Ethics in Practice: Managed Care and the Changing Health Care Environment

Medicine as a Profession Managed Care Ethics Working Group Statement

Gail J. Povar, MD; Helen Blumen, MD; John Daniel, MD; Suzanne Daub, MSW; Lois Evans, DNSc, RN; Richard P. Holm, MD; Natalie Levkovich; Alice O. McCarter, MSW; James Sabin, MD; Daniel Sulmasy, OFM, MD, PhD; Peter Vaughan, PhD; Laurence D. Wellikson, MD; and Amy Campbell, JD; for the Medicine as a Profession Managed Care Ethics Working Group*

Cost pressures and changes in the health care environment pose ethical challenges and hard choices for patients, physicians, policy-makers, and society. In 2000 and 2001, the American College of Physicians, with the Harvard Pilgrim Health Care Ethics Program, convened a working group of stakeholders—patients, physicians, and managed care representatives, along with medical ethicists—to develop a statement of ethics for managed care. The group explored the impact of a changing health care environment on patient-physician relationships and how to best apply the principles of professionalism in this environment. The statement that emerged offers guidance on preserving the patient-clinician relationship, patient rights and responsibilities, confidentiality and privacy, resource allocation and stewardship, the obligation of health plans to foster an ethical environment for the delivery of care, and the clinician's responsibility to individual patients, the community, and the public health, among other issues.

For author affiliations, see end of text.
See related article on pp 126-130.
*For members of the Medicine as a Profession Managed Care Ethics Working Group, see the Appendix at www.annals.org.

Health care resources are finite; their allocation requires hard choices. Hard choices are at the heart of ethics. The ethical challenges posed by limits are not created by managed care but often must be addressed with and through managed care organizations.

Health care resources should be distributed justly. Powerful economic and sociopolitical forces simultaneously press both for and against the rationing of health care. Inflationary pressures, global competition, and widespread public endorsement of limitations on taxation and the size of government encourage the acceptance of health care rationing, while improved medical technology and individual desires impede its acceptance. Managed care is a prominent venue in which questions of access, justice, limits, rationing, need, medical necessity, and quality and other controversial, poorly defined, and unresolved questions about health care are being asked. Managed care did not manufacture these questions, nor can or should it alone answer them definitively. Nevertheless, patients, purchasers, insurers, clinicians, and other health care professionals are making decisions in managed care settings every day that depend on implicit answers to these questions. Compassion in relationships, trust in relationships and in the system, and the well-being of individuals and communities will ultimately depend on how these decisions are made.

The purpose of this set of principles is not to propose solutions to underlying economic and sociopolitical problems but to help people who grapple with the ethical and moral health care dilemmas that result from those problems. This often occurs in the managed care setting. These principles, which were developed by a group of patients, clinicians, ethicists, and managed care leaders, can help guide decision making. They apply to the delivery of health care, regardless of the setting or system. Each principle should be adhered to unless it conflicts with another enumerated principle. When conflicts occur or prioritization or ranking among principles is contested, these issues should be addressed in an open and collaborative environment.

STATEMENT OF ETHICAL PRINCIPLES

I. Relationships Are Critical in the Delivery of Health Services. They Should Be Characterized by Respect, Truthfulness, Consistency, Fairness, and Compassion

A. Health plans, purchasers, clinicians, and patients should be open and truthful in their dealings with each other.

The foundation of health care is built on patient-clinician relationships, including the patient-physician relationship. (The term “clinician” is used throughout this paper, although some categories of clinicians may have specific ethical or legal obligations in the provision of health care. Trust is perhaps most critical for the appropriate functioning of these relationships—trust that clinicians will promote patients’ interests and will maintain patient confidences. Third parties, such as health plans, provider groups, and purchasers, have long played a role in health care. However, in today’s changing practice envi-
environment, third parties have increasing control in the delivery and financing of care and in treatment decisions (1). Clinicians must consider patient interests. But they must also consider cost and quality concerns for health populations. This poses challenges to the patient–clinician relationship, and patients may question whether their individual interests are primary and whether continued trust is warranted.

Truthful communications are critical in health care. The degree of openness and honesty in a plan’s culture can affect the truthfulness of patient–clinician communication. Health plans should foster an environment built on trust through open and honest communications. For example, health plans should make publicly available the criteria by which coverage decisions are made and be forthcoming about what health care resources can reasonably be made available and at what cost. Purchasers should also be open about their role and their influence on the choices (or lack thereof) presented to individuals. Purchasers often influence the plans offered—and their structure and costs—to the insured. In the end, regardless of the number and types of parties deciding how to best deliver and finance care, a climate conducive to trust should be paramount.

B. Health plans, purchasers, clinicians, and patients should recognize and support the intimacy and importance of patient–clinician relationships and the ethical obligations of clinicians to patients.

Health plans, purchasers, and other parties who affect the patient–clinician relationship should not interfere with the bedrock of that relationship, which is a covenant of trust and respect for the dignity of the patient. Third parties play an important role in fostering an ethical environment in which individual needs of patients are respected (2). For example, an ethical environment promotes the patient–clinician relationship by supporting and facilitating the sufficient time and attention for the clinician to address the patient’s concerns. It also requires that clinicians be able to discuss all pertinent treatment options with their patients. Patients should feel secure in the confidentiality of their communications with their clinicians and be made aware of when, and under what limited circumstances, such confidences may reasonably be disclosed. Fostering an ethical environment that respects the patient–clinician relationship enhances shared health care decision making between patients and clinicians.

C. Clinicians should maintain accurate and truthful records.

Clinician professional obligations require not only fidelity to the patient’s welfare but also honesty in their communications about clinical decision making. Clinicians must be truthful when documenting patient information. For example, clinicians should not misstate the diagnosis or treatment to ensure coverage or maximize reimbursement. There is evidence, however, that sometimes they do (3). Misstatements perpetuate mistrust among parties and in the system and endanger patient care. Clinicians should pursue the other ethical channels available to them to advocate for patients (4).

D. Patients should not distort the truth in order to obtain benefits, nor should they expect their clinicians to distort the truth on their behalf.

Truthful and honest communication and action is not simply an obligation imposed on clinicians, health plans, and purchasers. In fact, patients play a critical role in fostering an ethical practice environment. If and when patients feel that their clinicians are not properly advocating for their best interests, or when they feel that the health plan requirements are applied unfairly, their voices should be heard. However, patients should question the ethical character of a clinician who would lie to or mislead others on their behalf. Dishonesty by individuals harms health care as a whole.

II. Health Plans, Purchasers, Clinicians, and the Public Share Responsibility for the Appropriate Stewardship of Health Care Resources

A. All parties should take part in a public dialogue shaping policies on the quality of and access to care.

Health care is not only a private concern. It affects the entire community. All parties should have a meaningful voice in the debates that shape our health care policies (5). Unique needs of individual patients must be respected, as should the needs of the patient population and the broader community. This respect will not be achieved without discussion of what resources exist, to what extent they are limited, what costs attach to various benefits, and how to equitably balance all these factors (6). Related efforts of states, such as Oregon, Hawaii, Georgia, and Minnesota, to determine how to allocate limited health care resources should be studied for their successes and failures in an effort to shape a more inclusive discussion. Moreover, because health plans hold a great deal of information on treatments and their costs and effects, health plans can collect, aggregate, and disseminate information—within the constraints of confidentiality requirements—that can promote evidence-based practice and the equitable distribution of health care resources. Obviously, this is an ongoing process that requires sustained effort and political leadership to realize an ethical health care environment.

B. Resource allocation policy should be made through an open and participatory process.

Resource allocation policy should not be made at the bedside (7, 8). All affected parties should help determine whether particular treatments or coverage options are cost-
worthy. The effort should be collaborative and on terms that are mutually acceptable, and should be conducted in an open and equitable manner so that trust in the system can be generated and maintained (9). Individual decisions are often idiosyncratic and inequitable when applied across patient populations. In practical terms, such ad hoc decision making wastes limited resources, particularly when the debate concerns questions that are likely to arise again and again, such as interpretation of coverage rules. Policy should be clear, internally consistent, and equitable.

Procedural rules and dispute resolution processes are necessary to ensure that patients and their unique situations are reviewed individually. This attention to process also ensures that ethical standards are observed in practice, not merely in word. Just as open discussion of policy is ethically appropriate, so are processes that respect individuals and their circumstances. The adequacy of the process does not ensure that rules will be followed or that each party will be satisfied with the outcome as applied. It does, however, foster trust and credibility—and the legitimacy of the process itself.

C. A clinician’s first and primary duty is to promote the good of the patient.

The patient–clinician relationship is the cornerstone of the provision of medical care, and the duty of patient advocacy is a fundamental element of this relationship that should not be undermined. Clinicians should base their counsel to patients on the best scientific knowledge available and the interests of the individual patient, regardless of the patient’s insurance coverage. Patient–clinician relationships and the principles that govern them, such as beneficence, nonmaleficence, respect for autonomy, truth-telling, confidentiality, and informed consent should be central to the delivery of health care (7). Although clinicians face an increasingly complex health care system, the duty to promote patient welfare within the system must not be undercut. Rather it heightens the need for advocacy, particularly for patients who are very ill.

D. Clinicians have a responsibility to practice effective and efficient health care and to use health care resources responsibly.

Although the patient–clinician relationship is primary, clinicians must also consider limitations of health care resources. Trust in health care professions relies on how effectively clinicians base their decisions on evidence of efficacy and apply professional standards fairly and appropriately, as well as the just use of health care resources (10). The clinician’s promotion of patient welfare includes the responsible stewardship of health care resources. Effective and efficient care is prudent care: using the most efficient means to diagnose and treat a condition that is respectful of a patient’s wishes and needs, using resources wisely, and ensuring the equitable distribution of resources. Recommendations about diagnostics and therapy, contributions to practice guidelines and formularies, and decision making on medical review boards should reflect the best clinical literature, with consideration of the cost-effectiveness of different approaches (7). Clinicians have an obligation to remain current in their fields and must be accountable to the public. As participants in the public dialogue, clinicians must also address racial, ethnic, and other health disparities that may result from or be perpetuated by allocation decisions.

E. Clinicians should advocate just as vigorously for the needs of their most vulnerable and disadvantaged, as for their most articulate patients.

In the changing practice environment, clinicians should pursue all necessary avenues to secure the care they deem essential for their individual patients, regardless of the barriers imposed on this advocacy. This ethical obligation of advocacy operates at many levels, particularly for those patients who may lack an effective voice in the system. The very ill and the dying are among the most vulnerable. When systemic barriers obstruct care for a class of patients who lack the ability to represent themselves, clinicians should advocate for equitable treatment.

F. Health plans should engage purchasers in a discussion about what health care needs can reasonably be met, given a particular level of premium, and should explain the reasoning behind their coverage, exclusion, and cost determinations.

As the costs of medical care have increased and as medical technology has advanced, society has been forced to confront how to allocate limited health care resources responsibly. Health plans have highlighted cost efficacy in decision making about coverage and benefits. Health plans and purchasers are not obliged, nor should they be required, to underwrite approaches to care that are individually desired but not justifiable on the basis of clinical or theoretical scientific grounds (7). They should not be required to cover treatments that are relatively cost-ineffective compared with other therapies for the same condition or other therapies offered by the plan for other conditions. Health plans should work with purchasers to ensure that benefits packages are consistent with the health care needs and cultural norms of purchasers’ constituents, and should explain to purchasers the costs of benefits packages.

Health plans must explain to purchasers and patients the reasoning behind coverage, exclusion, and cost determinations, both for individuals and for general policy decisions. Health plans should help publicize the costs and clinical benefits or harms of emerging therapies. Unless health plans share this information, purchasers and the public are disadvantaged when contracting for particular
benefits at reasonable premiums. Plans should fully disclose the conditions under which they operate (11).

G. Purchasers have an obligation to be truthful about what health care needs can reasonably be met given a particular level of premium. They should disclose to the insured the benefits and costs of plan options, as well as the reasoning and process for their selection.

In the end, purchasers often determine what options—if any—will be available. Thus, as with health plans, purchasers also have disclosure obligations. Purchasers should disclose the plan benefits and costs and the reasoning and process for their selection. Moreover, providing information and discussing what can reasonably be offered and at what cost will further enhance efforts to create an ethical environment.

H. Patients should have a basic understanding of the rules of their insurance.

Patients have a responsibility, to the fullest extent that they are able, to be familiar with insurance rules governing benefits and reimbursement. They should not expect clinicians to know the fine details of their coverage. While purchasers seek to restrain the costs of care, patients may face restricted choice and access. In making an informed choice, patients must be aware that this choice might limit coverage or reimbursement. Patients have an obligation to be informed and, if questions arise, to seek answers that satisfy their concerns.

To facilitate informed decision making, purchasers should ensure that health plan informational materials and required “summary plan descriptions” reach insured patients, and patients should read the materials. Although this may sound obvious, it does not always occur. Readily accessible ways to address prospective and current insured patients’ concerns should be available.

I. Contracts among health plans, purchasers, clinicians, and patients should reflect a commitment to effective, quality health care, and to consistency and fairness.

Health plans have done much to contain the costs of care. They should enhance efforts to improve quality. The Institute of Medicine says “quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (12). Commitment to continuous quality improvement should be an important goal and a driving force in the entire organization. Furthermore, health plans should ensure that the entities or individuals with whom they contract also uphold commitments to effective, quality health care.

Health plan contracts should also ensure that all patients are treated fairly by eliminating barriers to equitable access, notwithstanding legitimate resource allocation concerns. Upholding the principle that individuals in similar situations be treated similarly, patients covered under the same contract should have equal access to the same benefits.

J. All parties should honor their contracts, agreements, and responsibilities, and a fair review process should exist to aid in resolving conflicts.

The obligation of open and truthful communications also requires honoring those responsibilities—contractual or other—that a party assumes. If a decision or provision is questioned, concerns should be raised through an appeals process, political process, or other open forum. Only through an open, thoughtful, and honest airing of disagreements or problems can any systemic issues be addressed.

Adequate internal and external mechanisms must be in place to address disputes about medical necessity, coverage decisions, or other claims of patients and their clinicians. Patients and clinicians should use an appellate process when they are unsatisfied with a plan’s denial of benefits or reimbursement decision. Moreover, appeals should proceed in a timely manner with sensitivity to the seriousness of the patient’s health condition. The court should be an avenue of last resort.

III. All Parties Should Foster an Ethical Environment for the Delivery of Effective and Efficient Quality Health Care

A. Health plans and health care organizations should not ask clinicians to participate in arrangements that jeopardize professional ethical standards.

Health plans and health care organizations are uniquely positioned to promote quality care and to seek continual improvement in the care that patients receive. Financial or other practice incentives should enhance the provision of quality care and support professional ethical obligations. Agreements should address the conflict of obligations among the interests of the individual patient, the patient population, and the health plan. Plans should provide adequate resources and information to physicians and other clinicians in fulfilling their professional obligations. This includes promoting continuity of care and investing in measures to improve patient safety, quality, and quality monitoring. In turn, physicians should participate in formulating standards of care and collecting outcome and quality data. Arrangements with physicians and other clinicians should promote the right care in the right place at the right time. Incentives that support these goals encourage patient, clinician, and purchaser trust.

B. Physicians should only enter into agreements with organizations and others if they can ensure that these agreements do not violate professionalism and ethical standards.
Business ethics and professional ethics differ and may lead to conflict. Physicians must resist unethical practices tied to participation in contracting plans. There are times when the individual physician may not occupy a strong position from which to advocate for change. For example, contracting may be controlled by the physician’s group practice, or contracts may be held with particularly powerful health plans that dominate coverage of the potential patient population in a region. Although quitting the plan is an option, speaking out against the practice and dealing with the purchasers to modify the business demand that might have created the conflict are other options. In different circumstances, large provider groups or academic medical centers may have a commanding local presence.

Physicians and other clinicians should respect the professional and business ethics implications of their actions in approaching such discussions. Health plans, which rely on premium dollars for reimbursements, operate in both the clinical and business domains. So do physicians, insofar as they contract with others for payment. Unaffordable care is inaccessible care. Plans and physicians should work together to ensure that agreements do not cut ethical corners or endanger access to care.

C. All parties have an ethical obligation to protect the confidentiality of patient health care information. In general, identifiable patient information should not be shared without the patient’s consent, except where the health and safety of individual persons or the public may be threatened or as required by law.

Clinicians have an ethical obligation to protect identifiable patient health information. Identifiable patient information should be accessed only on a “need-to-know” basis, in compliance with state and federal laws, and should be limited in scope to the minimum amount of information necessary to accomplish the intended task. All parties, including health plans and purchasers, should actively promote patient privacy and confidentiality to ensure that information is used only for appropriate health care purposes. All parties should also have appropriate and clear boundaries in place to limit the collection of and specify the acceptable dissemination and uses of identifiable patient information.

Without an expectation of privacy, patients may hesitate to share their health problems or concerns fully and completely with their clinicians. This trust, and the ensuing communication, is a cornerstone of effective medical care and thus deserves widespread protection. Notwithstanding the need to collect blinded information for quality, research, statistical (compilation for data systems), or other such purposes, preserving confidentiality and privacy should be foremost in all clinicians’ and third parties’ policies, procedures, and actions.

IV. Patients Should Be Well-Informed about Care and Treatment Options and All Financial and Benefit Issues That Affect the Provision of Care

A. The clinician should provide appropriate information to the patient to support his or her informed consent to or refusal of treatment.

The clinician’s professional role is to make recommendations based on medical merit and pursue options that comport with the patient’s unique situation and preferences. To enhance decision making, patients must be well-informed about their conditions, treatment options, risks and benefits, and alternatives. Effective, open lines of communication must include disclosing material information to patients, including financial implications of treatment options when appropriate. The kind of financing and delivery system in which care occurs should not influence traditional obligations about when and how to disclose information (7). Information should be understandable and sensitive to the patient’s needs and response.

B. Clinicians should disclose their potential conflicts of interest to patients.

Every payment system creates incentives and potential conflicts of interest. No matter what the practice environment, clinicians must seek to ensure that the provision of a medically appropriate level of care takes precedence over considerations of financial benefit or harm imposed by the clinicians’ practice or health plan arrangement. All clinicians should avoid arrangements that are morally untenable. Patients should know the basis for health care recommendations they receive and whether contractual or other arrangements might influence clinician judgment to promote or limit treatment (13). Trust is imperiled when potential conflicts of interest are not disclosed or are disclosed ineffectively.

C. Purchasers and health plans should disclose to patients any arrangements that may influence care.

Purchasers and health plans should not impose arrangements, financial or otherwise, that undermine care. Purchasers and health plans must consider the ethical propriety of the incentive structures or arrangements they create and should disclose to patients these arrangements and their policies and practices that may influence care.

Health plans are the primary information source about what is and is not covered—and at what cost. For example, plans should eliminate incentives that are large and individualized; that is, arrangements that offer substantial rewards or penalties based on individual care decisions should be eliminated. It is not unreasonable to set some specified limits on coverage, particularly in an era of limited resources and rapid technological innovation. Rather, what is necessary is an honest assessment of those limits.
and disclosure of those limits to the individuals who are most affected by the limitations—patients.

D. Meaningful disclosure requires explanations that are clear and easily understood.

All parties should ensure that their communications to patients outline the benefits and limits of coverage in an understandable manner. For example, materials designed to educate or disclose policies are of little use if they are inaccessible to or beyond the comprehension of the reader. Different populations served might require different versions of these explanations. For example, communications with primarily Hispanic communities should include Spanish-language versions, or those with vision-impaired adult populations should provide large-print formats.

From the Medicine as a Profession Managed Care Ethics Working Group convened by the American College of Physicians Center for Ethics and Professionalism in partnership with the Harvard Pilgrim Health Care Ethics Program.

Acknowledgments: The working group thanks Amy Campbell, JD, Susan Coyle, PhD, and other staff at the American College of Physicians Center for Ethics and Professionalism who worked on this project.

Grant Support: This statement was developed as part of the project Managed Care Ethics: Principles to Guide Practice, which was funded by the Program on Medicine as a Profession of the Open Society Institute.

Potential Financial Conflicts of Interest: None disclosed.

References

APPENDIX

Medicine as a Profession Managed Care Ethics Working Group: Gail J. Povar, MD (Chair), Cameron Medical Group, George Washington University, Silver Spring, Maryland; Helen Blumen, MD, Aspen Systems Corporation, Rockville, Maryland; John Daniel, MD, Veterans Affairs Physicians, Inc., Richmond, Virginia; Suzanne Daub, MSW, Philadelphia Health Services, Philadelphia, Pennsylvania; Lois Evans, DNSc, RN, University of Pennsylvania, Philadelphia, Pennsylvania; Richard P. Holm, MD, Brookings Medical Clinic, Brookings, South Dakota; Natalie Levkovich, Health Federation of Philadelphia, Philadelphia, Pennsylvania; Alice O. McCarter, MSW, Harvard Pilgrim Health Care Ethics Advisory Group, New Community Services, Inc., Cambridge, Massachusetts; James Sabin, MD, Harvard Medical School, Harvard Pilgrim Health Care, Boston, Massachusetts; Lois Snyder, JD, American College of Physicians, Center for Ethics and Professionalism, Philadelphia, Pennsylvania; Daniel Sulmasy, OFM, MD, PhD, Bioethics Institute of New York, Medical College, New York, New York; Peter Vaughan, PhD, Fordham University, New York, New York; and Laurence D. Wellikson, MD, MedQuest Partners, LLC, Irvine, California.

Current Author Addresses: Dr. Povar: Cameron Medical Group, George Washington University, 8700 Georgia Avenue, Silver Spring, MD 20817.

Dr. Blumen: 107 East Lennox Street, Chevy Chase, MD 20815.

Dr. Daniel: Virginia Physicians, Inc., 7702 Parham Road, Suite 205, Richmond, VA 23294.


Ms. Evans: University of Pennsylvania School of Nursing, 420 Guardian Drive, Philadelphia, PA 19104.

Dr. Holm: Brookings Medical Clinic, 400 22nd Avenue, Brookings, SD 57006.

Ms. Levkovich: Health Federation of Philadelphia, 1211 Chestnut Street, Philadelphia, PA 19107.


Dr. Sabin: Department of Ambulatory Care and Prevention, Harvard Medical School, 133 Brookline Avenue, 6th Floor, Boston, MA 02215.

Ms. Snyder: American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.

Dr. Sulmasy: Saint Vincent Hospital and Medical Center, 153 West 11th Street, NR 815, New York, NY 10011.

Dr. Vaughan: Fordham University Graduate School of Social Service, 113 West 60th Street, New York, NY 10023.

Dr. Wellikson: Society of Hospital Medicine, 190 N. Independence Mall West, Philadelphia, PA 19106.