Physician Ethics in Managed Care Settings

Norman G. Levinsky, MD

A fundamental principle of medical ethics is that, in clinical practice, physicians must serve as fiduciaries who place the interests of patients ahead of other interests, especially self-interest.[1,2] However medical practice is organized, the potential for conflict between this ideal and the reality of physicians' behavior always exists.

In traditional fee-for-service practice, the possibility of personal economic gain may influence the practitioner, consciously or subconsciously, toward delivery of excessive medical services. Without an economic incentive, salaried physicians may provide less-than-optimal personal effort.

Ethical Tensions in Managed Care

As the cost of medical care in the United States has spiraled upward, pressure has increased on physicians to serve two masters—the patient and society—when making decisions about the medical care of individual patients.[3] More recently, the growth of managed care has added a third master, the economics of a managed care plan. Physicians caring for patients enrolled in managed care programs now may be expected to serve the financial goals of the managed care plans as well as the medical needs of their patients. Pressures to decrease expenditures in the care of individual patients, previously diffused into broad issues of societal versus individual needs, now are focused sharply by specific mandates from managers of health maintenance organizations (HMOs) to limit expenditures. Many trends in the development of managed care, including increasing competition among the growing number of plans, proliferation of for-profit plans, and demands by purchasers of health insurance for reduced premiums, have increased the potential for clashes between professional ethics and the realities of the medical marketplace.[4] As competition among managed care plans has intensified, reduction in cost has become a primary determinant of success—indeed, of survival. In this environment, even formerly ethical managers may press physicians to act as "double agents" whose decisions about the medical needs of individual patients are subordinated to the economic imperatives of the managed care plan.

From the perspective of professional ethics, two key features of managed care that are of great concern are incentives or pressures on physicians to limit clinical services and mechanisms by which nonprofessionals can control physician behavior. In fee-for-service practice, physicians struggle only with their own consciences. In managed care entities, managers can impose their standards on physicians.

The balance in emphasis between economics and professional judgment in patient care varies among managed care plans according to their history and organizational patterns.[5] A number of plans, especially some of the older ones founded with substantial physician input in the era before the ascendency of current pressures to control costs, largely retain an ethos of professionalism, in which the goal is to deliver medical care according to the physician's best judgment. Other managed care plans have developed a variety of mechanisms to tempt or pressure physicians to focus disproportionately on reduction of expenditures and to control physician behavior. Even in physician-generated independent practice associations (IPAs), the reality of competition may favor authoritarian management, rather than professionalism, and a business culture, rather than a physician culture guiding actual practice.[6]

Influencing Professional Behavior

Managed care plans may preempt professional judgment by not offering some services, such as trans-

From the Department of Medicine and Evans Department of Clinical Research, Boston University Medical Center, Boston, MA.

Address correspondence to: Norman G. Levinsky, MD, Department of Medicine and Evans Department of Clinical Research, Boston University Medical Center, 88 East Newton Street, Boston, MA 02118.

plantation, that their physicians might consider appropriate for certain patients under their care. A variety of methods may be used to induce physicians to reduce the use of available clinical services. In most plans, allocation of services is determined by primary care physicians, caregivers charged to serve as gatekeepers who limit access of patients to diagnostic studies, therapeutic alternatives, specialists, and hospitalization. Working on schedules set by management, primary care physicians also may be required to reduce their own services to patients to suboptimal levels, especially that most precious component of primary medical care, their own time. This requirement is especially ironic, as time is critical to a fundamental principle of primary care practice, the creation of a personal bond between the physician and the patient as a whole person, not simply as the bearer of a symptom or a medical problem. Obviously, economic factors also influence the schedule of the fee-for-service practitioner, but ultimately, the balance between income and practice standards is set by the physician alone.

Managed care plans can use at least three mechanisms to influence or control activities of their physicians. First, practice standards may be set by management and enforced by periodic reviews of each physician's practice.

Second, financial incentives may be offered to the physicians to reduce patient care expenditures. These incentives may include return to the physician of a share of an annual capitated budget, if the budget has not been expended fully. Bonuses may be based on cost-conscious practice within established norms. In IPAs, a portion of established fees may be withheld, to be paid only if the practitioner or the whole plan meets certain economic goals. Both data[7] and common sense indicate that financial incentives do work.[8] Because it is widely accepted that the opportunity for personal financial gain is one explanation of overuse of medical care in fee-for-service practice, it is hard to see why financial incentives to reduce care would be ineffective in managed care practice.

Third, the ultimate threat available to HMO managers is dismissal of the salaried physician or elimination of the self-employed physician from the panel of providers. As a surplus of physicians is becoming a reality in the United States,[9,10] the threat of dismissal or elimination represents an increasingly potent incentive to physicians to conform to the dictates of management. An oversupply of most specialists already exists and will grow as access to specialists is limited by extension of managed care to a large fraction of the American population. Although currently there is a shortage of primary care physicians, managed care plans are turning to midlevel practitioners to offer a large share of primary care. There soon may be more primary care doctors than required by managed care companies. The ability of managers to control physician behavior will increase dramatically in an era of physician glut.

Remedies for Ethical Tensions in Managed Care

As noted at the beginning of this article, the potential for conflict of interest in patient care exists in all forms of organization of medical care. No systematic remedies have been devised to minimize the risk that physician self-interest in fee-for-service practice will result in wasteful or even harmful overtreatment.[11] Only the professional ethics of individual practitioners oppose the potential impact of economic gain on practice standards. On the other hand, no management subtly or overtly pressures independent physicians to place economics ahead of professional ethics.

Do any means exist to reduce the risk that the pressures of the marketplace will override professional ethics when clinical care is delivered under the aegis of managers? A priori, one might presume that the potential to foster professionalism of practitioners, for example through peer review, might be greater in organized physician groups in managed care than among largely unorganized fee-for-service physicians. Ideally, well-conceived and effective quality assessment measures should achieve this goal. Using practice standards or guidelines set by professional groups, quality assessment programs in each managed care entity would review patient care to ensure that high quality and cost-effectiveness are maintained. Regrettably, current quality assessment techniques are blunt tools to achieve this ideal.[12] It seems improbable that adequate quality assessment methods will become available within the next decade to permit dependence on this mechanism to maintain practice standards. Even when suitable quality tools become available, it is doubtful whether managed care plans pressed to meet the demands of buyers for low prices will implement them unless required by government regulations.

The possibility that quality assessment programs might reveal the need to increase patient care expenditures and thus require increased premiums will inhibit their use unless buyers select managed care plans according to quality. Unfortunately, the distinction between amenities and quality of care is not necessarily evident to buyers. In my judgment, quality measures, while potentially a valuable tool to en-

courage delivery of adequate clinical services, will not be adequate in the foreseeable future to resist the pressure in managed care plans to place cost reduction first.

Without close monitoring of the effect on patient care by quality assessment methods, substantial incentives to physicians to limit care should be eliminated. It is unreasonable to tempt physicians with the potential for substantial personal gain through bonuses or incentives for reducing expenditures for care of their patients. We physicians "have not yet turned our collars around and we continue to live in a capitalist society where money counts."[6]

Evolving case law may represent a tool, albeit a dangerous and expensive one, to curb excessive zeal to reduce costs at the risk of suboptimal patient care.[13] Even as an employee of a managed care plan, each physician is still responsible for his or her individual actions. Moreover, managed care plans are liable for selecting competent physicians and for the quality of care delivered by their physician-employees. Negligent implementation by the plan of cost control mechanisms resulting in injury to patients is actionable. Just as the threat of malpractice suits is believed to induce physicians to overuse diagnostic technology, the threat of lawsuits may induce both management and physicians in managed care plans to avoid underuse of appropriate medical care.

The most realistic guardian against an improper balance between economics and ethics in a managed care plan is a culture of professional and patient involvement in setting its standards for patient care.[2,5,13] The board of directors of every managed care plan should include patients and physicians in sufficient numbers to have real influence on management decision making. Historically, a number of successful nonprofit HMOs have been organized in this way. Whether this is possible in for-profit managed care plans is doubtful; their managers have a fiduciary responsibility to their stockholders that may conflict with their duty to their clients.[15,16]

Responsibilities of Physicians

The ultimate protection of professional standards is for physicians to tell patients the truth and openly to reveal pressures to serve two masters—the patient and the bottom line of the managed care plan.[1,2,5,14] It is uncertain to what extent physicians will be willing to maintain this professional ideal at the risk of sanctions, such as termination from managed care plans. Patients and their employers (insurance buyers) must be informed if necessary elements of care are eliminated from contracts or if there are pressures on or incentives to physicians to reduce needed care. Effective appeals processes and professional standards bodies are vital in each managed care plan to resolve tensions among patients, physicians, and managers about the appropriateness of clinical care decisions.

However, physicians should not "game the system"[17] by manipulating information or pressuring administrators to provide care demanded by patients if, in their professional judgment, the care is unnecessary or futile. Managed care plans are closed economic systems in that a limited number of premium dollars must suffice to provide the care required by all patients in the plan. In an open system, such as the US healthcare system, dollars saved in the care of one patient will not go to help another. In a managed care program, dollars do flow from one patient to another or to reduced premiums (unless diverted to profit or "retained earnings").

Managed care exerts both subtle and overt pressures on physicians to limit services to patients. In a real world of economic imperatives, competitive pressures, and an oversupply of physicians, will high standards of medical professionalism survive? Physicians might be able to maintain the historic ideals of their profession in day-to-day medical practice in managed care settings, but the prognosis is uncertain. The economic forces that managed care plans can exert on physicians make it unlikely that physicians alone can uphold the primacy of professional ethics in managed care settings. Patients are physicians' natural allies. Increasingly, patients are becoming aware of the impact of managed care on their health and satisfaction. The media now regularly feature stories of drastic reductions in hospital stay after childbirth[18] or of denial of emergency care to patients in HMOs.[19] If physicians ally themselves with their patients, they may be able to avoid becoming corporate employees who keep gates rather than care for patients.

··· REFERENCES ···

1. Rodwin MA. Conflicts in managed care. *N Engl J Med* 1995;332:604-607
2. Council on Ethical and Judicial Affairs, American Medical Association. Ethical issues in managed care. *JAMA* 1995;273:330-335.
3. Levinsky NG. The doctor's master. *N Engl J Med* 1984;311:1573-1575.
4. Kassirer JP. Managed care and the morality of the marketplace. *N Engl J Med* 1995;333:50-52.
5. Clancy CM, Brody H. Managed care: Jekyll or Hyde? *JAMA* 1995;273:338-339.
6. Shenkin BN. The independent practice association in theory and practice: Lessons from experience. *JAMA* 1995;273:1937-1942
7. Hillman AL, Pauly MV, Kerstein JJ. How do financial incentives affect physicians' clinical decisions and the

financial performance of health maintenance organizations? *N Engl J Med* 1989;321:86-92.
8. Hillman AL. Health maintenance organizations, financial incentives, and physicians' judgments. *Ann Intern Med* 1990;112:891-893.
9. Wennberg JE, Goodman DC, Nease RF, Keller RB. Finding equilibrium in the U.S. physician supply. *Health Affairs* 1993(summer);12:89-103.
10. Council on Graduate Medical Education. *Fourth Report to Congress and the Department of Health and Human Services Secretary*. Washington, DC: US Government Printing Office; January 1994.
11. Franks P, Clancy CM, Nutting PA. Gatekeeping revisited—protecting patients from overtreatment. *N Engl J Med* 1992;327:424-429.
12. Epstein A. Performance reports on quality—prototypes, problems, and prospects. *N Engl J Med* 1995;333:57-61.
13. Hall RCW. Legal precedents affecting managed care: The physician's responsibilities to patients. *Psychosomatics* 1994;35:105-117.
14. Emanuel EJ, Dubler NN. Preserving the physician-patient relationship in the era of managed care. *JAMA* 1995;273:323-329.
15. Relman AS. Salaried physicians and economic incentives. *N Engl J Med* 1988;319:784.
16. Scovern H. Hired help: A physician's experiences in a for-profit staff-model HMO. *N Engl J Med* 1988;319:787-790.
17. Morreim EH. Gaming the system: Dodging the rules, ruling the dodgers. *Arch Intern Med* 1991;151:443-447.
18. Gordon S. Braking the OB express. *Boston Globe* July 1, 1995:57-58.
19. Gentry C. HMOs' cost-cutting frenzy is a pain. *Boston Globe* July 4, 1995:11.