
Ethical Decision Making in Managed Care Environments

by Judith Wilson Ross

Ethics committee members need to look carefully at their frequently unarticulated beliefs about the value of health care and the role of health care institutions and professions before considering what constitutes an ethical response to changes in the way that health care is delivered.

Hospitals that once had few managed care patients now contract with one or more plans which account for a large number of admissions. This shift to managed care introduces new ethical issues with which ethics committees are not always familiar and which they are not always confident in approaching.

This paper addresses some of the new issues, illustrated by an ethics committee case analysis. The analysis reveals committee members' ambivalence in dealing with managed care problems, showing *support* of change in health care, and simultaneous *fear* of change.

Ethical Issues

There have always been inconsistencies and injustices in a health care system organized around ability to pay. Now, however, managed care plans evaluate not only the need for the patient's admission, but the need for each day of continued care and treatment. Thus caregivers face more directly a third party payer's willingness to pay for treatment. Moreover, managed care plans' policies on payment differ one from another. Health care professionals, consequently, are dealing with inconsistencies in length of stay from patient to patient, all of whom are insured. In addition, there is vast variation in whether certain diagnostic tests and preventive measures are reimbursable. The following case study illustrates these points.

Case Example

A terminally ill patient in a managed care plan was admitted to the hospital on a Friday evening after her physician was besieged by the woman's family to "do something." The managed care plan refused to authorize the admission because the skilled nursing facility in which the patient was residing could have provided the same care as the hospital. The refusal did not occur until Monday, by which time the patient's condition had deteriorated. She was still stable enough to transfer to the nursing home, although it was clear to those caring for her that she was dying. Because of slowness in the hospital system, the discharge order was not written until Tuesday, by which time the patient *was* unstable and in the dying process.

When the case came to the ethics committee as a retrospective review, the response of most committee members and of most care team members was to attack the managed care plan and the case manager who had relayed the information to the care team and, eventually, the hospital administration for failing to intervene. It was a prime example, most felt, of the uncaring nature of managed care: the insistence that a dying patient be put in an ambulance and shipped back to a

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nursing home in order to save money. The caregivers believed that she would probably have died during the ambulance ride itself. The patient did, in fact, die in the hospital within the hour after the scheduled transfer.

In the ethics committee discussion of the case, most members believed that the managed care plan had caused the ethical problem. Some were angry that a hospital staff member was serving the managed care plan by being a case manager, viewing the case manager-nurse as on the side of the "black hat," yet being paid by the hospital, the "white hat." Others looked with anger at the hospital itself, indicating that not only the managed care plan but the hospital had sold out to money concerns.

It seems understandable, as one not involved in the case, why people had felt and acted as they had. Yet the committee indicated that nothing done had been understandable. The case was characterized for them by a sense of chaos and, I think, by a sense of impending doom. But it was also clear that managed care had

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become the scapegoat for general distress about changes in care delivery that the people involved experienced every day. Committee members felt unable to control any health care decisions, and those who would be controlling them were perceived as neither kindly nor caring. The new power holders were trying to make a quick and excessive profit, trying to save money in cold-hearted ways, or were "just following orders." Such opinion is repeated in the literature. For example, physician Howard Spiro (1994) writes, "Physicians are being turned into clerks and mechanics by a bureaucracy that regards 'health care workers' as interchangeable modules. Financial constraints, of which managed competition is the latest example, look to

measure out medical practice in units that can be weighed, delivered, and paid for like parcels."

Spiro believes that what is going on is chaotic or unreasonable. But this case is neither chaotic nor unreasonable. First, it is understandable as an observer why the family turned to its physician. Family members were distraught about the patient's declining state and believed that if the patient could only be admitted to the hospital, then it was possible that one of medicine's miracles, even if only temporary, would work for her. Endless television programs extol "medical miracles," and the people who watch those programs believe that they are entitled to a possible miracle when faced with the death of a beloved family member. This media-sponsored belief in miracles is reinforced by health care professionals' prevalent belief that patients and families must never be left without hope. Unfortunately, promoters of this compassionate practice customarily fail to note that while encouraging the patient and family to have hope, the caregivers themselves have no hope on the basis of their experience and knowledge.

Second, it is understandable why the physician, when faced with the patient and his family, had her admitted to the hospital. By admitting her, he took responsibility for the patient's distress. Physicians are trained to take charge. The argument over physician decision making and paternalism largely arises because physicians are trained to make decisions, and patients and their families often welcome the physician's intervention. Physicians also have learned *not* to take on the role of financial counselor or bereavement counselor. If the physician had explained to the family that hospitalization would not help the patient and that they should prepare themselves for the patient's death, or that the insurer would not approve hospitalization, the physician would be obliged to talk about two things that are not only difficult to say but that the family does not want to hear. No one wants to be the messenger delivering news of either impending death regardless of treatment, or of what may appear to be cold-hearted, financially-motivated abandonment by rich doctors and rich hospitals.

Third, it is understandable that the managed care plan refused to pay for the patient's care during the hospitalization. An insurance company is not a charitable organization. Unfortunately, our health care is delivered primarily through for-profit insurance companies, but some people believe this is the only acceptable alternative to avoid "big government" programs. In a health care system without built-in cost restraints, the insurer is obliged to provide restraints because those who pay for insurance refuse to accept ever higher premiums. Reimbursement formats, such as the Medicare DRG system, were designed so that specific kinds of restraints in providing services would be determined by caregivers and hospitals. When those failed to reduce costs, the next step was for the insurers to restrict care directly by deciding on a case-by-case basis when to approve reimbursement.

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Fourth, it is understandable that the nurses were distressed by the possibility that the patient would be discharged. Patients in the final stages of death have been considered appropriate candidates for hospital beds. In the first half of this century, most deaths occurred at home, but now almost all deaths occur in the hospital. Because the hospital has become where one goes to die, nurses (and family) were alarmed because the insurer did not agree.

Fifth, it is understandable that the administration, because the hospital has limited funds for unreimbursed care, did not step in. The caregivers noted that the hospital is mission-driven and cares about providing health care for its community. Yet, because the patient did not need the level of care the hospital gives, the administration was reluctant to use limited dollars except for patients who required such care.

However, although understandable, the various

courses of action advocated by those involved in the case may not have been justified. For example, families may desperately need help in facing the death of a loved one, but it does not follow that they are always able to determine what kind of help they need. They may need help in dealing with their grief and feelings of loss and in creating some kind of closure to their relationship with the patient. They may need help in knowing that someone knowledgeable will be with them when the patient dies. They may need help in processing the information that the patient is going to die. Hospitalization doesn't provide this kind of help, although it is often advocated as if it did. Hospitalization did not solve any problems for this family. Even though family members and the caregivers were used to seeing hospitalization as a solution and having hospital care denied was painful, the managed care organization may have been right.

Similarly, hospital caregivers are accustomed to thinking of dying patients as "belonging" to them in some way, and having them die somewhere else is wrong. But is that opinion justified? The public talks about a desire to "die with dignity" and without the intrusion of acute care "treatment," suggesting Americans do not see death in the hospital as the preferred option, at least in the abstract. What would be *wrong* with this patient's death in a nursing home? If she were not in an unstable condition so that she risked dying in the ambulance (which does lack dignity and respect, one could argue), why would it be morally wrong to say that she should return to the nursing home to die? Would it be essentially abandoning the patient, as the nurses felt it to be? Is the nursing home an inferior place to die? Or would it be a responsible act in the face of a changing understanding of the role of the acute care hospital?

Hospital administrators have the authority to decide when to provide unreimbursed care, but they owe their staff an explanation about how those decisions are made and what principles drive them. Making such "rationing" decisions privately or even secretly drives the public fear that the decisions are made arbitrarily rather than rationally, based on reasonable policies.

Further, staff should know how they can seek to have an exception considered and who controls the discretionary judgment.

Medicine and Cultural Beliefs

Variations of this case will occur repeatedly in managed care situations. It demonstrates the distress and ambivalence managed care provokes among ethics committee members. The varied opinions regarding responsibility and ascertaining the ethical mode of action stem, I contend, from a mythic understanding of health care. There are several attitudes deeply embedded in us that, when articulated and investigated, allow us to recognize and deal with our ambivalence about the new modes of health care delivery.

The most important myth about health care is that it is good for us. Americans believe that more health care is better and that ensuring universal coverage will ensure better health. All Western cultures do not share this attitude. The average British citizen, for example, is hesitant about getting involved with a hospital and this is reflected in the United Kingdom's lower per capita use of invasive procedures and British physicians' higher thresholds for considering a procedure to be appropriate (Brook et al. 1988, 750-53).

The source of this "more is better" belief lies in the unique place medical care has had in our society for the past thirty to forty years. It has been the recipient of enormous and unprecedented sums of public money for medical research and the wars on various diseases. This investment has given US health care a reputation for being both very aggressive and very advanced. The repertoire of treatments that are available has vastly improved. Most Americans have become more hopeful—even excessively confident—that, as a result of medical care, they will live longer and be rescued from death if they experienced serious illness. However, Bernadine Healy, former director of NIH, recently referred to the research task undertaken by NIH as "America's field of dreams" (NIH 1994, 1493-8), which may more accurately characterize what research dollars have purchased.

We repeatedly hear that our medical treatment is "the best medical care in the world." Continuous technological advances give both the public and health care professionals the impression that health care is an important source of national pride. Health care is, then, the undisputed good. The natural logic of this implies that health care reform should provide *more* health care for everyone, not *less* care for anyone.

Research studies showing that the poor and ethnic minorities are less likely to have access to health care and, when they do, are less likely to receive services encourage the belief that if everyone received the same level of health care, the health status of the poor would be more like that of the rest of the population. This belief strongly leads us at the political level to argue for the justness of universal health care coverage. Yet, there is considerable evidence that access to health care will not significantly alter poor peoples' health status outcomes (Friedman 1994, 1535-8).

It is seldom acknowledged that the vast amount of health care research in the United States has not led to improved medical outcomes for us as a society. The initial improvements in longevity in this country, for example, came from public health measures. Currently, the British, the Canadians, the Germans, the French and other Europeans all do as well or better as the U.S. does with much less money spent, with much less treatment given. The U.S. wars on disease have been fought zealously, but with much less success than is generally acknowledged. The media do not tell us that only twenty percent of the medical treatment we use is supported by good scientific evidence of benefit, let alone more benefit than burden or risk (Cotton 1993). The wide practice variations that exist in the U.S. and other countries suggest a "system" of health care that is seriously lacking in science or rationality, a system in which *where* your child lives rather than his or her physical condition may be the single most important determinant in whether that child has, e.g., a tympanostomy (Kleinman et al. 1994; Bright et al. 1993).

The second myth of health care is that it is morally wrong to interfere with the doctor-patient relationship

in any way that would limit access to potentially effective treatment for the patient. This myth largely arises in our culture because health care, unlike anything else in this society, was arranged in the past thirty to forty years so that professionals, insured patients, and their families increasingly came to feel that issues of cost ought never to interfere with availability of interventions. Because third parties paid, while the first and second parties made the decisions, decision making was disconnected from cost. As younger physicians and nurses and even patients entered a system in which finances for acute care were not an issue (at least for those safely insured), they increasingly came to believe that finances *should not* be an issue.

Health care professionals often express that they should never be forced to do less than is best for their patients; that the very nature of professionalism requires them always to do—or at least offer to do—what is best for the patient. However, what is most expensive is not necessarily the best. More important, however, is a reality check: in every society, professionals are virtually never in a position in which they are able to provide everything that a client or patient thinks is in his best interest. Clergy, lawyers, and teachers all operate within certain society-imposed constraints. The highly educated and often equally dedicated teacher who faces forty or more eight-year-olds in a small room all day long for nine months of the year does not think that she or he is doing the best teaching under the situation. Teachers do the best they can for their students within acceptable constraints. Lawyers who are public defenders may want to provide more research, more investigation, and more support for their clients, but they, too, must operate within realistic economic constraints. Even clergy are constrained by the economic realities of their parish. And, in medicine itself, psychiatrists have long known what it means to do their best for patients in the face of minimal, if any, insurance coverage when patients have limited ability—often because of their illness—to pay for their care.

These two cultural beliefs—that recommended and desired medical care is always beneficial, and that money should not affect medical treatment decisions—

need to be recognized in today's managed care environment. Ethics committee members, in analyzing their own ideas and feelings about what medicine and acute care hospitals and insurance offer, will be better prepared to take on the ethical challenges provoked by new health care financial arrangements.

Each ethics committee will have its own experiences with how managed care changes long-standing ways of delivering health care. The ethical dimensions of the shift are still amorphous. Ethics committee members need to challenge their own feeling that power is being lost by good people and taken by people who are not properly motivated. Attempts to discern ethical dimensions will be most productive if the process is not prejudged. In reviewing the past twenty years, we recall how uncertain it was that withdrawing Karen Quinlan's ventilator, or stopping artificial nutrition and hydration, or forgoing "futile" treatment was even a justifiable decision, let alone the right decision. We accommodate major change slowly; ethics committees would do well to make judgments cautiously and think carefully before deciding who has the moral high ground.

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