

2002

Managed Care and Undividing Loyalties

Daniel P. Maher

Follow this and additional works at: <https://scholarship.law.edu/jchlp>

Recommended Citation

Daniel P. Maher, *Managed Care and Undividing Loyalties*, 18 J. Contemp. Health L. & Pol'y 703 (2002).
Available at: <https://scholarship.law.edu/jchlp/vol18/iss3/14>

This Comment is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

MANAGED CARE AND UNDIVIDING LOYALTIES

Daniel P. Maher

Over the last several years, a good deal of the literature on managed care in the United States has addressed the apparent transformation of the medical profession caused by an increasingly dominant payment system. In the words of Marcia Angell (then Executive Editor of *The New England Journal of Medicine*), managed care organizations turn physicians into “double agents.”¹ Whereas historically the medical profession has emphasized that the primary goal of the physician is the welfare of the individual patient, managed care appears to have forced physicians to keep an eye on another party—society, the managed care organization, or other participants in the plan. This division of the physician’s loyalty is accomplished, in part, by appealing to the physician’s self-interest (usually in the form of financial reward and punishment based upon how the physician treats or manages not to treat the various patients who participate in the managed care plan). The division of loyalties is regarded as a problem chiefly because it undermines patients’ trust in physicians’ professional conduct. That trust is predicated, in part, on the belief that physicians, in the ordinary conduct of the profession, treat a patient for the benefit of that patient and not for the benefit of others.

Citing the fiduciary responsibilities of physicians to patients is one way of speaking about the primacy of the physician’s loyalty to the patient as distinct from the physician’s concern to make money or to save money or resources for some group other than the patient upon whom he practices the art of medicine. In this understanding, the art of medicine exists to preserve and promote a good, namely health, by deliberate, specialized action. Health is not only desirable, but also naturally good. When a person turns to a physician for assistance, that person is calling upon the physician’s expertise or art for his or her own benefit. As human beings we make a moral judgment that health or health care has a certain place in our lives and we pursue that goal, through these means, as one partial good within our comprehensive understanding of what is good for us as human beings. The physician embodies the art and acts for the patient’s benefit, not in virtue of personal affection for the patient, but in virtue of

1. Marcia Angell, *The Doctor as Double Agent*, 3 KENNEDY INST. OF ETHICS J. 279, 279-86 (1993).

the art's orientation toward its own end. The physician suppresses personal attachments to, or dislikes for, patients and instead acts as an agent of the profession or art for the sake of a good established independent of the art. The physician behaves the way any physician would behave and the patient is treated the way any patient would be treated because, from the point of view of the profession, the individual characteristics of the physician and the patient that are not directly related to the good of health and the art of medicine are irrelevant.²

One of the techniques employed by managed care for controlling costs appears to interfere with this relationship because it concentrates the physician's attention on his or her own personal interests precisely at the time that the physician is supposed to be suppressing those interests in favor of the patient. In other words, the difficulty is not merely that managed care encourages physicians to pay attention to something in addition to their other responsibilities, but that it induces them to modify their professional actions in view of their personal circumstances for the sake of managed care organizations. In the words of Edmund Pellegrino, fiscal incentives and disincentives "deliberately pit the physician's obligations to self and family against his or her own obligation to patients."³ It is of course possible that what is good for the patient and what is good for the physician coincide; the point is that the physician as physician should pursue the course that is good for the patient, without concern for the fact that it is also good for the physician. Nonetheless, it is also true that there is documented evidence that one effective way, perhaps the most effective way, to reduce costs in the provision of medical care is to make physicians at least partly accountable for those costs.⁴ Physician behavior can be modified through fiscal incentives. To the extent that patients are aware of the competing motivations that might influence what physicians say or do or, indeed, decline to say or do, patients lose trust in physicians. Consequently, patients look at their physicians more like auto mechanics who might be inclined to take advantage of them and less like lawyers who might be willing to exploit the rules in their favor. In other words, patients are reduced to looking upon their physicians with suspicion. Going to the doctor ceases to be the

2. See Robert Sokolowski, *The Art and Science of Medicine*, CATHOLIC PERSPECTIVES ON MEDICAL MORALS 263, 263-75 (1989).

3. Edmund Pellegrino, *Interests, Obligations, and Justice: Some Notes toward an Ethic of Managed Care*, THE JOURNAL OF CLINICAL ETHICS, (1995).

4. S. Shortel, *The New World of Managed Care: Creating Organized Delivery Systems*, 13 HEALTH AFFAIRS 46, 46-54 (1994); M. Hall & G. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992).

enlistment of a professional in the pursuit of what is naturally good and becomes a skirmish of the patient against a self-interested physician, and other patients competing for health care resources. Managed care appears, in this light, to be like the Hobbesian social contract—a remedy for the war of each against all, which remedy presupposes and preserves the fundamental self-interestedness of individuals.

Obviously, the traditional understanding of physicians' having a fiduciary responsibility to patients recognizes that human beings are not exclusively self-interested and are in fact capable of rising above self-interest. The appeal to physician self-interest relied upon by managed care does not deny that physicians are capable of generous actions; it does not reduce their fiduciary activity to a disguised self-interest. Nevertheless, it does assert a certain understanding of human nature. Specifically, the techniques employed by managed care point out that a very reliable way to motivate human beings is to appeal to their self-interest. For centuries physicians have relied upon a similar understanding of human nature. The ancient tradition, dating from as far back as the days of Lucretius, of sweetening bitter-tasting medicine in order to ensure that the patient drinks it, indicates that physicians understand that patients have concerns that are not identical with the natural good of health. When physicians recognize that a spoonful of sugar helps the medicine go down, they admit that a more comprehensive understanding of human nature, beyond the specific concern of their art, is necessary to accomplish the goal of the art. Physicians are better physicians when they know that some patients need medicine to be sweetened in order to incline those patients to do what is genuinely good for them. An administrator of a managed care organization might reflect upon this understanding of human nature for a moment and then hastily issue a directive ordering participating physicians to stop prescribing medicines that taste good. Less fancifully stated, it is not at all implausible that the difficulty patients encounter when dealing with the administrative end of managed care might be a deliberately chosen strategy to control costs by discouraging access to the system. When the issue is framed in this way, it looks like the tradition of medicine uses its understanding of human nature to encourage people to do what is good for them, whereas managed care uses its understanding of human nature to encourage people to do what is inexpensive. Managed care appears to replace the concern for patient welfare with the concern for fiscal welfare. It is probably more accurate, however, to say that managed care holds both these concerns in tension, but reverses the hierarchy.

A recent U.S. Supreme Court case has solidified this one dimension of managed care in the medical profession. Congressional promotion of health maintenance organizations is understood as an endorsement of the financial incentives given to physicians to limit treatment. According to one commentary on this case: “[t]he Court said that when plans manage costs through incentives to physicians to limit care, these physicians play 2 roles, as clinical caretakers and as benefits administrators, and thus make ‘mixed’ treatment and ‘eligibility’ decisions.”⁵

The authors of this commentary consider these “mixed” decisions to be troublesome especially because, as many others have noted, when physicians “mix” their concern for financial consequences with their concern for the well-being of a patient, the very possibility of dereliction of fiduciary responsibilities to patients threatens the trust of patients in physicians.

Without denying or minimizing any of these concerns, there remains a meaningful sense in which this mixing of physician loyalties, however imperfect it may be, represents a step in the right direction. Specifically, it is a step toward overcoming the abstractness of the traditional way of speaking about the physician’s fiduciary duty to the individual patient to the exclusion of other concerns. This understanding is not identical with, but has a tendency toward, what may be called a Thrasymachean understanding of physicians. According to Thrasymachus, the physician in the precise sense, the physician as physician, is solely concerned with the effective practice of the art of medicine and has no regard for extraneous concerns like money.⁶ By calling this an abstract understanding of medicine, attention is drawn to the fact that the physician is never simply a physician and the patient is never simply a patient. Both are human beings situated in a context where many other things are good besides the health needs of this particular patient. “The physician’s emphasis as physician is on commutative justice, but this cannot exist apart from a more comprehensive ethic of managed care that would include an ethic of the collective, corporate, and societal obligations to the care of the sick as well.”⁷ Precise focus on the art and its end abstracts from a host of legitimate human concerns of which health is only one and by no means

5. M. Gregg Bloche & Peter Jacobson, *The Supreme Court and Bedside Rationing*, 248 J. AM. MED. ASS’N 2777 (2000). For additional analysis of this case, *Pegram v. Herdrich*, see the collection of essays in YALE J. HEALTH POL’Y, L. & ETHICS 159-213 (2001), which came to my attention after completing this essay.

6. PLATO, *THE REPUBLIC*, Book I, 340d-342e.

7. Edmund Pellegrino, *Interests, Obligations, and Justice: Some Notes toward an Ethic of Managed Care*, THE JOURNAL OF CLINICAL ETHICS, (1995).

the most important one. By forcing the physician to consider cost as well as treatment, the practice of managed care takes a step toward a more comprehensive and unified appraisal of whether what we do with the art of medicine is good.

The same point may be approached from the patient's side. It is commonplace to observe that the kind of health insurance used in the United States insulates patients from the genuine costs of the medical treatment they seek. Thus, patients are able or even forced to make decisions about health care in abstraction from, or abject ignorance of the true costs of that care. But there are costs. In those cases where patients *are* directly paying for their health care, they prove to be able to think about cost as well as many other human concerns at the same time as they make decisions about their health. Thinking about cost is not inherently opposed to good decisions in health care. In fact, it is irresponsible to pretend that there are no costs.

So when managed care forces physicians to make "mixed" decisions, this may well be a step in the right direction. This is not to say that physicians should be the ones who think in this "mixed" way, but only that this kind of thinking needs to occur. Rather than mixed decisions, it is better if we can speak of these decisions as integrated. Treatment and non-treatment decisions need not be merely the accidental result of competing, privatized interests of individual patients, physicians, managed care administrators, investors, plan participants, governmental agencies, etc. Instead, prudence or practical wisdom may be employed to attain, or at least aim at, an integrated understanding of the practical good in these situations.

To the extent that managed care forces physicians to make "mixed" decisions, a step toward reconciliation or integration of what first appeared as antithetical, competing interests is taken. This is a move in the right direction insofar as it is a step away from an abstract, artificially partial approach that ignores the significance of decisions here and now for others later and elsewhere. A formidable difficulty remains. By calling this a step in the right direction, it is presupposed that practical wisdom is possible. Also, it is presupposed that a prudent integration of the various human concerns, including health and money, is possible. Quite a few people deny this is possible. Consider two ways in which this denial appears. First, from the physician's standpoint. Marcia Angell offers the following objection to the practice of physicians' being responsible for these sorts of mixed decisions:

When doctors act as double agents, they are merely acting on their own particular prejudices. They are deciding that this or

that medical services cost too much. This is not a medical judgment, but a political or philosophical one. Another doctor (or a plumber or electrician) might make quite a different judgment.⁸

Obviously, this is true, but the implication here is that the diverse judgments are morally or philosophically equivalent, because they are all prejudices. That there might be a practically wise judgment or that we could recognize it are not treated as serious possibilities. From the patient's standpoint, patient consent or autonomy is regularly used to resolve all sorts of questions about what constitutes good medical treatment. The goodness or badness of abortion in the case of a diagnosed fetal defect and the goodness or badness of assisted suicide are taken to be resolved in individual cases by appeal to patient autonomy. Autonomy in this understanding is an inscrutable standard. Whatever the patient autonomously decides is accorded a kind of unchallengeable sacredness, not because of any recognized excellence of the quality of the practical reasoning employed, but solely because it is the expression of the patient's own preferences or values. This kind of respect for autonomy refuses to distinguish between prudence and folly; both of these go by the name of autonomy. The result, then, of this step in the right direction is that managed care points us toward the kind of considerations that would be necessary to arrive at a practically wise integration of health care and cost, but it does so in a time or a context in which we do not believe practical wisdom is available.

Notwithstanding these difficulties, we must recognize that widespread disbelief in practical wisdom does not render it impossible for practical wisdom to arise. In this context, practical wisdom means the capacity for the kind of judgment that achieves the practicable good through recognition of an appropriate ranking of the several concerns in individual cases. It tends to arise, neither in legislation nor in public policy decisions, but in individuals who have the opportunity to appraise the complexities of situations that call for decision. This means that individual patients or physicians are those most likely to be able to determine what is an appropriate integration of concerns for the several goods at stake in any decision. In the absence of the possibility of perfect legislation that would guarantee the best possible outcome in all situations, the most that can be hoped for is that practical wisdom is permitted to arise in those people and situations open to it. That is to say, when a particular physician or patient

8. Angell, *supra* note , at 285.

is capable of judgment that appropriately integrates concern for a variety of goods, law and policy ought not to be in the way.

