IMPLICATIONS OF MANAGED CARE FOR MEDICAL ETHICS*

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INTRODUCTION
Physicians have always "managed care" of their patients by recommending appropriate diagnostic tests and treatment, referring patients to consultants or specialists, and coordinating most aspects of care. Contemporary use of the term "managed care," however, refers to procedures and systems used by third party payers, both private and government, to control payment and affect access to health care services. Managed care has already substantially affected the practices of most South Carolina physicians, and promises to become even more prominent under many of the proposals for national reform of health services financing.

This statement is a commentary on our changing professional relations, as well as an attempt to clarify ethical obligations in the evolving professional environment. Our purpose is not to judge managed care: it is now a fact of professional life, and its prevalence is increasing. Rather, our purpose is to examine the ways in which the professional relations of physicians are affected by managed care.

The introduction of new and nontraditional techniques to control finances and services has produced uncertainty in many physicians about their ethical obligations to their patients, to colleagues, to third parties, and to society. Moreover, many physicians express decreasing levels of satisfaction with their work, at least in part because of perceived loss of professional autonomy imposed by managed care.

PROFESSIONAL WORK
The motivations of physicians in choosing medicine as a career and in sustaining professional life are many. They include the rewards of service to others, the opportunity to seek new knowledge continually and apply it in clinical service, virtual assurance of more or less economic success, enjoyment of the power to help others through superior knowledge, and the rewards of prestige and status accorded physicians in our society. These motivations are present in varying mixtures in each of us, and for each of us, the proportions change at different stages of our careers. If economic success, power, and prestige are major sustaining factors, the vagaries of managed care and health services reform may toss us about unpredictably; then, the practice of medicine could become mere labor, with little of the satisfaction of earlier years. If, on the other hand, the opportunity to serve and the rewards of lifelong learning are the most important professional rewards, medicine can continue to be exciting and satisfying under almost any system of health system reform.

THE PHYSICIAN AS FIDUCIARY TO THE PATIENT
Holding the best interest of the patient as the first priority of professional life has long been part of medical ethics, and is explicitly stated in the SCMA code of ethics.1 This principle has led to such statements as: "Physicians are required to do everything they believe may benefit each patient without regard to costs or other societal considerations,"2 and "Asking physicians to be cost-conscious...would be asking them to abandon their central commitment to their patients."3

These views arise from the Hippocratic tradition of beneficence and from the belief that physicians owe special obligations to patients because patients, qua patients, are vulnerable.

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Their vulnerability arises from the association of illness with compromise of clear thinking that may distort the patient’s ordinary judgment, as well as from important differences in medical knowledge that weigh the balance of power in favor of the physician’s side of the relationship. The special obligations of physicians, not owed under general contractual circumstances, comprise a fiduciary, or trust, relationship, manifested as fidelity to the patient’s best interest.

Ordinary business ethics do not apply to the physician-patient relationship. The patient’s vulnerability requires a fiduciary commitment on the part of the physician to serve a patient’s medical interests above his own financial interests. This commitment is realized on two levels, individual and social. First, the physician must place his patient’s interests above his own. Second, the physician must place his patient’s interests above those of all others, including the interests of business, government, and society.¹

This commitment was more easily realized in the past, when retrospective reimbursement and cost-shifting allowed for a unitary approach to the delivery of health care. Recent trends in reimbursement, including capitation and managed care plans, raise important questions. How does a physician maintain fidelity to a patient under these circumstances? Does he have new responsibilities to all patients in a health plan⁷ or to everyone in society, given resource limitations? What obligations does the physician owe to the plan versus the patient?

The advent of managed care has produced potential challenges to the traditional fidelity of physicians to patients in the context of limits to care imposed against the patient’s good in favor of the good of society, the good of the health plan, and the good of the physician. Haavi Moreni has offered a proposal to clarify some of those boundaries: a divided standard of care.⁶ Physicians are held to a standard of medical expertise, which is “the level of knowledge, skill, and effort that he is expected to deliver to every patient whom he accepts for care, regardless of the patient’s income.” A second standard, the standard of resource use, “is the level of medical and monetary resources to which the patient is legally entitled…[which] is a function, not of what some physician thinks he needs, but of what care or coverage the patient or others have purchased for him.” Someone other than the physician is thus cast in the role of rationer. This division of standards should be recognized in medical ethics, by society, and in the law.

The limits to care set by society or by a health plan are likely to be ambiguous, however, so the divided standard offers little guidance to the physician in deciding whether to be an advocate for the patient or for particular interventions. Treatment options that are not beneficial to the patient need not be presented to the patient nor should they be advocated by the physician. But what of beneficial interventions? What are the physician’s obligations when a beneficial treatment is excluded by the plan? Susan Wolf has suggested an algorithm to guide the physician in informing patients and advocating on the patient’s behalf, based on whether or not the plan excludes a potentially beneficial treatment, or whether the plan gives the physician discretion in limiting care.⁷ Under her algorithm, the physician is always obligated to inform patients of potentially beneficial treatment. The obligation to be the patient’s advocate for a specific beneficial service may vary, however. We propose a modification of her algorithm to reflect advocacy obligations under varying degrees of benefit and plan designs. (Figure 1).

Fidelity to the patient’s interests extend to interprofessional relations as well. Health plans often require that consultations be sought only from specified physicians. Not all physicians are of equal ability, ranging along a spectrum from outstanding to incompetent. There are long established procedures for dealing with questions of competence, and these are not altered by managed care.⁸ Not many physicians are located at the lower end of the spectrum, but there are some, and those few may have the formal credentials to be included on a plan’s approved consultant list. If a physician has reason to doubt the competence of another physician to whom referral is mandated by the plan, his obligation to the patient requires that he not make such a referral. Health plans should have alternate referral options to anticipate and accommodate such contingencies.

Physicians must regard their own levels of compensation as well as patient services under managed care as moral issues. In such systems, scarcity and abundance of resources are shared
among patients. "Gaming" a health plan for one's own monetary gain or for the benefit of patients is unethical, because such actions violate duties of veracity and beneficence, and, in addition, violate the contractual justice and promise-keeping premises which underlie social contracts. As Moreim states:

Widespread gaming represents a systematic assault on patient-payer contracts. Payers and patients necessarily draw limits on their mutual obligations. Payers cannot agree to provide literally limitless care, any more than patients can pay literally limitless premiums. The physician who systematically undermines such legitimate limits through gaming not only threatens the integrity of individual agreements, he also invites economic anarchy by assaulting the confidence with which people can make such agreements in the first place.10

Physicians should cooperate with resource rationing within a health plan. They cannot ensure that resources saved in the care of a particular patient will necessarily accrue to needier patients, but it is clear that resources spent on a particular patient will not be available to others. Fiduciary obligations to patients do not include gaming the system.

Physicians have obligations as citizens and as health care professionals to involve themselves in fashioning resource allocation systems that are morally grounded. A general form of this obligation is part of our ethical code and has been discussed elsewhere.11

THE INEVITABILITY OF A MULTI-TIERED SYSTEM

It is not clear what sort of national health services financing system we will have when the current congressional debate is completed. The possibilities range from a predominantly market reform12 to a British or Canadian style of monolithic, single level system. Many of the non-market reform proposals (we include Clinton's and related versions of managed competition in this group) place a high value on "equity" in providing health care to all citizens. But what kind of equity underlies such systems?

In considering the meaning of equity in health care, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research rejected the definition of equity as "equality."13 Equity as equality characterizes delivery systems such as a national health service (Britain) or an insurance model (Canada) under which each citizen is guaranteed the same level of health care. Examining the means by which health care might be equalized reveals inherent severe shortcomings. There are two ways health care resources can be equalized — levelling up or levelling down: to level up, social funding must provide each individual with the current high level of resource consumption available to those with private means; to level down, all must agree or be compelled to receive a lower level of care. The former is achievable only at the expense of other social goods, such as defense or the justice system. The latter is achievable at the expense of one's freedom to spend private dollars as one wishes. Blumstein and Sloan14 submit that neither of these alternatives is necessarily feasible nor desirable:
Levelling up would require such a staggering commitment of resources that other public priorities would unduly suffer: levelling down would promote gross inefficiency, lower quality, achieve a dubious sort of equity in which waiting time would be the main resource allocator, and threaten fundamental precepts of freedom by barring individual expenditures for health above some arbitrary limit set by government.

The President’s Commission rejected the notion of equity as equality in health care, but embraced equity rather as an “adequate level of health care.” This would provide a basic level of care for all while also permitting a stratified system characterized by inequality. Given the difficulties inherent in any attempt at levelling, a multi-tiered health care system seems inevitable in American society. The standard of care required of physicians, or what physicians owe their patients, must reflect this duality. The prospective reimbursement structure of managed care makes it unreasonable to expect physicians equitably to allocate resources which they do not own or control, as was possible under retrospective, fee-for-service reimbursement. This difficulty is addressed by Morreim’s divided standards, the standard of medical expertise and the standard of resource use, discussed above.

FINANCIAL INCENTIVES

Not all financial incentives to limit care create the same degree of conflict between the physician’s and others’ interests and the patient’s. The degree of influence of a financial incentive varies according to the percentage of the physician’s income which is placed at risk, the frequency at which incentive payments are calculated, and the size of the group of physicians upon which the economic performance is judged. For example, a small group of physicians will feel the effects of sharing financial risk more intensely than a large group. In general, the threat to the quality of care increases when financial incentives are closely linked to treatment decisions about individual patients and to physician performance over short periods of time, and when there is a high level of financial risk to the physician. In addition, a for-profit managed care system may employ stronger financial incentives than a not-for-profit arrangement because of the pressure to pay profits to shareholders.

Because of these difficulties, an important ethical obligation of health plans as moral agents is to avoid creating financial incentives for physicians to deny patients potentially beneficial treatment. Marc Rodwin argues that there are many reasons patients may be denied care: unavailability of resources and specific plan exclusions, for example. Pitting physicians’ interests against patients’ is too blunt an instrument, discouraging needed as well as frivolous treatment. We agree with this position, and suggest that there are parallel obligations of health plans not to offer and of physicians not to accept financial incentives to deny beneficial care to patients. Such incentives include, among others, hold-backs, bonuses, and penalties based on consumption of plan resources by patients.

It could be argued that under fee-for-service financing, the physician stood to benefit financially from treating patients, so too much or unnecessary care resulted. There is a fundamental difference between the two situations, however. Under the older fee-for-service system, the physician is responsible directly to the patient, and the patient is unequivocally the object of his loyalty. Under managed care, however, the physician’s loyalty is divided between the patient, who is receiving the service, and the plan, which is paying the bill in the role of the patient’s agent. Therefore more frequent opportunities and greater temptations for the physician under managed care to act for interests other than the patient’s. It is true that fidelity to patients’ interests has not been universally honored by all physicians in the past, but nonetheless the concept has been a robust component of the identity of medicine as a profession. The growth of managed care in the past decade has been associated with clearly increasing fragility of that important aspect of our ethic.

The medical profession is at a watershed of identity. Two defining ethical positions are:

(1.) We can accept as ethical any and all financial arrangements designed by health plans to control expenditures, including incentives for physicians to deny or withhold care in order to maximize their own incomes. This choice will move us away from the ethic of fidelity only to...
the patient, toward an ethic based on divided loyalties. Or (2) we can reject as ethically unacceptable financial incentives that place our obligations of fidelity to the patient at significant risk. There is a notable lack of data on outcomes of treatment associated with different kinds of financial incentives; that is, we know very little about how the health of patients is affected by behavioral changes in physicians induced by managed care, or about its effect on patients’ trust of physicians. It is therefore difficult to identify a middle ground between these two positions. Because of the central importance in medical ethics of physician fidelity to the patient’s interests, the burden of proof that a particular financial incentive does not harm the relationship of trust of patient for physician lies upon those who claim there is no harm.

It seems clear to us that financial incentives pose a threat to the identity of medicine as a caring, protective, trusted profession. Unambiguous commitment to the Hippocratic tradition can be achieved by rejecting as unethical financial arrangements that undermine fidelity to the interests of patients. Such arrangements include rewarding (for lower resource usage in their patients’ behalf) or penalizing (for higher usage) individual physicians or small groups of physicians over short periods of time. Risk-sharing by large groups of physicians over long periods of time (say, a year or longer) may pose less risk to the physician-patient relationship.

Health plans use financial incentives to change physicians’ behavior and there is no doubt that they can be effective. Behavioral changes have two effects: they change resource usage and they move physicians away from choices (presumably in the patient’s best interests) they would otherwise have made. These changes relate directly to each other: larger effects on resource usage are associated with greater movement of physicians’ choices. Thus, there is a fundamental conflict between the goal of the health plan to reduce resource costs and the goal of the physician to serve the patient’s best interest. Financial incentives that have little or no effect on physician behavior are the only ethically acceptable ones, but they also are of little or no value to the plan. In view of this standoff between the plan’s financial interests and the physician’s ethical obligations, one wonders whether there is any place for financial incentives for physicians in managed care systems. Perhaps cost control can best be achieved through mechanisms that do not interfere with obligations of fidelity and do not threaten the patient-physician relationship. These may include explicit service exclusions, specific rules governing the decision process, and monetary limits on services. Such controls can be administered by non-physicians under Morreim’s standard of resource use. Their effect on quality of care is not clearly understood and should be studied to quantify possible effects.

When a customer engages in ordinary business interactions, the governing rule is caveat emptor. This is not the expectation of a patient entering a hospital or doctor’s office; rather, the expectation, supported by thousands of years of tradition, is that the physician will act as fiduciary to the patient. This circumstance places an extra burden of honesty and truthful advertising on both physicians and health plans to notify potential patients of the existence, nature, and magnitude of cost control measures, both physician incentives and service limits, that might result in denial of care.

Financial incentives are not the only threat to the physician-patient relationship under managed care. There will be other more subtle incentives to deny care. For example, package pricing is becoming widespread. A contract between a large company and a health plan may set a specific price for an operation, for example a coronary bypass, including all hospital and physician services. This price is paid for every such operation, regardless of cost. Pressures from administrators within the plan may be brought to bear on cardiologists and surgeons not to operate on patients with multiple comorbidities who are therefore likely incur costs substantially higher than the contracted price. Moreover, mortality rates are likely to become one of the criteria by which companies choose health plans. Administrators of the plan are then likely to influence physicians to deny coronary bypass operation to a patient with higher (say, five to 10 percent) risk than the average patient (about one to two percent) because of the upward effect on mortality rate (this problem is unlikely to be solved soon by risk adjustment, because outcome assessment is a developing technology). Thus, there will be
pressures on physicians to deny care to some patients (for example, by declaring them inoperable); the heart patient with diabetes, peripheral vascular disease and chronic renal failure who is likely to require high cost intensive care for more than a day or two; the patient with a low left ventricular ejection fraction and a "high" mortality risk of 15 percent). Physicians should be aware of subtle pressures to ration care in this manner, and should not succumb to them. Rather, criteria for exclusion should be explicitly described by the plan.

ADDITIONAL CONSIDERATIONS
Health care reform is likely to bring patients into the health care system who are of low economic status and not of social stature equivalent to that of the physicians caring for them. This may exacerbate existing problems in medical ethics. Wolf suggests' that self-determination is most likely to be based on truly informed and valid consent when three conditions are met: (1.) the physician and patient can easily communicate with one another; (2.) the patient trusts the physician enough to communicate his real preferences; and (3.) the patient has enough real options to make self-determination meaningful. All these are currently problems for some patients. For example, poor black women may not communicate well with physicians, and are more likely than other women to suffer punitive measures for drug abuse during pregnancy: there is a low level of trust of physicians and the health care system by such women. Moreover, patients in nursing homes often lack choice, control, independence, and the ability to articulate choices clearly, so have few real options for meaningful self-determination.

Physicians are obligated to do more than give information and respect choices of patients; in addition, they should identify and overcome barriers to clear communication. By helping patients to find resources they may not have known existed, physicians may help to create more options, allowing greater self-determination for such patients.

The South Carolina Medical Association has an important advantage over many other state medical associations. Managed care has not yet gained as substantial a share of our health insurance market as it has in other states. We are therefore in a position proactively to propound and observe guidelines designed to maintain our Hippocratic identity to an extent not possible elsewhere; for example in Massachusetts, California, and other states the livelihoods of many physicians already heavily depend on health plans that use the most pernicious types of incentives. Despite perceptive works like those of Moreim and Wolf, the bioethics-community in this country has not developed a consistent position on the ethics of managed care, leaving the medical profession with little guidance on how to respond to perceived threats to professional integrity. The guidelines we suggest may be a model for other states.

ETHICAL GUIDELINES
1. Physicians must abide by the rules of the health plan in financial matters and in provision of services, but are encouraged to challenge the rules within an established appeal mechanism when advocating for a patient.
2. Physicians must inform patients of medically appropriate, potentially beneficial service alternatives, regardless of cost or coverage by the plan; they should not allow concern for desirable outcome statistics to interfere with informing or advocating for patients.
3. Physicians should encourage the plan to anticipate conflicts between medical judgment and policies in routine practice and in emergencies, and help establish routes for routine and urgent appeals.
4. Physicians should advocate (provide or, in case of denial by the plan, appeal) on their patient’s behalf for all services that may be beneficial and are not excluded by the plan, and excluded services that are more than minimally beneficial. They may but are not ethically bound to advocate on the patient’s behalf for excluded services that are only minimally beneficial.
5. Physicians should insist that any plan in which they participate use no system of financial gains and losses that encourages physicians to limit beneficial services they may offer to patients.
6. Physicians must assure that their contractual agreements restricting referral or limiting service options are disclosed to patients (acceptable mechanisms of limiting ser-
services include exclusions and procedural rules specified in the plan-patient contract, and that the plan makes adequate disclosure to all patients prior to enrollment.

7. Physicians should promote an effective program of peer review to monitor and evaluate the quality and appropriateness of patient care services provided within their practice settings.

8. Physicians are responsible for medical decisions and quality of care, irrespective of conclusions reached by reviewers; they must act always on the basis of their own best judgment.

9. Physicians should make special efforts to overcome barriers to clear communication with patients of cultural and socioeconomic status different from their own, respect their values, and help to identify resources that will increase options and optimize self-determination.

10. Physicians should not refer patients to colleagues they feel may not be competent, even if the referral is mandated by the plan; moreover, when an issue of competency has been raised, there should be an established policy to evaluate the charges and make disposition, while respecting confidentiality and privacy of all concerned parties.

11. Physicians should, in their roles as citizens and as health care professionals, help to fashion resource allocation systems that are morally grounded.

REFERENCES

5. We will use the term health plan or simply plan to refer to any type of managed care organization throughout this essay.
7. We acknowledge the ambiguity inherent in the term "beneficial." It means "of benefit," but who decides what is of benefit? The physician is in a position to say what treatments are effective in a physiological sense, but the patient's values must be the major determinant of the "value" of a particular intervention. For a more detailed discussion, see Truog RD, Brett AS, Frader J. The problem with futility. New Engl J Med; 326:1560-3, 1992; and Sade RM. Medical Futility and ineffective care: a proposal for hospital policy. J So Carolina Med Assoc. In press.
13. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Securing Access to Health Care (Government Printing Office, 1983), vol. 1, p. 20. The commission recognized the necessity of a two-tiered health care system because "trying to prevent such inequalities would require interfering with people's liberty to use their income to purchase an important good like health care while leaving them free to use it for frivolous or inessential ends. Prohibiting people with higher incomes or stronger preferences for health care from purchasing more care than everyone else gets would not be feasible, and would probably result in a black market for health care." 18:19.
19. We have discussed earlier the role of the expressed ethics of a group or association in portraying its chosen identity. See Sade, 1980.