

CHAPTER 2

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ETHICAL DILEMMAS IN MANAGED CARE FOR THE PRACTITIONER

1. INTRODUCTION

Those who believe in the cycles of history must be struck by the dramatic upheavals at both the beginning and end of this concluding century that have characterized American medicine. Some particular historical analogies are also in order. The beginning of the twentieth century saw the evolution from the Dark Ages of American medicine as the Flexner Report set needed standards for education and training. By the 1950s, the age of technology, like the Renaissance and later Age of Faith, led to an exuberance of discoveries, treatments and hope that seemed unbounded. But now, as a new century dawns, the Reformation is with us in the form of cost awareness and containment and shows no hope of abating now, or in the near future (Boisaubin, 1994, pp. 1-2).

Driven now by rising public expectations of excellent, available, comprehensive and affordable care, and yet bridled by the current unwillingness of American industry, government, and probably the populace, to pay for the requisite changes, the practice of medicine is being restructured in ways unimaginable only ten years ago (Inglehart, 1994, pp. 1167-1171). Although many realized that important changes were coming, the magnitude and speed of the changes has been almost inconceivable and has been likened to the restructuring of Eastern Europe after the fall of Communism, or the hypothetical rebuilding of the entire American automotive industry from the ground up.

But often lost in the high-level debates and machinations of the corporations, organizations and populations served, is the elemental dyad of patient and physician, which makes up the ultimate nucleus of the whole endeavor. Every overriding administrative or governmental dictum for change ultimately results in an impact upon a solitary patient and physician in a particular health care encounter. And often these higher-level decisions and policies, multiplied and modified countless times over as they descend to the practice level, bring about these changes in unique and sometimes wholly unanticipated ways. These changes are not only in the mechanistic and business aspects of medical care, but impact some of the core issues of professionalism and morality that typify the patient-physician relationship.

This paper will focus upon the ethical issues and changes that impact primarily the practicing physician, but also the patient, through the individuality and

uniqueness of their relationship. This analysis will start at the very beginning of the endeavor, with the physician's decision to join a managed care enterprise, and then analyze the evolution of patient-physician decision making in both fee-for-service and managed care examples, ultimately recommending an optimal medical care model. Next, important psychological issues that impact moral decision-making will be addressed, and finally, some guidelines and recommendations will be made for both individual and group undertakings with the goal of benefiting both patient and physician.

2. JOINING THE NEW ORDER: CHOICE VERSUS COERCION

For virtually all practitioners, the first set of moral, professional and economic challenges encountered is the decision whether to participate at all in managed care practice. In an ideal world of physicians acting in both the best interests of their patients, and their own professional standards and ideals, this would be a reflective, carefully analyzed decision, balancing the strengths and weaknesses of the proposed practice plans. However, a large part of this deliberation is now concretely manifested in the written practice contract which contains a myriad of definitions and terms, and an entirely new lexicon, including "designated provider" and "medical necessity", among countless others. These contracts contain detailed descriptions of requirements for entry, exit, or termination from the practice plan. There are elaborate descriptions of how consultants might, or more likely might not, be utilized, and the related roles of primary versus secondary or tertiary care. There are careful explanations of the financial structure and systems of billing and payment, and whether a capitated system exists. The point is that this detailed legalistic, administrative and economic jargon of the arrangements dominates and often overwhelms the analysis and thinking of the practitioner. And in fact, any references to professional standards, much less moral or philosophic ones rarely, if ever, exist. This dominance largely excludes the more fundamental issues, such as whether this plan of care is in agreement with, or conflicts with, the physician's own moral and professional standards of care. It also never raises issues such as whether this business arrangement is a conflict of interest in terms of offering financial incentives (for example, selective cost containment) that might benefit, or more likely potentially harm the patient (Rodwin, 1995, pp. 604-607). In fact, the entire document is purely a business agreement, with the unwritten but tacit assumption that other professional, or even moral standards that might be held to by the physician are subservient, or at the least, should not conflict with the business plan. And for appropriate questions that the physician might have concerning, for example, how to question or challenge an administrative decision, he or she is referred only to the "appeals section" which usually describes how this might be undertaken, only by the truly courageous, with Byzantine clarity. In totality, the dominance of the business and restrictive aspects of the document cloud and blur the physician's basic concerns about professionalism and morality, including autonomy, trust and altruism, by totally changing the language of communication about these

issues. And if in fact the physician wants to understand more about what the document truly says, he or she is encouraged to speak with an attorney -- not another physician, and certainly not a moral philosopher.

Since most physicians, until recently, have been quite naïve in dealing with these kinds of contracts, their very real ignorance of the content is substantial. Much like any American purchasing a new home when faced with the intimidating legal documents that accompany this endeavor, physicians do not like to admit that they do not really understand what this transaction is all about. Therefore they take the proverbial "leap of faith" in signing the contract, and merely hope for the best. Nor is it possible for the practitioner to anticipate how and in what form this contract will truly impact the daily relationship between that physician and any given patient. In addition, this arrangement creates a new and unique facet in the relationship between physician and patient, as both are now subject to many of the same organizational requirements and restrictions, although they may view the guidelines in fundamentally different ways.

Last, and not inconsequential, are the increasingly indirect but economically coercive aspects of these contracts for the practitioner. As managed care has increasingly dominated health markets, the individual practitioner finds herself realizing that she cannot practice profitable medicine without joining local, regional or national managed care enterprises. Very real conflicts of interest can evolve as the physician finds the need for personal success and income potentially pitted against the best interests of the patient (Shortal, 1998, pp. 1102-1108). Personal conscience and professional standards are severely tested by the pragmatic needs of making a daily living. In sum, as a beginning, the business contract usually trumps the moral covenant of the new patient care system.

3. THE EVOLVING PATIENT-PHYSICIAN RELATIONSHIP

There is almost universal agreement that many aspects of the patient-physician relationship are being changed by the introduction of managed care, and often in a deleterious manner. A recent survey of over 1000 primary care practitioners in managed care revealed that two-thirds of them believed that the overall impact upon their relationships with patients was negative, particularly in terms of ethics (Feldman, 1998, pp. 1626-1632). A majority of them believed that managed care diminished their ability to place the interest of the patient first, and to avoid conflicts of interest. The same number perceived that the continuity of the relationship was being undermined. Almost half believed that their ability to respect patients' autonomy was reduced and one third believed that confidentiality was harder to respect. It is also significant that when these and other physician surveys comment upon the positive aspects of managed care, they emphasize preventive medicine and cost containment, but virtually no published study has showed a perceived positive impact upon the patient-physician relationship or the related ethical issues. Other surveys and articles that have focused upon the relationship from the patient's viewpoint have noted the negative aspects of real or potential loss of trust in the

The Ethics of Managed Care: Professional Integrity and
Patient Rights

Bondeson, W.B.; Jones, J.W. (Eds.)

2002, XII, 185 p., Hardcover

ISBN: 978-1-4020-1045-3