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Doctors, Ethics, and Managed Care

by

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Doubting Thomas wasn't all bad! He was the model for the good scientist! He had to have the facts of a case. He had to make empirical observations, and then and only then could he come to an understanding of the truth. Jesus, Himself, was also a good scientist! He showed in his public ministry that he was who he was. On a Sabbath day in Nazareth, his home town, Jesus, proclaimed some lines from the prophet Isaiah and the sacred scroll was returned to its customary place. The message was one readily identified with the almost unimaginable leadership initiatives the Hebrew people expected to find in their long-awaited messiah. It described someone imbued with God's spirit who would up lift the poor, free captives, announce the intimacy of the Lord's abiding presence and even return sight to those who were blind. Jesus looked over his local congregation and made the astounding statement, "Today this Scripture passage is fulfilled in your hearing." (Lk 4:21) For this claim he would be respected and reviled, honored, and ridiculed. But Jesus backed up his claim with deeds. From the very beginning of his public ministry Jesus was identified not only as a preacher and teacher but as a healer. Understandably couched in the language of their times and culture, diseases and disabilities, chronic conditions and wasting illnesses all gave way to the curative words and healing touch of the Nazarene who personified the compassion of the Father of all life. The evangelists vie with each other in describing individual healings which inevitably prompted the hoping and the hopeless to clutter the roadside as he passed through their midst. There was Peter's mother-in-law (Mt 1:29-31), the crippled man (Jn 5:1-9), the ten lepers (Lk 17:11-19), the Canaanite woman (Mk 7:24-30), the man with the withered hand (Lk 6:6-11 & Mk 3:1-6), the daughter of Jarius (Mk 6:21-24), the entombed Lazarus (Jn 11:1-44), the paralytic who found peace of soul more precious than the restoration of his limbs (Lk 5:17-26), and of course the sensitive

bantering and, in some ways, humorous narrative of the Sabbath cure of the man born blind (Jn 9:1-41). Some 41 healings in all are described in the various Gospels.

Matthew tries to summarize this frenetic activity: "And he went all about Galilee, teaching in their synagogues and preaching the gospel of the kingdom and healing every disease and infirmity among the people" (Mt 9:35). His analysis of the Lord's impact further north was similar, "So his fame spread throughout all of Syria, and they brought him all the sick, those afflicted with various diseases and pains, demoniacs, epileptics, and paralytics, and he healed them" (Mt 4:24). Luke's conclusion is more succinct: "And they departed and went through the villages, preaching the gospel and healing everywhere" (Lk 9:6). Each of the synoptics has its version of Jesus giving the great commission: "He called the twelve together and he gave them power and authority over all devils and to cure diseases and he sent them out to proclaim the Kingdom of God and to heal." (Lk 9:1-2) "He summoned his twelve disciples and gave them authority over unclean spirits with power to cast them out and to cure all kinds of disease and sickness." (Mt 10:1)

We physicians are the spiritual inheritors of this aspect of the great commission to the Apostles. Ours is truly a God given ministry. We do our work because of the rule of God given in nature and freedom by the Father to Jesus and by Jesus to the twelve (*Exousia* in Greek — translated by Jerome into Latin as *autoritas* — authority). *Exousia* rests upon a practical insight into the Good, the True, and the Beautiful. It comes with experience and is manifested upon recognition of the Community. It is characterized by wisdom, equanimity, talent, charisma, and selflessness. It results from the recognition by both Doctor and Patient that their relationship is not oriented to one or another of two individual human beings, but to a "Third thing", i.e. to God! This is why we can truly say that medicine is a profession. In considering managed care, we must keep this concept of *exousia* always before us.

In addition we must always be attentive to recent Church social teaching concerning health care as an individual right. The primary warrants for this position are expressly theological involving three themes that, while interconnected, can be analyzed separately. The first is an appeal to the dignity of the individual made in the image of God. The second is an understanding of the common good, which in contrast to secular liberal theory, sets forth an organic vision of society with duties incumbent upon institutions according to the purpose of society as established by God. The third theme, which follows in the emodern encyclical literature as an extension of the traditional emphasis upon the common good, is the regulative ideal of what's called social justice. Social justice is a specific substantive ideal meant to speak to the increasing duties of governments and institutions to provide the material conditions necessary for individual dignity. Leo XIII in *Rerum Novarum* speaks about certain material conditions that must be established to safeguard the dignity of individuals, Pius XI in *Quadragesimo Anno* emphasized the legitimate needs that persons have for material well-being of a certain minimum level. John XXIII in *Pacem in Terris* said: "we see that every man has the right to life, to bodily integrity, and to the

means which are necessary and suitable for the proper development of life. These means are primarily food, clothing, shelter, rest, medical care and finally the necessary social services. Therefore a human being also has the right to security in cases of sickness, inability to work, widowhood, old age, unemployment, or in any other case in which he is deprived of the means of subsistence through no fault of his own." Paul VI in *Progresso Populorum* build on Pius XI's theme. He said: "Material well being is not simply instrumental in value. It is not a means of a dignified life. It is, rather, integral to the standard of all moral value, human dignity." John Paul II said in *Laborem Exercicem*: "Christian tradition has never upheld the right to private property as an absolute and untouchable. On the contrary, it has always understood this right with the broader context of the right common to all to use the goods of the whole of creation; the right to private property is subordinated to the right to common use, to the fact that goods are meant for everyone."

Managed care does not support human dignity, the common good, or social justice!

Health Care Delivery Changes

There have been two transforming changes in the American health care delivery system in this century. The first was when a group of public school teachers in Houston, Texas during the great depression contributed about fifty cents a week to a fund and organized an insurance program to pay members' bills for any needed hospitalization and attending doctor's services. This was a transforming, indeed a revolutionary change, for it introduced a payer system for medical and hospital care that interposed a third party between the physician and hospital care that interposed a third party between the physician/hospital and the patient. This action of the Houston school teachers was the beginning of what is now known as the Blue Cross/Blue Shield Hospital and Medical Insurance program. Many incremental changes have been made in this concept over the years. An important one was when the federal government undertook in 1965 to provide the financial support for such a third party payer system for Social Security beneficiaries by establishing the Medicare program and, in conjunction with the several states who elected to join, a cooperative third party payer system for the poor, namely the Medicaid program. The second transforming change in the American health care delivery system occurred in 1994 when the Congress failed to enact a national health care system as recommended by the Clinton administration. Following this failure the private health insurance sector driven by market forces was able to capture over 40% of the total population for managed care insurance plans in less than a year. It was also able to persuade the Republican Congress which came to power in January of 1995 to adopt as a cost cutting measure, the concept of managed care as the ideal insurance program for recipients of Medicare and Medicaid.

No other changes to date within this century in our health care delivery system have had such a profound effect. The managed care system as the ideal third party payer system is celebrated by its proponents as the panacea for the out of control

expenditures for health care in the American economy. Such expenditures now amount to about 16% of the gross domestic product. Health care economists have for many years warned that a country which spends more than 10% of its gross domestic product for health care will eventually go bankrupt.

George Will, the syndicated columnist, in a very provocative article published on January 18th last on the op-ed page of the *Washington Post* pointed out that in 1930 the average life expectancy in the United States at birth was 58 years for men, and 61 for women. By 1990 it was 71 and 79 years respectively. Until the 1930's the average manufacturing worker toiled nearly 50 hours a week with few rights or benefits. In 1996 about 80% of all workers have employer paid health insurance. As late as 1948 retirement was not a certainty; about half the men over 65 worked. In 1995 after decades of supposed "Deindustrialization" industrial production was 40% higher than in 1980, 90% higher than in 1970, and 350% higher than in 1950. Between 1929 and 1933 output declined almost 25%. In the worst postwar recessions (1973-74 and 1981-82) output declined just 4.9% and 3%, respectively. Will asks why during this epoch of unprecedented achievement has America become preoccupied with perceived failure in our national life. He suggests that the answer may be found in Robert Samuelson's new book "The Good Life and Its Discontents: The American Dream in the Age of Entitlement, 1945-1995". He says that postwar progress bred an entitlement mentality which in turn bred disappointment that the nation was not living up to unattainable promises. The belief was that we were entitled to what ever is possible: that a rapid, uninterrupted and painless increase in prosperity is possible and that such prosperity would banish most social ills. This dreamlike concept of progress was accompanied by a decline in the sense of responsibility. Samuelson believes that the mobilization of society for the Second World War blurred the distinction between governmental and private responsibilities. The post war agenda of unideological "problem-solving" politics erased the distinction between problems that can be solved and conditions that must be endured. For example, in 1970 the man who had been Lyndon Johnson's chief economic adviser said that recessions are "fundamentally preventable, like airplane crashes and unlike hurricanes." Thus did economics once the "dismal science" that explained costs and limits, become the "cheery science" encouraging the delusion that proper politics is (like another postwar chimera, the "science of management") merely a matter of experts' techniques. We can say the same about managed health care.

Managed health care strives to limit spending, typically by paying doctors and hospitals only a fixed amount for each patient under their care — capitation. The payments for the sick and well are supposed to balance and leave a profit for health maintenance organizations (HMOs) and other managed-care enterprises. This concept goes far beyond the original idea of a health maintenance organization first envisioned and proposed by Dr. Paul Ellwood of the University of Minnesota School of Medicine. To its enthusiasts, managed care eliminates waste and emphasizes preventive medicine. In actuality it compels doctors and hospitals to skimp on needed care — or deny it entirely for under capitation doctors get paid nothing extra for providing more rather than less care and often if the doctors have above average visits, laboratory studies, specialist referrals, or

hospitalizations, they are penalized monetarily. In 1988 71% of workers who had health coverage through company-provided insurance had a fee-for-service indemnity plan and 29% had managed care. In 1995 only 30% of workers had such an indemnity plan while 70% were enrolled in managed care programs. Most participants can no longer select their own doctors freely. They must either join an HMO which assigns them a doctor or pick from list of approved doctors in managed care networks. This change occurred so rapidly in part because managed care evolved beyond traditional HMOs. These are essentially clinics with their own buildings, equipment, and staff doctors. To convert fee-for-service medicine to this sort of managed care would have required the dispossession of countless thousands of doctor's offices. Instead, managed care accommodated the existing deployment of doctors by absorbing them. Some managed care systems are building their own facilities for the provision of technological services such as radiology, same day surgery, etc. Others contract for specific service under with independent hospitals and clinics. Most are organizing the physical facilities under their control to provide a spectrum of care appropriate (as defined by the business executives running them) to the needs of their enrollees. This includes acute intensive hospital care, subacute care, rehabilitation convalescent care, short term nursing home care, hospice care, and home health care. The managed care systems are doing this by purchasing, constructing or contracting with appropriate health care facilities needed to achieve their goals. This permits the managed care organization to provide a continuum of care which is tightly under its control. Appropriate levels of care for the shortest needed time, they claim, can thus be given. Patients can be moved quickly and expeditiously throughout this network with a minimum of expense. Decisions for medical care are guided by rigid protocols, or algorithms which may well distort doctor-patient relations and delay needed treatment. Care is monitored not by physicians, but by non-professionals. In theory competition among managed care plans for patient groups will cut cost and improve service. And health care spending has indeed subsided. In a recent survey, employers' insurance premiums rose only 2.1% in 1995, down from 11.5% in 1991. Although some savings may be temporary — ending obvious waste — a study of California, where managed care is most developed, suggests that much waste is not eliminated. In a recent study conducted by the Rand Corporation the state's health spending regularly rose, but less than national spending, between 1980 and 1991. Hospital spending rose half the national rate; doctors' spending was 30% lower. Managed-care plans achieve some savings by having hospitalization rates about half the national average. The distribution of expenditures has also been altered by managed care plans. Payments to all providers represented 61% of total expenditures in 1994 down from 88% in 1993 while administrative costs increased from 3% to 30% in managed care plans in the same time periods. Generally the return to share holders in for-profit managed care plans has been good. The CEO of one such plan earned 3 million dollars in 1994!

The Bottom Line

Mary McGrory, the syndicated columnist who comments always in a most amusing way on our national politics and problems, wrote recently about managed

care. She said: "More and more people find that their health decisions are being made by bookkeepers rather than doctors. The Hippocratic oath is being trampled on by the bottom line. The brutal business of sending mothers home after one day in the hospital — even those who have had Caesarean delivery of twins — has caused such an outcry that several states have passed laws mandating longer stays. Doctors complain that routine tests and treatments are vetoed by bookkeepers. Even the filling of a prescription at your local drugstore is subject to the bean counters. Try to get your medicine from your friendly pharmacist three days before the insurance company says you should have run out, and see that there is nothing too small for their notice. No allowance is made for people who drop pills on a dirty floor!"

Managed care programs are interested in the flow of money in and out of the system. The flow of patients is secondary! There have been no studies done as yet on whether managed care's savings come from increased efficiency as they claim or from reduced access and/or quality. There are no procedures set up in the managed care organizations to assess quality of care. HMOs just assume that quality is there. Research on the policies and procedures utilized by for-profit managed care systems for creating, implementing, and evaluating practice guidelines, evaluating quality care and patient satisfaction, practice variation across geographical areas, as well as effective utilization review programs is desperately needed. The bottom line for managed care systems is profit for the shareholders as Mary McGrory so astutely point out. Consider how the system works: In for-profit managed care, medical providers have a strong financial incentive to deny care because they paid a capitation fee for each patient they have on their rolls. Consequently, the more care they have to provide the less money they make. A recent study by Public Citizen's Health Research Group suggests that there are large discrepancies between the care given patients of for-profit HMOs and those served by non-profit managed care providers. Medicare beneficiaries enrolled in for-profit HMOs were five times more likely to file appeals because their requests for care have been turned down than were those beneficiaries enrolled in not-for-profit HMOs. HMOs of both stripes often have their decisions to deny care reversed by the Health Care Financing Administration, the federal agency that manages Medicare. The study showed 45% of appeals were reversed. The current administrative overhead for Medicare is two cents on the dollar, for Medicaid about a nickel, for private insurers generally about 15 cents on the dollar for overhead and profit, and for private managed care operations average a whopping 20% overhead. Dr. Steffie Woolhandler at the Harvard School of Public Health published a study in the *American Journal of Public Health* recently. This study showed that the number of managerial staff members in hospitals in the United States grew from 129,000 in 1968 to over one million in 1993 and much of the increase is due to managed care programs' requirements to ration care through a utilization review process.

This transforming change which spurred the growth of for-profit managed care programs has turned health care into a corporate battlefield increasingly governed by the promise of stock market wealth, incentives that reward minimal care and a brand of aggressive competition alien to front-line doctors for whom

dressing for success still means wearing khakis and a lab coat. A paradigm shift has taken place in which doctors have become "gatekeepers", patients have become "covered lives" and remote managers decide who gets treatment, and who doesn't and what kind of treatment will be given.

This transforming change has created a number of serious ethical problems related to the practice of medicine. Physicians following the Judiac-Christian ethical principles exemplified by Jesus, the Christ have always put the best interests of their patients foremost as the guiding principle in their practice of medicine. The doctor-patient relationship is the cornerstone for achieving, maintaining and improving health. The maintenance of the doctor-patient relationship is seriously threatened under managed care systems. Physicians in such systems are asked to serve as "double agents" weighing competing allegiances to patient's medical needs against the monetary costs to society. Most people underestimate the magnitude of the conflict between a physician's functioning under a managed care system. There is an irreducibility of conflict between cost-driven, as opposed to care-driven health care policy. As Dr. Edmund Pellegrino emphasized: "Delays in care, postponement of consultation or hospitalization . . . impersonality, loss of dignity, and magnification of suffering . . . influence the quality of care, degree of satisfaction, and functional capacity of the ill, but are not easily resolvable issues under a managed care system. These are the care issues that cannot be ignored in a cost controlled system." Allocation decisions that involve "bedside rationing" and that may include denial of a consultation or procedure that might benefit the patient conflict with the physician's traditional role as the patient advocate. Good primary care internists, pediatricians, and family practitioners are being forced to take on the role of being mediocre specialists. Financial incentives to control or limit care compromise the physician's duty and loyalty toward the patient and may seriously harm the patient's trust in the physician. The gold standard of medical practice has always been and should continue to be the patient's and not the physician's best interests. Physicians must be advocates for their patients and not the physician's best interests. Physicians must be advocates for their patients before they consider their own autonomy, income, and prerogatives. The ethics of medical care should be totally divorced from the costs of rendering that care, but it cannot be for pragmatic and political reasons. Clearly, managed care and managed competition are cost driven and not care driven. Physicians under managed care must remain advocates for their patients. The physician is inescapably a moral accomplice if harm is done to the patient. The physician must also recommend and do what is best for the patient and not become a functionary of the system. Although the physician-patient relationship under managed care may be somewhat distorted, the patient's interests can and must be safeguarded. Patients should not have to view their providers as case managers or gatekeepers, but as caring and concerned physicians who work under certain restrictions dictated by social values and cost considerations. The term managed care is an oxymoron since "care" requires flexibility and judgment, whereas "managed" implies rigidity and rules. Managed care thus intrudes on and limits the physicians' autonomy. The art of medicine must still take precedence over the business of medicine.

Example From History

History often repeats itself. This indeed is the case of managed care. We only have to go back to the late 18th century to see an example of managed care which occurred at the Royal Infirmary, Edinburgh between 1750 and 1880. This experiment was ultimately a failure and resulted in an ethical crisis for the physicians at the Royal Infirmary. John Gregory's book on ethics was the only good thing that came out of this disaster.

His book "Lectures on the Duties and Qualifications of a Physician" published in 1772 outlined the ethical dilemmas which resulted for the physicians connected with this managed care enterprise. The Royal Infirmary founded in 1730 and supported subsequently by the gentlemen of the city was run by lay managers. Individuals who sought care in the charity ward staffed by the University trained gentlemen physicians first had to get a ticket of recommendation from one of the supporting Lairds recommending admission. The individual then present himself to the lay manager who screened him to see if he had any condition associated with a fairly sure mortality. If such obtained he was denied admissions for the physicians did not want a high mortality rate on the charity ward they operated to sully their reputation for brilliance and success. This is an early example of market segmentation. The physicians who had studied under the famous Dr. Young, inventor of forceps, soon vied for female patients who formerly had always been attended in their confinements by female midwives. A good example of fighting for the market share.

The city of Edinburgh had a generous supply of "healers" — University trained gentlemen physicians, barber surgeons, apothecaries, midwives, and others perhaps best lumped together under the term "quacks." There was no set pathway into medicine. There were no qualifications which had to be met. There were no licensing or certification procedures. Gregory's qualifications were that he was a University trained physician who had studied on the continent and was a Fellow of the Royal College of Physicians, Edinburgh. Any one who called himself or herself a healer could compete. And with this abundant supply of healers, competition was fierce for patients, treatments, theories and remuneration. Self interest of the healer came before the interests of the patient. Specialists (the gentlemen physicians and surgeons) were competing with the generalists (the apothecaries and barber surgeons) for giving primary care. All were struggling to make a living. Many of the healers had to go to other locations outside of Edinburgh or go into other trades. In California today where managed care programs are most highly developed we see an oversupply of physicians. This has resulted in underemployment (cutting of salaries in managed care corporations), unemployment, and reeducation of physicians for other health related work such as utilization review, forensic medicine, etc. There has even occurred a medical migration out of the state of California into other states to the East causing great anxiety for specialists in these states over possible loss of business and income.

Gregory astutely pointed out the ethical problems that this system of managed care produced. He was particularly concerned that the physician should be the

moral fiduciary of the patient. He insisted that the first duty of the physician should be knowledge of the patient's illness, that the physician should blunt his self interest, and that he should act always for the best interest of the patient. All of the ethical problems with which Gregory was concerned, we see duplicated today in the managed care enterprise. Physicians were competing with each other for patients. Lay concepts of health and disease were competing with scientific knowledge and theories. There were lay managers in control of resources. Doctors could not be trusted to use resources prudently when fee for service was in place because it was felt that physicians were notoriously poor business managers. The patient kept asking: Then whom can I trust? Gregory pointed out that the ultimate duty of the physician was to act as the fiduciary for the patient and to practice in a responsible way always putting the best interests of the patient before self interest or the interests of the managed care institution — then the Royal Infirmary — now as we see the HMO or the profit managed care system!

What should physicians do in this era of managed care when we know, as I hope that I have shown, that medical ethics is surely often compromised by this type of enterprise? The insurance lobby in Congress is very, very powerful. Individuals in the vicinity of Hartford certainly know this better than the “collier in Newcastle” from Washington! Since it appears that managed care programs are here to stay, at least for a time until the American public becomes fully aware of their shortcomings and demands change, physicians must be able to somehow work in this new environment. The Woodstock Theological Center is a nonprofit, independent, research institute established in 1974 by the Maryland and New York Provinces of the Society of Jesus to address topics of social, economic, and political importance from a theological and ethical perspective. It is located on the campus of Georgetown University. The Center recently held a symposium on the Ethical Considerations in the Business Aspects of Health Care. Many excellent suggestions came out of that symposium for health care professionals and organizations on how to live ethically in this era of managed care. I strongly recommend to all of you for your study their publication put out by the Georgetown University Press.

I think one can learn a lot also from the experience of the physicians in Arizona. The western part of the nation has lead the way in the development of managed care programs. The Blue Cross programs started in Houston during the Great Depression. The Kaiser Permanente plan was erected in California during World War II. The citizens of Arizona, a sunbelt state and a haven for retiree Snowbirds, have taken to managed care programs with great enthusiasm. But the programs are different from those in many other places — the managed care programs are for the most part preferred provider networks which have been organized by the health care workers and facilities. Doctors took the lead in setting up the organizations and developing systems of care which included private physicians in office practice, and institutions such as hospitals, same day surgical outpatient facilities, radiological practices, and the like. The physicians who created these organizations took control away from the lay managers and bookkeepers and drew up the practice protocols and the algorithms for treatments programs. They developed good utilization review programs as well

as effective quality care programs which were designed so as not to violate ethical practices in medicine. The state has seen its costs for medical and hospital care tumble through a system of managed care introduced 13 years ago. The savings came from careful monitoring and correcting inappropriate use of the emergency room, inappropriate lengths of stay, and inappropriate hospitalizations set up under guidelines created by health care professionals. This was accomplished by a very good and intensive educational program mounted by the providers to promote an understanding on the part of beneficiaries of preventive medicine. Also the health providers transformed their approach to patient treatment. They now focus on social as well as medical needs — what the Arizona State Medical Society has adopted as a slogan: “Taking care of problems before they occur”.

As must be evident by now, I am a “doubting Thomas” when it comes to the success of managed care. This activity seems to be so fraught with problems of a professional and ethical nature, some of which I hope I have enumerated above, that surely when the American public comes to realize just what a pig in a poke they have been sold, they will revolt perhaps within 8-10 years and demand real reform. Then, please God, hopefully we will get a real national health plan whose politics and procedures will be created not by lay persons but by health professionals. After all the US and South Africa are the only industrialized countries in the world which do not have a national health plan. It seems to me in preparation for this eventual outcome, we health care professionals should see to it that some of our number — doctors, nurses, pharmacists, physical therapists and the like study and get degreed and credentialed in law, business, philosophy, management, and computer science and other appropriate disciplines so that true health care professionals will be able to move into the administration of such a national health program to insure that it is governed and operated so that the best interests of the patient are always in the forefront. In this way we who work in the various health care professions can truly carry out our God given mission passed on by Jesus to the Apostles and by them to us with the “Exousia” of the Father as our guide and inspiration.
