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INTRODUCTION: THE ETHICS OF MANAGED CARE

Managed care has revolutionized the organization and distribution of medical services during the last decade and it continues to reside at the center of our national debate about the rights and integrity of patients, the right to health care, the cost of health care, and the entitlements of capital investors.

Traditional fee-for-service medicine and its related insurance programs began to develop difficulties when advances in medical technology, the rising expense and duration of medical specialty training, the cost of government-compliant research, and the complexity of full-service hospitals threatened to push the price of clinical care beyond the insurance industry's ability to pay and still retain a level of profitability.

Physicians with an ever-growing array of evaluation and treatment options used them liberally, sometimes to diagnose and cure, sometimes to protect themselves against future claims of inadequate effort, but always certain in the knowledge that medical insurers would honor their invoices. A culture raised on the philosophy that every human life was beyond price agreed that the only satisfactory medical care was the most extensive medical care, and that no expense was too great in the effort to prolong life and restore the afflicted to health. These generous thoughts were not difficult to maintain when anonymous third parties actually paid the medical bills. When those third parties, the medical insurance companies, sagged beneath the load, they responded by raising premiums to the large and small employers who offered subsidized health insurance in their benefit packages. Employees in turn were asked to accept higher premium shares, higher deductibles, and higher co-pays. As costs rose without a ceiling in sight, dissatisfaction with those costs rose as well.

Managed care, whether in health maintenance organizations or in other organizational configurations, offered a solution that seemed acceptable to many. The HMOs would accept an advance of a flat rate per capita for all the people in a covered group, offer preventive medicine programs which would control the incidence, suffering, and cost of major illnesses, and rein in the extravagances of physicians who prescribe unneeded tests and unproven therapies. These measures were believed to save American medicine and at least stem the rate of increase of medical costs.

But the goal of managed care was management, not care. Managed care organizations were run by people trained in the culture of the insurance industry, not

in the culture of medicine, and they saw their mission as a generation of profit for stockholders, not necessarily medical care for clients. Cost-effective medicine was the goal in the context of a profit-making enterprise. Although preventive health care programs were promised, very few were realized and they were not nearly comprehensive. The definition of unnecessary testing slowly expanded to mean virtually any high-cost test requiring the service of a medical specialist, and low-priced generalist physicians with limited diagnostic and therapeutic skills were made available to patients with the instruction they should limit their access to high-cost specialists. Managed care organizations tended to reward primary care physicians who avoided specialty referrals, and severed contracts with those who persisted in sending their patients to outside consultants. Most notoriously, managed care organizations maintained veto authority over the provision of complex and expensive care, and that veto was often wielded in defiance of a physician's recommendation by managed care employees without medical training or experience.

Managed care did indeed slow the rate in increase of medical costs, but not without limitations on the care provided to patients and the professional integrity of physicians. Managed care organizations were so successful that they could provide extremely high salaries to their executives even in the context of limiting cost and care.

It is these developments that the papers of this symposium addressed. The most fundamental ethical issue is posed in the first paper by Dr. Edmund Pellegrino: Is medical care a commodity like any other commodity, and are the transactions between patient and physician like those between buyer and seller in any other area? Or, as Dr. Pellegrino argues, is medical care a different kind of service provided by professionals who, using their professional judgement, direct themselves toward the interest of patients who come to them facing the challenges of their medical needs? In other words, how much of medicine can, or ought to be, a business subject to the usual restrictions of the marketplace?

The papers which follow begin from considerations of this important question and elaborate upon other ethical dimensions which the complexities of managed care have brought to prominence.

Managed care is also about a new physician role, very different from the traditionally benevolent caretaker and patient advocate. The gatekeeper physician is the entry point to the managed care system and controls patient access to other resources within the system. The physician-gatekeeper is usually a primary care physician with an organizational responsibility to keep care at that level rather than refer complex problems to more expensive specialist care. In this role the physician becomes a representative of the managed care organization's fiscal goals rather than an advocate for his patients' health.

In the older fee-for-service system physicians were paid more for doing more. Some claim that this model led to excessive use of laboratory tests and procedural therapy with excessive treatment increasing iatrogenic illness and even mortality. In a managed care system, the physician is often paid more for doing less, and the

physician is asked by his employer to practice cost-effective, efficient, parsimonious medicine, sometimes reducing service at the expense of necessary care. When a physician's income is dependent on conservation of resources to the benefit of the HMO's profit margin, and patient care is considered a debit on the books, the quality of care is very likely to suffer.

Physicians have long prided themselves on their ability to exercise their judgement independently for their patients' benefit. Fee-for-service models value this right and the individual patients' integrity with the understanding that profit-driven excesses will occur as aberrations. In HMOs, decisions about patient care practices are often made by groups and/or clerks following a cost manual. There may not be enough money in the managed care system for more CT-Scans, or physician groups may have decided that such scans are not indicated and won't be compensated for headache patients. Physicians may be required to obtain second opinions before hospitalizing a patient, and be subject to additional "quality assurance" controls, or have their procedures reviewed by non-medical personnel.

The practices of HMOs raise questions of patient privacy and confidentiality. Patient records are regularly reviewed by others for purposes of quality assurance, the documentation of practice for incentive payment purposes, or for use in building larger databases. In the HMO model, employers who pay for enrollees' care, and who may even have a management role in the health maintenance organization, can obtain access to the patient's medical record even though they have no professional role in treatment and may use confidential patient information in personnel decisions without the patient's knowledge.

At a more personal level of competition, the physician may lack confidence in the specialists in the health maintenance organization and want to refer a patient to an expert outside of the plan. In some places there can be no alternative but to refer the patient to specialists in the plan even when their expertise is questionable. This forces the physician to decide whether to serve individual patient or the health maintenance organization.

The intellectual discipline of medical ethics presumes that medicine acknowledges an ethical responsibility. That ethical responsibility has been well developed since the time of Hippocrates, and continues to evolve in its particulars. It has been consistently characterized by compassion for the suffering of the infirm, the physician's agreement to place the needs of his patient above his own, and a sense that the therapeutic relationship includes, but somehow transcends, the simple exchange of goods and services for money typical of other transactions within the culture. Ethical considerations do not often merge easily with corporate goals.

Managed care appears, then, to be based in a value system directly contrary to the foundations of medical ethics. Having been forced to live together, can these two cultures reach accommodation? Many of the nation's leading medical ethicists gathered to explore this question and the papers in this volume represent their attempt to deal with these very difficult questions. Has managed care performed the over-arching ethical act of saving American medicine, and does it deserve our gratitude and our respect for its methods? Do the traditional concepts of medical

ethics become obsolete when the bills have to be paid? Does the physician who receives his daily bread from the corporate budget of a managed care organization owe his first loyalty to its stockholders or to the afflicted patient before him, whose illness threatens to diminish corporate resources? Can patients continue to trust their physicians with the knowledge that this question remains unresolved?

As our government, our citizenry, and our corporate centers debate and work through these issues, each on behalf of its own advantage, the writers whose work appears in this volume offer some most helpful guidance. They have our deepest gratitude for grappling with these very difficult issues.

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