The Linacre Quarterly

Volume 62 | Number 3 Article 3

August 1995

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Recommended Citation

Manning, Michael (1995) "The Ethical Physician as Negative Gatekeeper?," *The Linacre Quarterly*: Vol. 62: No. 3, Article 3.
Available at: http://epublications.marquette.edu/lnq/vol62/iss3/3

The Ethical Physician as Negative Gatekeeper?

by

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Introduction

Many physicians today feel beleaguered. The medical marketplace is becoming increasingly commercialized and controlled by large health insurance companies that can dictate which physicians their members may see by virtue of their physician panels.[1] These new marketplace dynamics along with a growing surplus of physicians have induced many physicians to enroll as providers in Health Maintenance Organizations. The primary care physicians in these organizations are typically obliged to serve as "gatekeepers" to the medical goods and services provided by the insurance company.[2] Participation in such "managed care" often places physicians in a role for which their medical training has ill-prepared them — a role rife with conflicts of interest. Many physicians are angered by being asked to abandon traditional patient-centered ethics for the sake of corporate and sometimes personal profit. This paper examines current HMO gatekeeping practices and concludes that unless significant reforms are made in the gatekeeping role, there is a conflict of interest between ethical medical care and HMO gatekeeping. It describes a model which has been proposed to reconcile the conflict between the needs of the patients and the responsibility to society.

Medical Ethics and the Tradition Images of the Physician

The shaman was the physician's forerunner. In primitive cultures, the shaman served as a combination of priest and medicine-man. He or she healed through mystical, ecstatic and magical means using both ritual and psychoactive substances. The shaman presided over many community liturgical functions. As medical knowledge progressed, religious and medical roles came to be exercised by different groups, the clergy and medical profession, respectively.[3]

Many still find priestly characteristics in the physicians' role. This is understandable given its shamanic ancestry.[4] The very word "profession" refers to the profession of vows that signified entrance into a particular state of life.[5]

Barnard[6] argues that the physician's work resembles that of priests in three important areas. First, the nature of illness is such that patients come to the physician not only with biological distress, but with existential anxiety as well (about death or disability, for example). They look to their physician for help in dealing with both types of concern. Second, the therapeutic relationship incorporates the physician's personal qualities of care and concern. The way in which a physician carries out his or her role is an expression of who he or she is as a person. Third, medical work, like that of ministry, is value laden both in its individual and social contexts. The work a physician performs is linked to his or her social and moral vision. Sound ethical codes are those that depend on character. Professions invoke metaphors of family or monastery or military colleagueship — in short, they appeal to character.[7]

May describes several images that have been used to portray the physician.[8] In the image of physician as parent, we see the doctor as a beneficent, paternalistic, authoritarian caregiver who knows what's best for the patient, even if the patient is ignorant of his or her own best interests. This is one of the oldest and most revered images of the physician and has given a heavy paternalistic tone to medical ethics.

The physician has also been seen as a fighter of disease and death, sometimes at all costs. A term like *medical armamentarium* comes from the tendency to view the physician as a combatant against disease. A physician's exhaustive use of every last treatment to forestall death may also be inherited from this tradition.

The physician can also be seen as a provider of healing technology or information. The depersonalized, commercialized and specialized nature of modern medicine has contributed to this perception of the physician. The modern emphasis on patient autonomy also fosters this image of the physician. The physician-patient relationship is reduced to an interaction between consumer and provider.

Finally, the physician can be seen as covenanter; this is the image May finds most cogent. The covenant model recognizes those elements of the health care relationship that cannot be defined by contract. The relationship entered into by doctor and patient binds them both together in ways that differ from a simple business relationship. In a coventantal relationship, the more powerful of the parties agrees to accept some responsibility for the more vulnerable of the two partners. The covenant does not give free reign to self-interest, subject only to *caveat emptor.* A covenant based ethics encourages professional self-regulation and discipline, equitable distribution of health care goods and services, and a pervasive sense of fidelity to all aspects of the physician-patient interaction.[9]

Some features of a covenant are also contained in the notion of a fiduciary relationship, which has gained more widespread acceptance than the idea of covenant. A fiduciary relationship is a form of paternalism for which beneficence is the governing principle; it emphasizes the trustworthiness of the professional —a trustworthiness that can, in principle, be relied upon.[10]

The physician is also seen as a businessperson. This view of medical practice promotes patient autonomy[11] and counters the heavy-handed paternalism of the traditional doctor-patient relationship. There are two categories of patient autonomy models: the consumer model and the contract model.[12] In the consumer

model, the patient shops for medical goods and services just as he or she would for any other commodity and purchases them from the physician. The physician has the duty to obtain informed consent, perform the services competently, and in all ways facilitate the patient's elf-determiniation. In the contract model, the physician and patient enter into an agreement that is binding on both parties, the ethics of each arrangement will vary from relationship to relationship. Third parties have little or no right to interfere with the agreement between the physician and the patient. Both the contract and the consumer models are legalistic, tend to minimize mutual responsibility and are based on patient autonomy. As modern medical transactions become increasingly businesslike, some have advocated applying the principles of business ethics to medicine. They advocate the use of codes that have been developed to handle conflicts of interest in the legal profession in the medical profession as well. Most disputes or conflicts then become matters of contract law rather than ethics[13].

There are those who see the physician as a "zealous advocate" for the patient in a health care system which is confusing and sometimes inimical to the patients' best interests. Morris[14] likens a physician treating his patient in the present health care delivery system to an attorney representing the best interests of his client in a courtroom. Several authors who write on the issue of health care reform find power in this analogy.

Principles of Medical Ethics

Since ethical behaviors vary greatly depending on which image of physician one envisions, effort was directed at elucidating general principles of medical ethics that transcend the individual models. Several principles were outlined which have become classic in the medical ethics literature. These general principles are beneficence, nonmaleficence, justice and autonomy.[15] While these principles have been powerful tools in the hands of medical ethicists, their strict application lacks a consideration of the character of the physician and respect for the individuality and autonomy of the patient. Shortcomings in the use of these principles when analyzing medical decision making has led to various attempts to hierarchically arrange the principles, or alternatively ground medical ethics in virtue theory, feminism, casuistry or experience.[16]

Virtue Theory Grounded in the Physician-Patient Relationship

Is there a theory of medical ethics that transcends the role models and yet allows for more human characteristics than strict principlaism? Pellegrino and Thomasma have proposed an ethical theory grounded in the dynamic healing relationship between physician and patient.[17]

Pellegrino and Thomasma define the healing relationship as the essential dynamic in medicine that distinguishes it from all other professions. They describe five unique features of this relationship that characterize the "internal morality" of medicine[18]. First, patients are autonomous, but vulnerable individuals when seeking medical care. Their illness has robbed them of a certain degree of freedom, and they approach the physician as one who has the knowledge and skill to restore it. The inequality of this transaction imposes de facto moral obligations on the

physician to protect the vulnerable patient from exploitation. Second, the relationship is fiduciary in nature. Patients may be alert consumers and intelligently question the physician, but at some point they must simply trust that the physician can and will help them. They must trust that the physician will act out of something other than self-interest. Third, medicine is both art and a science. Most serious medical decisions entail moral decisions as well. The character and beliefs of the physician play an important role in shaping what both patient and physician view as being in the patient's own good. Fourth, medical knowledge is not proprietary. Society not only finances the research and teaching of medical knowledge, but allows violations of privacy and human dignity to secure it, and thereby gains a stake in its ownership and use. Finally, the attending physician is the "final common pathway" for whatever happens to a patient. There can be no medical or moral buck-passing in this regard, even when ethics committees or HMO policies and procedures are involved.

After describing these unique characteristics of the medical healing relationship, Pellegrino and Thomasma define the nature of the physician-patient relationship as teleological, i.e. oriented toward the patient's goals. The long term goal is health (conceived broadly); the short term goal is cure, or at least amelioration of the disease and its consequences. From the teleological nature of relationship and from the five-fold internal morality of medicine, Pellegrino and Thomasma derive principles that ought to govern this relationship. Among such principles are beneficence, nonmaleficence, patient autonomy and justice. The concomitant virtues of fidelity, phronesis (prudence), justice, fortitude, integrity and self-effacement (the list is not exhaustive) can be derived in turn from these principles.[19] This model is an important attempt to link principles and virtues and ground them in the nature of the physician-patient relationship. It will offer important advantages in the analysis of conflicts of interest.

The Gatekeeper

The erosion of the paternalistic model of medical practice and the rise of the autonomous patient model, along with the demand by insurance carriers to control medical costs, spurred the gatekeeping method of health care delivery. The priority of the medical doctor, as seen from the insurance companies' point of view, shifted from "do *anything* that will help" the patient to "do *only* what will help[20]."

De facto Gatekeeping

Pellegrino and Thomasma describe three types of gatekeeping performed by physicians.[21] First is de facto gatekeeping. In practicing medicine, the physician recommends tests, procedures, hospitalizations, etc. to meet the patient's needs. When the physician does so, the physician is obliged to ensure that the tests are effective and beneficial. The tests must yield information useful to the particular patient and the recommended procedures or therapies must alter the course of the disease. The physician remains the patient's advocate while performing this de facto role. The physician is obliged to obtain tests and use treatments that are beneficial to the patient, and not to restrict access for purely financial or economic reasons.

Many believe the role of de facto gatekeeper, when ethically performed, entails

no conflict with the patient's good. Economics and ethics, individual and social good, and doctors' and patients' interests are all in congruence.

Others are not so sanguine. They hold that the incentive to perform testing enters the medical relationship the moment a fee for service is demanded. The financial inducement this provides to perform testing has been disastrous for the health care delivery system. Critics contend that physicians have disregarded the good of the patient and society and have overutilized medical resources to their own economic advantage. Physicians are in the enviable position of recommending services and being the very people to profit from their performance.

The physician cannot escape this type of gatekeeping, however. It is in the very nature of medical practice to make recommendations for or against testing and therapy. Even the way a physician budgets his or her time can be seen as a form of gatekeeping.

Positive Gatekeeping

A second type of gatekeeping is positive gatekeeping. In positive gatekeeping, the physician purposefully enhances profits and increases utilization of medical resources[22]. The physician acts like a salesperson who markets medical skills and services and attempts to reach the broadest segment of the population possible. Many condemn this form of gatekeeping, and in its most egregious forms it smacks of huckstering. There are many subtle forms of this conflict of interest in the new medical economy, however. A form of positive gatekeeping is at issue in the controversy over self-referral, (i.e. the referral of patients to facilities owned in whole or part by the physician), fee-splitting and physician investment.[23] The complex financial arrangements between hospitals and physician groups, imaging centers, diagnostic laboratories, etc. make it difficult for the individual practitioner to be aware of potential conflicts in this area. Furthermore, as competition for patients increases, some hospitals insist that physicians on their staff use that hospital as their "primary" hospital in which to admit patients. This limits both the physician's and the patient's freedom of choice.

The advertising practices of the HMO's need careful scrutiny. HMO advertising tends to inflate patient expectations and may create demand for the very same goods and services which its policies mean to limit. Inflated expectations increase the likelihood that patients will suspect the allegiance of a physician who impedes access to an expected benefit (a subspecialty referral, for example).[24]

Negative Gatekeeping

A third type of gatekeeping[25] has become popular with the success of HMO's in the healthcare marketplace — negative gatekeeping.

Medicine's initial exposure to this type of gatekeeping came with the advent of the diagnosis related groups (DRG) system for reimbursement of hospitals. A hospital is paid a predetermined amount for a specific diagnosis, regardless of the patient's length of stay in the hospital, or the cost of medical resources consumed during the stay. Physicians were encouraged by hospitals to admit patients only when absolutely necessary, deliver more efficient and more intensive hospital care,

and discharge patients quickly. The hospital's profits were enhanced or diminished, depending on the physician's efficiency. As long as the patients' DRG diagnosis could be made to reflect their clinical conditions, there did not seem to be a conflict of interest between patient and physician. Even so, the axiom of discharging the patient "quicker and sicker" had validity according to critics of this system. Under the DRG system, a rather cynical "gaming" of the diagnoses developed as hospitals scrambled to obtain maximal financial reimbursement for each admission.

A more broadly conceived negative gatekeeping role is being fostered by the HMOs for ambulatory patients. The physician's gatekeeping duty is to coordinate and deliver medical care and minimize the use of diagnostic and therapeutic interventions, especially the most expensive ones. The HMO designates the primary care physician to perform this role. A chief feature of this form of gatekeeping is the physician's responsibility to someone other than the patient for his or her clinical decisions and their financial consequences. The physician is urged to be "cost-effective," many of the money saving measures are also said to increase quality of care. The important feature is that a third party has entered the physician-patient relationship. The physician's behavior is no longer governed solely by his or her own ethics and responsibility to the patient; he or she is also responsible to a third party, usually a profit-oriented insurance company. The physician is held accountable as much for the quantity and cost of medical resources he or she authorizes as for their appropriateness and quality. When financial incentives to physicians for limiting access to medical goods and services are put in place, the conflict of interest between patient and physician becomes even more acute. Now the physician has a financial incentive to withhold diagnostic testing and therapies, including subspecialty referrals. In some plans, the physician's reimbursement suffers for each subspecialty referral made[26].

Marcia Angell decries the "double agent" status of physicians who are forced into this dilemma.[27] The negative gatekeeping role of the physician comes from a comparatively recent belief among social planners and many physicians themselves that the physician has a responsibility not only to deliver medical care to the patient, but to conserve and wisely allocate society's scarce medical resources as well. ANgell believes the incentives to ration medical care which places physicians in this double bind are primarily economic and were initiated by third party payers who reacted against increasing expenditures and widening deficits.

In Angell's view, there are three reasons cited by proponents of negative physician gatekeeping. First, society demands it as a cost saving measure. Second, since insurance companies pay for most of the health care budget, they should decide how the money is spent. Third, the physcian must act as a responsible steward and allocate health care resources wisely. While she discounts the first two arguments and finds some appeal in the third, she advocates instead eliminating waste, "closing" the health care delivery system and applying the same rules equally to all. Most importantly, she cites the double agent role as a conflict of interest between "patient-centered" ethics and the insurance companies' (and physicians') profits. She echoes the sentiments of many physicians when she

observes that sick people need and expect their doctor's single purpose to be to heal them. While vigorously advocating reform of the health care system, she exhorts physicians to eschew the role of double agent.[28]

Toward a Solution

Is there any hope for a solution to resolve the conflicts between the demand of the negative gatekeeping role and the challenge to preserve medical professionalism?

One of the healthiest moves toward a positive solution has already begun — a public discussion of the issues involved. Proposals toward a just solution cannot be the province of the medical profession alone, nor even worse, should they come from the board rooms and stockholder's meetings of health care corporation. The discussion must include professionals, patients, taxpayers (when not in the role of patient), economists, ethicists and theologians. The proposals must edify the professional character of the physician and reinforce, not assault, the doctor-patient relationship.

Financial conflicts of interest for the physician, especially those that result from negative gatekeeping roles must be minimized. Direct financial incentives to deny care or services must be avoided.[29] The reimbursement policies of all major HMO's should be scrutinized with this in mind. The American Medical Association and the American College of Physicians are in a good position to undertake this task. If they are careful to avoid self-serving behavior, they could become strong advocates for patients against the negative gatekeeping role. If the medical professional organizations are unable or unwilling to undertake this review, public policy groups should perform it.

An HMO must fully disclose the potential conflicts of interest in which it places its physicians. Critics of HMO's suggest that the HMO's select their hospitals based on discounts provided to their members, not quality; that they hinder their patient's access to specialists, and deliberately cater to generally healthy people who require fewer services. They contend that companies indue physicians to make decisions based on what's good for the company rather than what's good for the patient.[30] Lawsuits have begun to be brought which allege the negative gatekeeping inducements offered by the HMO contributed to the malpractice of their primary physician.[31] Forcing companies to disclose physicians' reimbursement formulas to its patient-members, may encourage the development of financial reimbursement that does not aggravate the conflict of interest inherent in the negative gatekeeping role.[32]

The framework suggested by Pellegrino and Thomasma of a virtue-based ethic grounded in the healing relationship between physician and patient offers advantages here. Medical decision-making in a climate which must respect patient's rights, yet be socially responsible, will always be difficult. It may be possible to broaden the principle and virtue of medical justice, a constitutive element in all models of medical ethics, to include its social and distributive components. Since Pellegrino's model is grounded in the physician-patient healing relationship, adequate safeguards for the patient should be ensured as society struggles with the notion of what distributive justice for health care resources is.[33] Consensus on the issue of distributive justice is certainly difficult to achieve. In

morally pluralistic societies, there may be no agreed upon definition of justice.[34] There may also be a discrepancy between what we want as taxpayers and what we desire when we or members of our families are patients.

By whatever means societal and financial concerns are introduced into the physician-patient relationship, they radically change the clincial encounter. These changes are hard to justify unless serious efforts are made to control waste and disproportionate profits in the health care delivery system.[35] If public planners insist on comparing the health care budget to the gross national products as a measurement of whether it is excessive, a realistic look needs to be taken at the sums spent on harmful substances like tobacco, cosmetics, advertising, etc.

We can do much to rescue medical ethics.[36] Until more widespread health care reform occurs, we must avoid putting physicians in the role of double agency.[37] Condemning direct financial incentives to withhold care and advocating[38], even legislating, full disclosure of HMO physician reimbursement policies to members, are but two of the steps which can be taken in the interim. Pellegrino and Thomasma's model can serve as a framework within which to continue the discussion about health care reform, and may facilitate the development of more clinically relevant medical ethics. The ethical physician of character can still be guided by the virtues traditionally inherent in the doctor—patient relationship (compassion, honesty, trustworthiness, confidentiality, etc.). Developing societal notions of commutative and distributive justice will help rescue the therapeutic relationship from conflict of interest.[39] Since justice is both a virtue and a principle, overarching principles might be found that apply universally, yet allow flexibility for the individual physician to act justly as he or she sees fit. The virtues are applied within a matrix oriented toward a healing relationship between patient and physician. This ensures that the practice of virtue becomes neither too abstract nor too individualistic.

The physician is not just a businessman or contracted employee. Whatever the medical profession borrows from business and legal ethics must be examined carefully. Most physicians and the general public still expect more of the medical profession than do the leaders of U.S. health care corporations. We need to listen to prophets like Relman, Pellegrino and Angell, who challenge us to rescue the best in the professional medical tradition even while we move ahead with health care reform.

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2. Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care,* (New York: Oxford University Press, 1988): 189. Physician income accounts for 17-20% of the expenditures, but physicians control directly or indirectly up to 80% of all health care expenditures.

3. William F. May, *The Physician's Covenant* (Philadelphia: The Westminister Press, 1983), 25-27.

4. See for example, James F. Drane, *Becoming a Good Doctor* (Kansas City: Sheed & Ward, 1988). Drane argues that the physician has become the modern priest. See also, Harry C. Meserve, "Examining Doctors," *Journal of Religion and Health* 32 (Summer 1993): 85-90. Meserve argues for a strong spiritual component in the role of the modern physician.

5. Robert L. Sevensky, "The Religious Physician," *Journal of Religion and Health* 21 (Fall 1982): 254-263. Sevensky uses the four concepts of vocation, neighbor, love and covenant to analyze the physician's role.

6. David Barnard, "The Physician as Priest, Revisited," *Journal of Religion and Health* 24 (Winter 1985): 272-286.

7. Shaffer, 113-115. Shaffer makes a strong case for the relevance of character and story in determining the ethical code of the legal and medical professions.

8. May, 36-144.

9. May, 142-143.

10. Richard M. Zaner, "The Fiduciary Relationship and the Nature of Professions," in *Ethics, Trust and the Professions: Philosophical and Cultural Aspects*, eds. Edmund D. Pellegrino, Robert M. Veatch, John P. Langan (Washington, D.C.: Georgetown University Press), 47.

11. For a discussion of autonomy as it affects the physician-patient relationship see, Dan W. Brock, "The Ideal of Shared Decision Making Between Physicians and Patients," *Kennedy Institute of Ethics Journal* 1 (March 1991): 28-47. See also Stephen Wear, "The Irreducibly Clinical Character of Bioethics," *The Journal of Medicine and Philosophy* 16 (1991): 53-70. Wear argues persuasively for realistic expectations of patient autonomy based on policies drawn up by those with clinical experience in bioethics and medicine.

12. Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 169-170.

13. See Mark H. Waymack, "Health Care as a Business: The Ethic of Hippocrates Versus the Ethic of Managed Care," *Business and Professional Ethics Journal* 9 (no. 3 & 4): 68-78. Waymack argues that since a member enrolls voluntarily in an HMO and knows the "rules" of allocation, there is no conflict of interest on the physician's part when the patient is denied a possibly beneficial procedure or treatment due to cost constraints. There are several major problems with the argument in this paper. First, can the patient can absolve the physician of moral responsibility by a "freely" chosen contractual agreement? Further, since employees are free to choose only those plans offered by their employer, their freedom of choice may be illusory. Finally, an individual in our society is not "free" to sell him or herself into slavery. This paper maximizes the autonomous individual, but has absolutely no regard for the weak or powerless. It is a prime example of the emphasis on autonomy without sufficient concern for covenantal or fiduciary responsibilities.

14. Tim Morris, "Cost Containment and the Ethical Foundations of the Professional-Client Relationship: The Case of Physicians," *Professional Ethics* 2 (Spring/Summer, 1993): 88-111. See also E. Haavi Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics*, Dordrecht, The Netherlands: Kluwer Academic Publishers, 1991), 93.

15. Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 57-59.

16. Ibid., 53

17. See also Charles J. Dougherty, "Ethical Values in Health Care Reform," *JAMA* 268 (4 November 1992) 2409-2411. Dougherty proposes three intrinsic values (respect for the dignity of persons, caring in therapeutic relationships and protection of the least well-off) and three instrumental values (service to the common good, containment of health care costs, and simplicity in the system of health care provision) as worthy of protection in a revised helath care delivery system.

18. Pellegrino and Thomasma (1988), 40-61, 193-195

19. Pellegrino and Thomasma (1993), 193-195.

20. E. Haavi Morreim, "Fiscal Scarcity and the Inevitability of Bedside Budget Balancing," *Archives of Internal Medicine* 149 (May 1989): 1012-1015. (emphasis mine)

21. Pellegrino and Thomasma (1988), 172-183.

22. Peter Franks, Carolyn Clancy and Paul A. Nutting, "Gatekeeping Revisited: Protecting

Patients from Overtreatment," *The New England Journal of Medicine* (6 August 1992): 424-429.

23. Arnold S. Relman, "Dealing with Conflicts of Interest," *The New England Journal of Medicine* 313 (19 September 1985): 749-751. Relman deals with these specific issues in this editorial.

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25. The Lancet (editorial), "Calling all Gatekeepers: This is an Emergency," *The Lancet* 343 (5 February 1994): 305-306

26. Marc A. Rodwin, *Medicine, Money and Morals: Physicians' Conflicts of Interest* (New York: Oxford University Press, 1993), 157-158.

27. Marcia Angell, "The Doctor as Double Agent," *Kennedy Journal of Ethics* 3 (September 1993): 279-286.

28. Ibid., 283-285.

29. Relman, NEJM 313: 750.

30. Ron Winslow, "HMO Juggernaut: U.S. Healthcare Cuts Costs, Grows Rapidly and Irks Some Doctors," *The Wall Street Journal*, 6 September 1994

31. Rodwin, 168.

32. Douglas F. Levinson, "Sounding Board: Toward Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans," *The New England Journal of Medicine* 317 (31 December 1987): 1729-1730.

33. See E. Haavi Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics*, Dordrecht, The Netherlands: Kluwer Academic Publishers, 1991), 81-100 for an excellent discussion on economic problems of distributive justice in the Health Care system.

34. Peter D. Toon, "Justice for Gatekeepers," *The Lancet* 343 (5 March 1994): 585-587.

35. Cf. 20. In this article, the president and founder of US Healthcare's annual salary of $9.8 million dollars and $11.4 million in dividends on stock options is defended as "definitely not excessive" by the company's chief legal officer. One might question the wisdom of involving people with this mentality in discussions about health care reform. The salaries and compensation schedules of health care company officials should be open to scrutiny as much as physician fees and income.

36. Arnold S. Relman, "Practicing Medicine in the New Business Climate," *The New England Journal of Medicine* 316 (30 April 1987): 1150-1151. Relman makes several practical suggestions for the physician to avoid conflict of interest: physician income should be limited to money earned by services personally provided or supervised; physicians should avoid any arrangements with a for-profit corporation that rewards them for choosing a particular service or facility; physicians should avoid direct employment by a for-profit corporation; physicians should not enter into an arrangement with any organization that directly rewards them for withholding services from their patients.

37. Alan L. Hillman, Mark V. Pauly and Joseph J. Kerstein, "How Do Financial Incentives Affect Physicinas' Clincial Decisions and the Financial Performance of Health Maintenance Organizations?" *The New England Journal of Medicine* 321 (13 July 1989): 86

38. Susan M. Wolf, "Health Care Reform and the Future of Physician Ethics," *Hastings Center Report* 24 (March-April 1994): 28-41. See also Michale D. Reagan, "Physicians as Gatekeepers: A Complex Challenge," *The New England Journal of Medicine* 317 (31 December 1987): 1731-1734.

39. Pellegrino and Thomasma, 94-116. See also Philip S. Keane, *Health Care Reform: A Catholic View* (New York, New York/Mahwah, New Jersey: Paulist Press, 1993), 136-144 for a discussion of the Catholic view of distributive justice in health care.