The Ethical Dilemma in the Managed Care Environment

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ABSTRACT

The advent of cost containment and the rapid expansion of managed care in American has created an industry that has a multitude of ethical dilemmas. There has been a shift of medical decision making from that of the physician and patient to that of a healthcare delivery system. Thus ethical decisions regarding patient care are no longer made by physicians, but by managed care organizations. Medical ethics has combined with technology and created medical bioethics. Modern medicine is now entering into socioethics that focuses on utilitarianism. For managed care organizations to become successful, ethical decision making must be guided by an ethical framework that includes business, biomedical, socioethical and managerial considerations. The consumer must also become an advocate for change and increase awareness and responsibility regarding controlling healthcare costs.

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There are a myriad of ethical dilemmas that plague the current healthcare delivery system in the United States. With the advent of managed care and cost containment, there has been a shift of medical decision making primarily from that of the physician and patient to that of a healthcare delivery system. The advent of managed care has changed the emphasis of care to that of cost containment. This contradiction has caused tremendous upheaval in the delivery of care and perceptions of Americans regarding healthcare. Thus, many serious life threatening ethical concerns have surfaced as evidenced by lawsuits and legislation related to managed care organizations. Ethical issues also exist that must be defined and resolved in order for managed care to become successful and accepted by the American public. Historical data related to the current situation and a review of business and biomedical ethical issues will be examined. Additionally, several possible solutions will be discussed as related to the current healthcare market of managed care.

Malinowski (1996) indicates that modern medical ethics have evolved from two separate eras of development. Professional domination is the first, with the era of bioethics following. During professional domination, medical ethics was determined by medical practitioners and was enforced primarily by the profession itself through boards and institutional proceedings. The guiding principle throughout this time was defined as highly paternalistic and authoritarian in fashion. During this era of paternalism, as Sorum (1996) advises, physicians were to act primarily in the interest of patients. As a result, Malinowski (1996) advises, the ethical principles that evolved were aimed at maintaining order among members of the profession and fostering respect from the community.

The era of bioethics or biomedical ethics emerged in the early 1970's. Bioethics is the application of ethics to biological sciences and healthcare (Mitchell, Uehlinger and Owen 1996). As Mitchem (1996) advises, bioethics attempts to educate physicians about the broader principles of ethics beyond those traditionally found in medical ethics and to adapt and apply these principles as they pertain to the unique situations created by high-tech medicine. One example of this includes the problem of dehumanizing patient care due to diminished physician-patient contact. Patients are diagnosed and treated via highly technical medical equipment and is replacing physician contact. As Malinowski (1996) advises, rather than being physician centered, bioethics moved medical ethics to a patient centered framework that focused on individual rights and patient autonomy.

Despite the different guiding principles of professional dominance and the bioethical approach, they both provided a single focus to patient interests with no regard for costs (Malinowski 1996). This lack of concern regarding cost containment during the professional domination and bioethics eras of healthcare has fostered the growth of managed care organizations. As a result of third party payment for healthcare costs, patients have become unaware of the cost of healthcare services up to and including highly technical diagnostic tests and surgery. Patients are not informed of or responsible for costs, and therefore, are not cost conscious consumers. As a result, a large portion of the American population has the perception that access to quality healthcare is a right, not a luxury or privilege.

As Malinowski (1996) advises, managed care is concerned with controlling costs, which is in contrast to previously stated medical ethics norms of putting the patient's interests first. Modern medicine is now entering into a third era of medical ethics called socioethics, which relates to medical ethics that are focused on utilitarian or society-based theories. Utilitarianism refers to the concept "that the morally best actions create the greatest benefits for the greatest number, and do so with the least cost, risk or harm" (Harvard Business School 1993). Today and into the future this ethical concept must be used to evaluate the rights of each patient against the utilitarian principle of doing the most good for the greatest number of people. This is due primarily to limited financial resources and ever expanding technology such as organ transplants.

This is a turbulent time for healthcare in America. As Koloroutis and Thorstenson (1999) advise, tremendous advances in healthcare have been made in the last twenty years. The ability to save lives that would have been lost to trauma and disease is remarkable. Significant advances in technology continue to alleviate pain and suffering and have the potential to eliminate disease. Americans are living longer and healthier and have better prospects for living "well" long into old age. It is a truly exciting time in healthcare. However, despite all of these advances, healthcare is fraught with conflict.

The rise of managed care, as Higgins (2000) explains, and market competition are transforming healthcare from that of a physician-dominated industry to that of a manager-dominated industry. As a result, the managed care revolution is undermining safeguards offered by medical ethics, such as those provided by the American Medical Association (see Appendix A), and are raising serious public concerns regarding the provision of medical care. As Friedman and Savage (1998) advise, managers and administrators of managed care organizations are torn between two conflicting, but equally compelling values. Providing the appropriate level

of health care conflicts with the need to keep expenses as low as possible to maximize revenues and keep the organization viable.

As Higgins (2000) suggests, managed care may be entering into a period of the greatest moral danger. Strong price competition, weak quality competition and fragmented governmental controls have created an environment that is easy to exploit. Cost containment pressure will increase in the future as managed care plans gain control over billions of Medicare and Medicaid payments and further reduce provider revenues. Conflicts of interest within the managed care arena will be the most serious ethical challenge.

Many physicians and ethicists view managed care as the demise of medical morality. This is because medical ethics is equated with the preservation of autonomy, both that of the physician and the patient (Holleman, Holleman & Moy 1997). According to this view, physicians cannot function without sacrificing integrity and patients are not able to function without losing autonomy. Two features of autonomy include the ability to think freely and the ability to act on one's decisions (Mitchell, et al., 1996). These concepts are important as they relate to the patient provider relationship. As Stone and Mantese (1999) advise, of the many models that describe the patient provider relationship, the deliberative model is generally preferred. This is because it requires the physician to engage in dialogue and exchange ideas. It also encourages patients to adopt the most medically relevant values and it empowers them both to select those treatments that best reflect those values. The main characteristic of this model is the discussion that takes place between the patient and the provider and the empowerment, or autonomy, of the patient through the physician's teaching and support. This is based on the belief that medical decisions are enhanced by the input and support of a well-informed physician. Recent studies have concluded that patients want a collaborative role in defining treatment options and desire a higher degree of involvement in the decision making process.

The very structure of managed care places great pressure on this patient provider relationship. Financial incentives are offered to physicians to encourage cost containment (Stone et.al., 1999). It is reported that these financial incentives cause physicians to believe that the quality of care provided to patients is compromised. This is due to the pressure to limit referrals, increase patient case loads, and limit the amount of information that is given to patients regarding treatment options. Utilization reviews are another way managed care has attempted to control costs. However, efforts to meet utilization guidelines may interfere with the quality of care provided and may not align with patient values.

Another method used by managed care organizations is the use of a primary care physician as the gatekeeper to care. Although in theory this appears optimal for the patient, many patients report difficulty in maintaining a relationship with their physician. This is due to frequent employer changes in health plans or physician movement between networks. Patients may be forced to choose a physician that is not of their choosing.. In addition, gatekeeper physicians are increasing their workload, which ultimately decreases access to patients. An additional role the gatekeeper plays, is determining access to specialists. Although this can be a benefit to some, this may actually hinder the care process, especially those with chronic medical problems. One of the most controversial mechanisms of managed care is that of the gag rule for physicians. This prohibits discussing all treatment options with the patient. This is in direct

conflict with the patient provider relationship in that the patient does not receive complete information related to options, outcomes and values. Lack of trust that treatment plans and referrals are in their best interest has also eroded the patient provider relationship. This lack of trust also permeates the managed care environment.

The shift of decision making from that of the patient physician relationship to the managed care organization creates a conflict of interest. Managed care companies must maximize profits and minimize costs to satisfy the stakeholders of the company. Of concern here are the biomedical ethics of beneficence and nonmaleficnece. As Friedman and Savage (1998) advise, beneficence involves providing benefits to persons, while at the same time balancing benefit and harm. According to the principle of beneficence, organizations are required to do all they can to aid patients. As Malinowski (1996) advises, some physicians allege that managed care organizations apply financial pressure to not treat patients. Beyond bonuses for containing costs, some organizations are imposing fines on physicians for excessive expenditures. This type of environment does not foster a positive patient care environment.

Nonmaleficence is thought to mean, "first do no harm". This involves a delicate balance between providing benefit yet doing no harm. There is a direct conflict between these two ethical standards and the way managed care organizations are operated. As Peeno (2000) advises, one universal barricade is the use of authorizations to limit or deny care. Benefit ambiguity also denies care. Benefits in question such as hospitalization, new treatments, or out of network referrals are determined by the organization, not on medical necessity. Even though many managed care companies refer to guidelines or protocols, they can pick and choose which to use to control the number of denials. These guidelines then become the norm and are used to define treatment and diseases. These examples are in direct conflict with beneficence.

The financial success of managed care organizations depends of exhibiting performance results in such areas as lengths of stay in hospitals, number of hospital admissions, referral rates and per-member-per-month costs. This type of economic control has evidenced itself in postpartum care and post surgical mastectomy patients. As these norms become standard, there is competition among the industry to beat them. As a result, when the norm went too far in the case of post partum care, federal and state legislature stepped in to stop such practices. Nonmaleficnece, "first do no harm", are in direct conflict with these practices.

As Friedman et al., (1998) imply, standards of justice deal with the equitable distribution of benefits and costs among individual, groups and organizations. Distributive justice focuses on the principle that all people should be treated the same unless there are relevant differences among them. As Peeno (2000) advises, in many managed care plans, financial gains are obtained by targeting high-cost, high-volume or high cost diseases such as AIDS or cancer. By targeting certain aspects of care, the organization raises authorization criteria. As a result, patients become the target for cost control. This appears to be a direct conflict with the concept of distributive justice.

As Friedman, et al., (1998) suggests, procedural justice focuses on the principle of fairness and is based on the idea of a social contract between an organization and its primary stakeholders. The conflict noted here is that a managed care contract is to provide healthcare services, yet are obligated to the stakeholders whose goal is financial profit. As Loewy (1996)

explains, managed care is in part based, on the assumption that market forces and competition will control costs and improve quality. In reality, competition among healthcare providers is more likely to enhance the income of it's stakeholders.

The heart of the dilemma regarding the managed care industry is that most are operating within a model of business ethics, not biomedical ethics. As Friedman, et al., (1998) advise, one of these is the principle-agent model which reasons that executive level managers are agents of the stakeholders and are therefore required to increase the wealth of the organization. Another business based ethic advocates principled moral reasoning as a basis for decision making. This is based on the concept that morality is good and should be seen as an end in itself, not just a method for increasing shareholders wealth. However, there is no definition of what is good. The third model uses a noninstrumental approach that implies ethics has a binding moral veto over the imperatives of increasing shareholder wealth and profit. The difficulty with this model is that there is no moral certainty in the majority of decisions.

In order for managed care organizations to provide quality healthcare services in a cost effective manner changes must be made. The public holds the healthcare system and its leaders to higher ethical standards than other businesses. As trust in the system declines, the public is demanding safeguards to protect quality and consumer interests. Moving from a patient provider centered ethic to an ethical framework that includes business, social and managerial considerations is a positive move in the right direction. The challenge to maintain or enhance trust and quality of care will be great. However, the biggest challenge will be to instill a social conscious in the American public that allows an appreciation for the limits of healthcare resources.

As Koloroutin et al., (1999) advises, the development of an ethical framework is the first step to creating an ethical organization. It is intended to provide guidance for decision making and to assist in resolving conflict. Any ethical framework for the managed care industry must support the process of ethical reflection, as this is a key component of organizational change. Guiding principles outline what the organization values and how it intends to behave. All decisions and actions within the organization must be evaluated against these principles. One example of guiding principles include: caring, advocacy, stewardship, respect, honesty and confidentiality (see Appendix B). As an organization readily identifies issues discovered by clinical experience, the "consciousness" of the organization will be raised with the possibility of making positive changes. The integration of such a framework is ultimately the most important step in the process.

As Phillips (1998) advises, major areas that require ethical consideration in the managed care industry include: governance, service structure, utilization management, quality, marketplace behavior and dispute resolution. As Higgins (2000) advises, the top ten ethical issues that need ethical attention include: coverage, experimental care, financial incentives, futile care, informed consent, marginal treatment, medical necessity, personal responsibility, professionalism and social mission. Just as every organization differs, every ethical framework will be different. However, the end result must foster an ethical environment for all involved.

The quest for quality of care, as Mitchell et al., (1996) advises, can be traced back to Florence Nightingale's observations of patient outcomes related to care processes. Along with

the growth of managed care came clinical databases related to clinical outcomes. This data can be used to facilitate benchmarking and allow organizations to compare similar patient outcomes. As van Amerongen (1999) suggests, the path to increasing value of the medical system is to hone in on outcomes and measurement. The ability to benchmark and compare across plans and regions will be necessary to determine if interventions are making any difference. Some forward thinking managed care organizations have already united the parallel functions of ethics and quality improvement as a framework for ensuring ethical decision making and quality patient outcomes.

Patients must also become stronger advocates in the role of healthcare. By increasing awareness and financial responsibility for cost of care, the consumer will develop a better understanding of the ethical dilemmas surrounding limited financial resources. One way to do this is to change the structure of healthcare plans. As Makeover (2000) suggests, all current healthcare plans are doomed to failure for a simple reason: benefits. It is human nature to get all the benefits one can get, especially if someone else is paying for them. When the consumer is actually spending their own money, much more caution is used to determine the value of goods. This is the basis for the one solution to the healthcare dilemma. Each person must have choice and control over how personal resources are spent on healthcare. Medical Savings Accounts (MSAs) were introduced 1996 by Congress. In theory all money used for insurance premiums is deposited into a tax-free account. Money is then withdrawn as needed for healthcare. The goal would be to find a co-payment level high enough to make people think carefully about spending their own money, yet not so high as to discourage obtaining healthcare. A secondary insurance would be necessary in the event that the MSA was exhausted due to a serious illness.

Another way to increase awareness of the American public is to provide different levels of insurance. Everyone would have "basic" insurance that covered basic care. A secondary insurance would be available for purchase that covered all expenses such as organ transplants and experimental treatments. This way the consumer would be forced to make a personal decision regarding the limits of resources allocated to healthcare.

The survival of managed care is riding on the industry's ability to demonstrate a strong ethical framework that promotes trust. Trends are emerging that assure that the ethical decisions of leaders in managed care will be more difficult that those of today. It is vital that all managed care leaders, healthcare providers, such as nurses and physicians, patients, and the general public recognize that their fate will be based on building an ethically acceptable framework for providing healthcare that maximizes outcomes within common goals and values.

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Appendix A

American Medical Association

Principles of Medical Ethics

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not lows, but standards of conduct that define the essentials of honorable behavior for the physician.

Principles of Medical Ethics

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud and deception.
III. A physician shall respect the law and recognize a responsibility to seek changes in those requirements, which are contrary to the best interest of the patient.
IV. A physician shall respect the rights of patient, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talent of other health professionals when indicated.
VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Appendix B

Guiding Principles

(Excepts from An Ethics Framework for Organization Change)

1. Caring – The principle of caring highlights the importance of serving members and patients as whole persons with attention paid to their individual circumstances and relationships. Caring emphasizes commitment to protecting and enhancing the dignity of patients and members. This principle incorporates the ethical principle of beneficence or the obligation to promote or do good.

2. Advocacy – This is the obligation to represent the interests of others or to act on behalf of others for their benefit. Advocacy is a critical ethical requirement in relationships and systems where an imbalance of power is an inevitable reality.

3. Stewardship - This requires that the system be a wise manager of the finite resources essential to the quality and duration of human life.

4. Respect – This honors individual values and preferences and the right to make autonomous and independent decisions.

5. Honesty - This is rooted in the principle of respect for persons and goes beyond simply prohibiting lying and deception. Honesty reflects an obligation to disclose information necessary for an individual to make an informed decision.

6. Confidentiality – This fosters respect for and privacy of the patient and is essential to the free exchange of information in a provider relationship.