. It covers a diverse set of organizational and financial arrangements from tightly-bound group practice health maintenance organizations (HMOs), to looser affiliations of physicians and hospitals linked by payment formulas, to traditional forms of practice managed through mean0.0 Op(frpractart-119 (pracretegynan -9 (I(thro -9 (c(thrors) -TJ

care, incentives that create serious conflicts of interest, and by their limits on physician and patient choices, as well as by rationing health services without the kind of public accountability that justice appears to require.[4] We can begin to explore some of these basic ethical issues by considering how the shift to managed care both shapes and reflects a shift in language, especially in our metaphors for health care.

Thinking Metaphorically

We often approach health care through various metaphors, perhaps in part because it concerns fundamental matters of life and death for practically everyone but frequently in quite mysterious ways. We thus try to understand it through something less mysterious. For instance, we may view physicians as parents, or nurses as advocates, while we interpret health care itself as a war against disease. David Eerdmann suggests that imagination involves "reasoning in metaphors."[5] In each use of metaphor we see something as something else, for example, we view human beings as wolves or life as a journey.[6]

sumers, from physicians and other health care professionals to health care providers, from health care to the health care industry, from care to costs, and from the healthy patient to the healthy bottom line.

Under the market metaphor, as George Annas observes, "health plans and hospitals market products to consumers, who purchase them on the basis of price."[11] Medical care is considered a business, with marketing through advertising and competition among profit-motivated suppliers, and its central theme becomes consumer choice. The market metaphor reconceptualizes medicine—"emphasis is placed on efficiency, profit maximization, consumer satisfaction, the ability to pay, planning, entrepreneurship, and competitive models." Business ethics replaces traditional medical ethics.

Many critics of this metaphor worry that the language of efficiency will virtually replace the language of care and compassion for the sick along with equity in distribution of health care. The poor and

through product-liability suits have become essential to prevent profits from being too relentlessly pursued." When extended to health care, the market metaphor conceals many of its public aspects, and it distorts the imperfections of the medical market.

In short, both military and economic metaphors illuminate certain aspects of health care, but they may not be adequate, even together, to guide and direct health care. Whether any particular metaphor is adequate to guide our policies, practices, and actions will depend at least in part on the values it highlights and hides, such as justice, fairness, equity; care, compassion, solidarity; liberty; and, yes, efficiency. An adequate metaphor must also somehow fit our real world, at least its emergent possibilities.

We should, Annas argues, "reframe" our debate on health care reform by replacing both our dominant metaphors, which together produce a "sterile debate" and which we cannot simply combine because their entailments are largely incompatible. Indeed, he suggests, the Clinton health care plan failed in part because it tried unsuccessfully to combine these two metaphors while also introducing other metaphors. Hence, Annas claims that we cannot even begin to think seriously about health care reform without a new metaphor that can enable us to "look deeper than money and means, to goals and ends." Neither the military metaphor nor the market metaphor can suffice, because each narrows "our field of vision," and each is now

technology, acceptance of death as natural and necessary, responsibility for others, and at least some degree of community. It can also help move us from standards of medical practice determined by the law, an integral part of the market, to standards that provide a greater role for ethics and ethical behavior in the practice of medicine."[12]

Still others have proposed nursing, a subset of health care, as a metaphor for the whole of health care, because it attends to caring more than curing and to hands-on rather than technological care. While the metaphor of nursing is also inadequate by itself, it could direct the society to alternative priorities in allocating resources for and within health care, particularly for chronic care.

The process of altering sociocultural metaphors is complex and uncertain, particularly when such metaphors as warfare and business appear to be relatively accurate descriptively (that is, within limits, they illuminate how we think and act), even though they are problematic normatively (that is, they distort how we should proceed). In contrast to Annas' proposal, we can rarely totally replace dominant sociocultural metaphors. Most often we retain such metaphors for some purposes but not others. Despite their systematic entailments, metaphors never convey all of the secondary subject, such as war in "medicine is war." For instance, even when wa BT-116waroec1 t8prob-

with many of our important values, which, of course, may shift over time, at least in their salience or weights.[13]

Conflicts of Obligation, Conflicts of Interest, and Threats to Trust

Consider the following case as a way to explore some of the basic ethical issues involved in managed care. It was prepared by physician Elena Gates, who is Associate Clinical Professor of Obstetrics and

Ethical Conflicts. Some of the participants in this case worried about apparent and real conflicts of interest and conflicts of obligation. Medical fidelity or loyalty traditionally assigns priority to the patient and his/her interests in two basic ways: (1) the professional effaces self-interest to some extent (though he or she is not expected to sacrifice it altogether) in any conflict with the patient's interests, and (2) the patient's interests take priority over others' interests, such as third parties' interests. In practice, the priority of patients' interests has never been so complete. For instance, physicians are not expected to care for all patients without remuneration. And conflicts of obligation and interest are not new in medicine or in other professions. They often concern the meaning, limits, and weights of obligations of fidelity and loyalty.

Conflicts of *obligation* occur when a physician has an obligation to the patient and an obligation to persons or entities other than the patient. Such conflicts can occur in two ways. On the one hand, a physician may have an obligation to the patient and an obligation to the MCO (among other entities). These obligations to the patient and to the MCO may not in fact conflict, according to one interpretation, because the physician's contract with the MCO may specify his/her obligation to the patient so that it does not conflict with the obligation to MCO. However, in reality, especially when traditional expectations undergo change, patients may and often do believe that traditional physician obligations to patients still stand.

So there may be a conflict between traditional profession-based obligations to patients and new organization-based obligations. Similar conflicts have emerged in other organizational settings, such as the military, prisons, certain companies, and sports medicine. They also arise in the context of research and teaching and anywhere else the physician is a "double agent."[15]

On the other hand, a physician may experience a conflict between an obligation *to do X* for the patient (an implication of the traditional or customary relationship with and obligation to the patient), and an obligation *not to do X* for the patient (an implication of the obligation to the HMO). It is thus both obligatory to do X and obligatory not to do X. Here the physician faces a genuine dilemma. This second conflict of obligations frequently grows out of but is not reducible to the

first. And it may appear in certain rationing schemes adopted by HMOs.

Managed care organizations ration health care in the sense of limiting access to some forms of potentially beneficial care on the basis of cost. Rationing may occur, for instance, when a primary care provider, who serves as a gatekeeper to various forms of health care, determines that a particular patient's medical complaint does not merit referral to a costly specialist. Such a judgment may reflect the particular rationing scheme the MCO has designed to serve its own goals in health care without substantial input from physicians or patients.

Constraints on physicians' abilities to act on behalf of their

strong enough to produce desirable results may be too strong to avoid undesirable results, especially in view of the uncertainty that pervades medical practice.

Threats to Public and Patient Trust. Some forms of managed care clearly threaten public and patient trust. Trust is confidence in and reliance upon others to act within moral limits both in general and in

lations of this test require that we imagine whether our action and its rationale can pass an audience of reasonable people. Hence, Sissela Bok proposes a publicity test in determining whether the presumption against lying can be rebutted. She asks agents to consider whether an imaginary audience of reasonable people would concur with their proposed lie.[22]

Such a test is important, but it may not be sufficient. For instance, largely because of concerns about public confidence, an American College of Physicians (ACP) position paper warns against "excessive or inappropriate rewards." While encouraging professional guidelines, it allows physicians to make their own individual decisions whether to accept gifts and honoraria, but recommends that they ask themselves, in the process of making their decisions, whether they would be willing to publicly disclose their financial arrangements. Physicians do not actually have to disclose their acceptance of such gifts and honoraria to anyone—not to patients, colleagues, professional groups, or the public. The ACP merely asks physicians to imagine the public's reactions to hypothetical disclosures in deciding what is appropriate. They never have to subject their decision to an actual test of public response.[23]

Actual Disclosure. Beyond her proposed imaginary audience, Bok also recommends that we also test maxims of action by considering the responses of actual people. For both rationing plans and conflicts of interest, public disclosure and patient disclosure are essential (but again not sufficient).

The participants in the obstetrics case presented earlier were unable to reach a decision about whether to accept the offer of $1,500.00 with a goal of reducing maternal hospital stays following uncomplicated deliveries from 1.8 to 1.3 days. Some argued that such a policy, with its incentive, would have to be disclosed to patients, and yet they were not able to agree on how to explain and justify it to their patients. Having actually to explain and justify a policy or practice to some public, especially one directly affected by the policy or practice, often exposes its moral deficiencies.

In addition to disclosing the rationing scheme and conflicts of interest created by financial incentives, physicians in MCOs ought to disclose the benefits, risks, and costs of procedures that are covered as

well as any that might be beneficial to the patient, even though they are not covered in the plan, as in the following case: Two sets of materials are widely used for hip joint replacement: The more expensive one will last indefinitely, while the less expensive one will last about ten years and then need replacement. The group performing hip joint replacement surgery in one MCO is now limited to using the less expensive one that will wear out in about ten years. A physician in that MCO has to decide whether to tell a patient in her early seventies that his group uses only the inferior but less expensive materials but that another group, a few miles away, uses the superior but more expensive materials.[24]

Many MCOs have "gag clauses" in their contracts with physicians to prevent just such disclosures. According to Neil Weisfeld, deputy executive director of the Medical Society of New Jersey: "It's more like managed silence than managed care."[25] According to many physicians, these restrictions on disclosure interfere with their obliga-

The traditional medical-ethical norm of confidentiality is now invoked not to protect information about the patient, but to protect information about the MCO from the patient and others. For instance, another clause in the U.S. Healthcare contract states that the physician "shall keep the Propriety Information [payment rates, utilization review procedures, etc.] and this Agreement *strictly confidential*." This is closer to trade secrets and the like than traditional medical-ethical confidentiality. Thus, however much their language resembles traditional medical confidentiality, MCOs justify these "gag clauses" largely by invoking business protections, such as trade secrets and proprietary information. This fits with the shift from a military metaphor to a market metaphor.

By contrast to MCOs' concerns about publicity, Gerald Winslow argues, with specific reference to rationing, that the "demoralizing effect of publicity depends not so much on the practice of publicizing the rule as it does on the types of rules that are publicized. . . . In the end, we cannot eliminate many of the distressing costs of rationing medical care. But publicity should help us bear these burdens together."[30] In arguing for a publicity test—actual as well as imaginary—I do not suppose that it answers all our problems. But, whether in self-referral or in accepting financial incentives to reduce services, "secrecy increases the ethical taint."[31] In addition, when patients know about their physician's conflicts of obligation and conflicts of interest, they can take more vigorous actions, exercise legitimate options, make appeals, and so forth. It is only fair for people to know what kind of game they are playing, and it is particularly crucial to inform them when the rules of the game have changed. Disclosure is absolutely essential—morally necessary (though not morally sufficient). After all if patients have legitimate expectations about physician conduct, based on codes of medical ethics, past experiences, and so forth, then they have a right to assume that those traditional, customary obligations of fidelity and loyalty persist unless they are informed differently. Medicine has not traditionally been a matter of *caveat emptor* but of trust, and *caveat emptor* should not now reign even under the market metaphor. But when must enrollees in MCOs be informed and how?

Disclosure and Consent at the Time of Enrollment. Even though I have concentrated on physicians' obligations of disclosure in the context of managed care, nothing I have argued denies the importance of general or global disclosure at the time people enroll in particular plans. Such a disclosure should include the MCO's rationing scheme as well as its financial incentives for physicians to restrict access to medical services and procedures. In addition, it should include information about ways to appeal a physician's decision and the like.

One fundamental question concerns the moral significance of consent at the time of enrollment, based on adequate disclosure. However necessary it may be—and I certainly view it as necessary—is it also sufficient to obviate the need for physicians' specific disclosures later? First of all, although morally required, "global disclosure of rationing incentives, rules, and mechanisms . . . at the outset of enrollment . . . presently is not done, and the details of what should be disclosed still have to be worked out."[32] Second, if such disclosure occurred at the time of enrollment, would it justify some subsequent rationing decisions without additional specific disclosure about the rationing incentives, rules, and mechanisms?

Mark Hall has proposed a "theory of economic informed consent" that in either of its two forms could justify, "silent rationing," i.e., rationing that is undisclosed at the time it occurs. General or global disclosure at the time of enrollment (or re-enrollment) in a managed care plan could be viewed as (1) "prior consent to the bundle of non-treatment decisions implicit in a more conservative (i.e., cost-sensitive) treatment style," or as (2) a valid waiver of the right to subsequent specific disclosures and consent at the time of actual rationing decisions. Prior consent, which Hall also calls "bundled consent," might appear to be an attractive way to combine respect for personal autonomy, represented by prior consent, with the successful management of health care costs. And there are relevant moral and legal

"a waiver of the right to be informed when a chosen rationing mechanism denies costly treatment of marginal benefit."[33]

In either prior, bundled consent or prior waiver, some conditions need to be met. Obvious ones include adequate information and, in addition, voluntariness of choice. Hall identifies specific disclosures not only that the MCO rations health care but that physicians will not always disclose this at the time of specific decisions, that patients may ask questions at any time and that their questions will be answered thoroughly, and that some nontreatment decisions will always be disclosed be(phyng)ns .5 tednot

ence in physicians' judgments about appropriate care "at the margins, or in situations of uncertainty."

Public Policies, Professional Character, and Social Ethics

Organizational Structures and Professional Character. Financial gain is generally a motive for professional life, but it becomes sinis-

A range of non-compliant acts may express and protect an indi-

in health law and ethics today."[42] Managed care now severely threatens this metaphor. However, as Rodwin argues, the law holds physicians accountable as fiduciaries only in very circumscribed situations—mainly by prohibiting non-abandonment, and by requiring confidentiality and informed consent. The classic fiduciary relationship clearly involves considerable trust, and usually involves a disavowal, often legally enforced, of conflicts of interest. As yet, however, physicians are not subject to the conflict-of-interest prohibitions that obtain for most classic fiduciaries. "As patients," Rodwin notes, "we would like doctors to work loyally for our individual interest. That is the crux of the fiduciary metaphor. Yet the law today goes only a small way in holding doctors to fiduciary standards. There are also significant social and financial demands for doctors to serve interests other than patients," especially in the context of managed care.[43] At the very least the law should bring its requirements for physicians as fiduciaries in line with its requirements for other fiduciaries in avoiding conflicts of interest.

Constraining Choice and Limiting Access While Controlling Costs[44]

The Illusion of Choice. The market metaphor's emphasis on free choice is seriously misleading in the managed care revolution. The illusion of choice—rather than real choice—prevails. One constraint is that most individuals cannot even choose the health plan they pay for. While Americans typically choose their own home, automobile, and life insurance plan, their choices about access to health care providers and services are largely determined by their place of employment. Over seven out of ten Americans purchase health insur-

health care, even though it is purchased through their copayments, deductibles, out-of-pocket cost sharing, and foregone wages.

In short, our new world of corporate managed care threatens choice in several interconnected ways—employers limit health plans, health plans limit physicians and hospitals, employees are limited in their ability to protect their interests or find other employment, and

lating costs—while failing to attend adequately to access as well as to availability and quality. Without a societal perception of and commitment to resolve the problem of access, a less costly system will still remain an unjust system. The fact that it is less costly in no way diminishes its injustice. Managed care arrangements to control costs have their own costs, including threats to the integrity of physician-

Endnotes

1 See, for example, K. M. Langwell, V. S. Staines, N. Gordon, *The Effects of Managed Care on Use and Costs of Health Services and the Potential Impact of Certain Forms of Managed Care on Health Care Expenditures* (Washington, DC: Congressional Budget Office, 1992); A. C. Enthoven, "Why Managed Care Has Failed to Contain Costs," *Health Affairs* 12, No. 3 (1993): 27-43; R. H. Miller and H. S. Luft, "Managed Care Plan Performance Since 1980: A Literature Analysis," *Journal of the American Medical Association* 271 (1994): 1512-1519.

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16 M. A. Rodwin, *Medicine, Money, and Morals: Physicians' Conflicts of Interest* (New York: Oxford University Press, 1993), p. 9.
17 *Ibid.*, p. 135.
18 S. Woolhandler and D. U. Himmelstein, "Extreme Risk—The New Corporate Proposition for Physicians," *New England Journal of Medicine* 333 (1995): 1706-1708.
19 E. H. Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics* (Dordrecht, Netherlands: Kluwer, 1991).
20 E. Larson, "The Soul of an HMO," *Time*, Jan. 22, 1996, pp. 44-52.
21 *Ibid.*
22 S. Bok, *Lying: Moral Choice in Public and Private Life* (New York: Random House, 1978).
23 This example is drawn from M. A. Rodwin, *Medicine, Money, and Morals*, p. 134.
24 A version of this case was presented by Norman Levinsky in a conference on informed consent sponsored by the University of Pennsylvania Center for

Quarterly 71 (1993): 663.

33 *Ibid.*, pp. 645-668.

34 These are all Hall's conditions. See Hall, "Informed Consent to Rationing Decisions," p. 664.

35 See P. S. Appelbaum's objection in "Must We Forgo Informed Consent to Control Health Care Costs? A Response to M. A. Hall," *The Milbank Quarterly* 71 (1993): 669-676; and M. A. Hall, "Disclosing Rationing Decisions: A Reply to P. S. Appelbaum," *The Milbank Quarterly* 72 (1994): 211-215.

36 D. Mechanic, "Trust and Informed Consent to Rationing," *The Milbank Quarterly* 72 (1994): 217-223.

37 Woolhandler and Himmelstein, "Extreme Risk—The New Corporate Proposition for Physicians," p. 1707.

38 Rodwin, *Medicine, Money, and Morals*, pp. 137, et passim.

39 D. H. Novack, et al., "Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems," *Journal of the American Medical Association* 261 (1989): 2980-2985.

40 Woolhandler and Himmelstein, "Extreme Risk—The New Corporate Proposition for Physicians," p. 1707.

41 Rodwin, *Medicine, Money, and Morals*, p. 180.

42 See M. A. Rodwin, "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System," *American Journal of Law and Medicine* 21 (1995): 256.

43 *Ibid.*, pp. 254-255.

44 For a fuller development of the themes in this section, see C. Engelhard and J.F. Childress, "Caveat Emptor: The Cost of Managed Care," *Trends in Health Care, Law and Ethics* 10 (Winter/Spring 1995): 11-14. I am grateful to Carolyn Engelhard for her collaboration and her permission to draw from our co-authored essay.

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"Managed Care: Why, How and for Whom?"
John A. Sbarbaro, M.D., M.P.H.

"Health Care Professionalism in a New Age"
Steven Miles, M.D.

"Legal Accountability of Physicians and Health Plans:
Compassionate, Proportionate, or Extortionate?"
E. Haavi Morreim, Ph.D.

"Ethics and Managed Care"
Daniel Callahan, Ph.D.

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