CHAPTER 24

Ethics Issues in Managed Care

Richard H. Rubin

The field of medical ethics has become increasingly important in both medical education and clinical practice. The expanding role of medical ethics has manifested itself in the escalating number of books and journal articles on this topic, in the percentage of medical schools that now include training in medical ethics as part of the standard curriculum, and in the growing number of hospitals nationwide where ethics committees meet regularly to resolve perceived ethical dilemmas.

Managed care has evolved to become a major factor in the delivery of healthcare in the United States. Although the term *managed care* refers to a rather heterogeneous group of institutions, a feature common to all managed care organizations (MCOs) is a systematic approach to controlling what has been a progressive escalation in healthcare costs in the United States since the 1970s.

The increasing prominence of both medical ethics and managed care has resulted in a number of well-publicized collisions, if not a head-on crash, between the two. The reason the two have collided has largely been their different perspectives of the moral universe and the social good. Medical ethics, undoubtedly influenced by the twentieth-century civil rights and consumer rights movements, has placed great emphasis on patient autonomy—the notion that every patient has a right to be treated with respect and dignity as well as to make all decisions related to their healthcare (the goal being an "optimal outcome" as defined by the fully informed individual patient). Thus, the focus has been on the primacy of the individual patient and the responsibility of physicians to be advocates for their individual patients.

Managed care, on the other hand, has clearly concerned itself with not only the health of individual patients but also the collective health of a defined population—namely, the MCO's membership or so-called medical commons. The question of what should take precedence in the physician's mind—the individual

patient or the collective medical commons—is at the crux of many disagreements between physicians and MCO managers. These often-wrenching ethical dilemmas have been complicated by the addition of still another element into the equation—the fact that the majority of MCOs are now of the for-profit variety, with a fiduciary responsibility to their shareholders.

Some observers have proposed that the potential for conflict among these various constituencies (individual patients, the medical commons, and shareholders) make the for-profit MCO model so ethically suspect as to have no rightful place in the US healthcare system. Others, meanwhile, contend that the currently dominant for-profit model is the most realistic and efficient means of achieving managed care's most overarching goal—namely, to exercise some semblance of ongoing control over the nation's healthcare costs.

While this debate rages on, physicians and managers in the managed care setting continue to face ethical challenges in their day-to-day work lives. This chapter reviews some of these commonly faced ethical dilemmas and offers useful and practical guidelines for both physicians and managers. It also aims to provide both physicians and managers with some appreciation of the issues faced by their counterparts and to help each group gain a better understanding of the other's thinking and perspective.

This chapter addresses seven questions:

1. What are the relevant principles of medical ethics?
2. What are the relevant principles of business ethics?
3. What ethics issues are commonly faced by physicians practicing in a managed care setting?
4. What ethics issues are commonly faced by managers in the managed care setting?
5. What are the legal ramifications for both physicians and managers in the managed care setting?
6. What ethical guidelines can be offered to physicians practicing in a managed care setting?
7. What ethical guidelines can be offered to managers in the managed care setting?

RELEVANT PRINCIPLES OF MEDICAL ETHICS

The task of medical ethics is to analyze and optimally resolve ethical dilemmas that arise in medical practice and biomedical research. Medical ethics is not a static, rigid entity; on the contrary, disagreements among acknowledged experts

are common. Much of medical ethics has concerned itself with end-of-life issues and medical decision making in the case of incapacitated patients. Focusing on the issue at hand, however, the following six principles of medical ethics have special relevance to managed care:

1. *Autonomy*. Autonomy refers to (1) a person's right to be fully informed of all pertinent information related to their healthcare, and (2) a person's additional right, after being so informed, to choose among or to refuse the available treatment options. Autonomy also implies a respect for the dignity and intrinsic worth of each individual person.
2. *Beneficence*. Beneficence is the commitment to "do good." It usually refers to the physician's obligation to work for optimal health outcomes for individual patients (although what constitutes an "optimal outcome" in a given situation is a decision that the competent, informed patient will help the physician determine).
3. *Nonmaleficence*. The flip side of beneficence is nonmaleficence—the commitment to "do no harm."
4. *Fidelity*. Fidelity is the notion that the physician should be faithful and loyal to the individual patient. It implies that the physician will, if necessary, subordinate their own interests to serve the patient's interests.
5. *Veracity*. Veracity, or truth telling, refers to the physician's responsibility to be truthful to the individual patient, avoiding deception and disclosing to the patient all information relevant to the patient's health.
6. *Justice*. In the realm of healthcare, justice implies that all patients should be treated fairly, without regard to their race, ethnic background, socioeconomic status, educational level, or other factors. *Distributive justice* refers to the related notion that the allocation of limited healthcare resources should be determined on a fair and equitable basis.

All six principles represent values that most thoughtful members of society would regard as worthwhile. However, even a brief consideration of the principles reveals how two or more of them could easily come into conflict and how two ethically astute physicians might differ in their viewpoints. For example, although practicing physicians typically think in terms of their responsibility to individual patients (including honoring the autonomy of individual patients), a public health physician entrusted to ensure the well-being of a wider community would likely view distributive justice as an overriding ethical principle. The difference in perspective between the practicing physician and the public health physician reflects, in large measure, the parties that each regards as the major stakeholders affected by their decisions. In the case of the practicing physician, the major stakeholders

are the individual patients the physician sees on a day-to-day basis. For the public health physician, the major stakeholders are the members of the community as a whole. In the real world of medical practice, ethical principles thus commonly come into conflict, with one's perspective typically determining which ethical principle one views as paramount in a given situation. The same situation is true whether the different perspectives are held by two physicians or a physician and a managed care executive.

RELEVANT PRINCIPLES OF BUSINESS ETHICS

Like medical ethics, business ethics is an example of what has been termed *applied ethics*—that is, ethics applied to a specific profession or occupation. Also like medical ethics, business ethics is a dynamic field where disagreement among acknowledged experts is commonplace. This disagreement may even extend to fundamental issues, such as what the goal of a business should be.

Many observers would contend that the obvious goal of any business enterprise is to be as financially successful as possible. If the business enterprise is a publicly traded company, a related goal would be to maximize profits for shareholders. Under this model, the guiding ethical principle for corporate leadership would be, first and foremost, to reward its investors—those who have risked their own capital in the company's interest. To take this line of reasoning one step further, any deviation from the investor-first principle might well be viewed as unethical, especially if it ran contrary to what shareholders were led to believe.

Others would contend, however, that investors represent only one group of stakeholders that the corporate leadership needs to consider when making decisions. In this view (the second model), the needs of other stakeholders are also a rightful part of the equation. Such noninvestor stakeholders include consumers, business partners, and employees. This so-called stakeholder model of business ethics is obviously more complex than the investor-first model and is one that many US businesses are now espousing.

In a third model, the corporate leadership might decide that the business enterprise should take on the additional role of enhancing the social good and allocate a percentage of its resources for that purpose. A number of US companies have followed this route, although they are hardly in the majority.

The three models described here illustrate the wide spectrum of thinking in business ethics. A major question in managed care, especially the for-profit model of managed care, has been whether healthcare should be considered just another business. The Woodstock Theological Center, a nonprofit research institute at Georgetown University, convened a diverse group of executives, healthcare professionals, and ethicists to develop a consensus statement of ethical principles

pertinent to the business aspects of healthcare. The Woodstock participants formulated the following six core principles, which are still valid today (Woodstock Theological Center 1995):

1. *Compassion and respect for human dignity*. The Woodstock group affirmed that patient care is the primary goal and responsibility of healthcare enterprises. Furthermore, the group declared it would be unethical for healthcare providers to exploit the vulnerability of patients to enhance the organization's or a professional's income or profits.
2. *Commitment to professional competence*. All healthcare professionals, including physicians, nurses, and healthcare executives, have an ethical duty to continue their educational efforts and enhance their competence.
3. *Commitment to a spirit of service*. Healthcare professionals have a responsibility both to the community they serve and to individual patients. This responsibility extends to providing uncompensated or undercompensated care to the poor and needy.
4. *Honesty*. Healthcare professionals and executives have a responsibility to be truthful in their interactions, including their interactions with each other and with patients and families. Medical records should also reflect this commitment to truthfulness and accuracy.
5. *Confidentiality*. Information pertaining to a patient should be shared only with the express permission of the patient or legal guardian, except as required by law.
6. *Good stewardship and careful administration*. Healthcare professionals have an obligation to use health resources wisely, carefully weighing the relative costs and benefits of the available treatment options.

The similarities between the principles of medical ethics listed earlier and the Woodstock compendium of ethical principles for those in the business of healthcare are noteworthy but not surprising. "Compassion and respect for human dignity," for example, clearly resonates with the principles of patient autonomy, beneficence, and nonmaleficence. In addition, the principles of "commitment to a spirit of service" and "good stewardship and careful administration" both relate to the notion of distributive justice. Finally, the potential for conflict between several of the principles of medical ethics cited previously mirrors a similar potential for conflict in the Woodstock group's core principles. In the setting of limited healthcare resources and market competition, for example, can the "provision of uncompensated or undercompensated healthcare to the poor and needy" realistically coexist with "good stewardship and careful administration"?

ETHICS ISSUES FACED BY PHYSICIANS PRACTICING IN THE MANAGED CARE SETTING

Before examining ethical dilemmas faced by physicians in the setting of managed care, a brief discussion of ethics issues faced by physicians in the pre–managed care (fee-for-service) era might be beneficial. Otherwise, the reader might get the erroneous impression that ethical dilemmas for physicians only arose when managed care came on the scene.

As its name implies, in the fee-for-service model of healthcare delivery, physicians were paid a specific fee for performing a specific service, whether that service was an annual physical examination or bypass surgery. Although some older physicians might hark back to the fee-for-service era as "the good old days," it was not free of ethical quandaries. For example, distributive justice was a major (if perhaps inadequately considered) problem, as the indigent and uninsured frequently could not afford the physician's fee and, except for charity care, were essentially shut out of the system. In addition, the physician's fidelity to the patient may sometimes have been compromised in a system where physicians were financially rewarded for providing services that might have been of questionable or only marginal benefit to the patient. Physicians' veracity (truth telling) may also have been less than optimal in the fee-for-service system if, for example, the physician just happened to be a part owner of the laboratory to which patients were referred for tests. Finally, in retrospect, nonmaleficence (the obligation to do no harm) may not have been observed as much as one would hope; one wonders how many patients in the fee-for-service system were ultimately harmed by procedures that were recommended for questionable or marginal reasons by physicians and surgeons who benefited financially from performing as many of those procedures as possible.

Unfortunately, ethical dilemmas for physicians appear to be no less common (and, some would argue, are even more common) in the setting of managed care. Many of these ethical quandaries are related to one fundamental question: In the managed care system, where should the physician's loyalty ultimately lie—with the individual patient, the medical commons, or the MCO itself? This fundamental question branches out into a number of others:

- Should the physician engage in the rationing of healthcare at the bedside of an individual patient?
- How should the physician respond when they believe that the patient requires the specific expertise of a consultant not on the MCO's panel of consultants?

- Under what circumstances should the physician prescribe medications not on the MCO's formulary—medications that might well be more expensive than those listed on the MCO's formulary?
- How much information related to diagnostic and therapeutic options should the physician disclose to the patient?
- How forcefully should the physician "fight" the MCO when the MCO makes a patient care–related decision with which the physician disagrees?

Rationing Care at the Bedside

A topic of ongoing—and often heated—discussion among medical ethicists is whether physicians should ration care at the bedside of an individual patient. Some observers would argue that a "new ethic" requires that the physician's level of concern about the medical commons be so pervasive as to influence the physician's recommendations to individual patients. Others, however, contend that to act in this manner undermines the very foundation of the patient–physician relationship—that is, the patient's expectation that the physician is the patient's advocate, recommending those diagnostic studies and therapeutic interventions that the physician believes are in the patient's best interest. After all, how can the patient trust the physician to give proper care if the physician is thinking primarily about the welfare of the medical commons? One view is that physicians should not engage in rationing healthcare at the bedside of individual patients because it violates the physicians' ethical responsibility of fidelity, an ethical responsibility that patients have rightfully come to regard as an underlying premise of the entire patient–physician relationship.

However, physicians should acknowledge the reality that healthcare resources are finite. Physicians can reasonably do so in at least three ways without violating the trust their individual patients have placed in them. First, physicians need to recognize that there is no ethical obligation to provide clearly useless or futile care, whether it is prescribing antibiotics for a viral illness or extending the life of a terminally ill patient with prolonged ventilator care. Second, all things being equal, physicians should prescribe the least costly among effective therapies. Why choose a more expensive quinolone antibiotic for an uncomplicated urinary tract infection, for example, when the inexpensive antibiotic trimethoprim-sulfamethoxazole will treat the infection just as well? Finally, the question of how best to enhance the well-being of the medical commons in an environment of limited healthcare resources is clearly a profound and entirely legitimate concern. This issue, and the

related matter of priority setting, should be addressed in an ongoing, transparent, and careful manner at the MCO's highest policymaking level, with thoughtful input from physicians as well as from the MCO's membership.

Choice of Consultants

A common question that arises for primary care physicians in the managed care setting is whether a specialty consultant on the MCO's panel is the optimal consultant for a given patient's clinical condition. The following two cases illustrate such issues in everyday practice.

> ***Case 1:*** A 50-year-old MCO patient with an inguinal (groin) hernia asked their primary care physician to refer them to a surgeon in Canada who they heard had developed a new technique for hernia surgery.
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> ***Case 2:*** A 74-year-old MCO patient with hearing loss and vertigo was diagnosed as having an acoustic neuroma, a relatively rare tumor of the acoustic (ear) nerve. Even though the MCO had contracted with a local neurosurgeon to handle all of the plan's neurosurgical procedures, the MCO's consulting neurologist advised the primary care physician to refer the patient to a nearby tertiary care medical center because the center had much more experience with the required neurosurgical procedure.

In Case 1, the primary care physician did not agree to the patient's request to be referred to the surgeon in Canada because the physician knew that the MCO's general surgeon was experienced in performing herniorrhaphy (hernia surgery) and that a high-quality outcome could be anticipated if the MCO's surgeon performed the operation.

In Case 2, however, the physician decided to refer the patient to the tertiary care center for the more specialized type of operation the patient needed. The MCO did not approve this referral at first, but after a series of appeals by the patient, the primary care physician, and the consulting neurologist (and after the patient informed the MCO that they had hired an attorney to ensure that their interests were safeguarded), the MCO reversed its initial decision. The patient subsequently underwent successful surgery at the tertiary care center.

If the physician has good reason to believe that the patient requires special expertise for appropriate care management, then the physician has an obligation to pursue the necessary out-of-plan referral with the MCO's administration.

Nonformulary Prescriptions

In many respects, the issue of prescribing nonformulary medications is analogous to the situation just discussed—namely, referring the patient to a consultant not on the MCO panel. If the physician is convinced that a nonformulary drug is superior to its counterpart on the MCO's formulary, then the physician should serve as the patient's advocate and prescribe the nonformulary medication, explaining to the MCO's pharmacists and administration why they made that choice. In addition, physicians should work with the MCO's pharmacy committee to modify the MCO's formulary when they believe such action is in the best interest of patient care.

Disclosure of Information

Physicians should adhere to the ethical principle of veracity (truth telling), disclosing to the patient all information pertinent to the patient's care. This information includes all relevant diagnostic and therapeutic options, because an informed healthcare decision on the patient's part is impossible if such information is withheld. Physicians should also disclose to the patient all relevant financial arrangements between themselves and the MCO because patients have a right to know about possible conflicts of interest, especially if such conflicts of interest could affect the care they receive.

In addition to their obligation to communicate in a truthful manner with patients and families, physicians also have an obligation to communicate truthfully with MCOs. Physicians should not try to "game the system" by providing MCOs with inaccurate or incomplete information, even when their rationale for doing so is to assist the patient in obtaining MCO approval for requested consultations, prescriptions, or other services.

Challenging the MCO's Decisions

Several of the scenarios mentioned can place the physician in the position of challenging decisions that the MCO makes. Without a doubt, this position can be uncomfortable for the physician—that is, being between the "rock" of fulfilling one's ethical responsibilities to the patient and the "hard place" of a potentially adversarial relationship with the MCO. The latter possibility is hardly a trivial issue. If the physician is a salaried employee of a staff model MCO, for example, the MCO could conceivably fire them for "not being a team player." In the more common situation, where the physician enters into contracts with a number of

MCOs to ensure an adequate volume of patients, the MCO could decide to terminate its contract with the physician. Depending on the precise wording of the MCO–physician contract, such termination (known in the trade as "deselection") can often be accomplished with minimal notice and without explanation or due process. Physicians routinely walk a tightrope in the managed care setting, one that might cause them to be less than forceful in their patient advocacy role.

Financial Incentives and Disincentives

In addition to the threat of deselection, MCOs use another instrument to influence physician behavior. Most MCO–physician contracts feature clauses outlining financial incentives, financial disincentives, or both. Financial incentives and disincentives are meant to engage the physician (or physician group) more actively in the MCO's cost-containment efforts by using a "carrot or stick" approach. Successful cost-containment efforts over the contractual term will result in the physician (or physician group) receiving a monetary bonus, whereas incurring excessive patient costs will result in money being withheld (usually in escrow). If financial incentives and disincentives are modest or are based on the performance of a sizable group of physicians, physicians will likely not be influenced by these arrangements when caring for individual patients. When the financial incentive or disincentive is significant and based on the performance of an individual physician or a small group of physicians, however, the physician's financial interest may be pitted against the patient's interest in a direct and disturbing way, raising the suspicion, if not the reality, of physician misbehavior if the patient believes that the care provided is somehow being compromised.

Pay for Performance

Since the beginning of the twenty-first century, the term *pay for performance* (P4P) has been used increasingly by healthcare policy analysts and in the medical literature (Doran et al. 2006; Ryan and Blustein 2012). As the phrase suggests, P4P involves a financial incentive for assiduously following a set of recommended clinical guidelines or, even better, achieving optimal patient outcomes. P4P can be applied either at the macro level (to hospitals or groups of physicians) or at the micro level (to individual physicians). A number of ethics issues have also been raised about P4P, especially as it pertains to individual physicians and so-called targeted outcomes (e.g., average level of blood sugar control in a physician's panel of patients with diabetes). For example, will a physician's MCO profile be enhanced (and a financial incentive gained) if the physician "fires" sicker or more challenging patients—the very patients, arguably, who need help the most?

ETHICS ISSUES FACED BY MCO MANAGERS

MCO executives also face a variety of ongoing ethical challenges. Some of these ethical dilemmas are similar to those faced by physicians, whereas others are different.

Persuasive Advertising and Selective Marketing

Veracity is usually not uppermost in the minds of those who produce radio, television, internet, or print media advertisements. The entire point of advertising, after all, is to present the product in the best possible light, and if some less-than-flattering details are left out in the process, that is to be expected. Unfortunately, in the case of MCOs, deceptive advertising can result in the prospective MCO member being misled—for example, when an ad implies that MCO members can see whichever specialist they please. The primary care physician is left with the responsibility of educating the new MCO member on how the plan actually works, including the fact that the "gatekeeping" primary care physician first has to make specialty referrals and the MCO member is usually restricted to seeing those consultants on the MCO's panel.

An issue closely related to advertising is marketing. From a bottom-line business perspective, a younger, healthier member is preferable to an older, sicker one. Some MCOs have been known to direct their marketing efforts to effectively exclude those members of the community who are most frail or infirm—for example, by holding sign-ups for seniors at dances or movie screenings, events unlikely to be attended by the bedridden, the housebound, or those requiring walkers or wheelchairs. Such selective marketing aimed at attracting the healthiest (and least costly) prospective members is like "cherry picking."

Although advertising that is less than fully truthful and marketing that is selective might be accepted behavior in other businesses, ethical healthcare organizations should refrain from engaging in such practices.

Disclosure of Information

Honesty should be the rule for MCOs, not only when dealing with prospective members but also when dealing with those already enrolled in the plan. Patients have a right to be informed of all pertinent diagnostic and therapeutic options related to their healthcare and of all financial arrangements between the MCO and its physicians (including incentives and disincentives) that could potentially affect that care. "Gag rules," whereby physicians are instructed to withhold such information from patients, should be prohibited.

Financial Incentives and Disincentives

For MCOs (and physicians) to simply disclose information pertaining to financial incentives and disincentives is not enough. From an ethical standpoint, such incentives and disincentives must be based on the performance of a sizable group of physicians and not be of such magnitude as to place the physician's personal financial interests in direct conflict with the interests of individual patients.

Ensuring Quality

Although each individual healthcare professional has a duty to maintain a high level of expertise and competence, the MCO is responsible for making sure that its members are receiving high-caliber medical care. From an organizational standpoint, high-quality care can be accomplished in several ways:

- Contracting only with well-trained and suitably credentialed primary care physicians and specialty consultants who are highly regarded in the local or regional medical community
- Working with physicians to establish diagnostic and therapeutic guidelines that are evidence based, especially for commonly encountered conditions
- Soliciting thoughtful physician and pharmacist input when developing the MCO's drug formulary, with a periodic review process to keep the formulary up-to-date
- Providing performance-based feedback to physicians through a carefully conducted and accurate profiling system and soliciting physician input in the profiling process
- Using patient satisfaction measures as an additional means to evaluate physician performance

Appeal Procedures

Either patients or physicians, acting in good faith, may on occasion disagree with the MCO's decisions, especially those related to patient care issues. MCOs need to have a clearly outlined appeal procedure in place. This appeal protocol should be logical, reasonable, and fair and should not be biased against individual patients. These qualities are especially important when questions arise as to whether a particular innovative or experimental therapy is covered by the MCO because

medicine is an ever-changing field. In addition, the MCO must clearly state that it will never act in a punitive fashion or take retribution against either patients or physicians who challenge the MCO's decisions or who otherwise participate in the appeal process.

Confidentiality

Like any other healthcare organization, MCOs need to have systems in place to carefully protect patient confidentiality. This includes adherence to the provisions of the Health Insurance Portability and Accountability Act.

Allocation of Resources

Because healthcare resources are finite and MCOs must remain economically competitive in a market economy, priorities in allocating healthcare resources need to be established. MCOs should make these allocation decisions in an open manner, with input from physicians and the MCO's members.

Fostering the Social Good

Because of the predominance of the for-profit MCO model, the US healthcare system has had difficulty financing several domains that may be considered under the general heading of "the social good." These include (1) medical education and the training of future healthcare professionals; (2) biomedical research; and (3) the care of the uninsured, who in early 2023 numbered about 25 million, according to a report released by the National Center for Health Statistics (Cohen and Martinez 2023; Tsai 2023). What role should MCOs (including for-profit MCOs) play in addressing such social concerns? The responsibility of healthcare organizations to promote the social good is not merely an issue raised by "ivory tower" ethicists. The *Code of Ethics* of the American College of Healthcare Executives (ACHE 2022), for example, says:

> The healthcare executive shall: Work to identify and . . . meet the health needs of the community[;] . . . promote an understanding of the social determinants of health and encourage initiatives to address factors influencing them . . . while applying short- and long-term assessments to leadership decisions affecting both community and society[;] . . . [and] support access to healthcare services to all people, particularly the underserved and disenfranchised.

LEGAL RAMIFICATIONS FOR PHYSICIANS AND MANAGERS IN THE MANAGED CARE SETTING

Ideally, ethical guidelines should suffice in causing physicians and MCO managers alike to do the right thing. However, inappropriate behavior sometimes crosses a line and becomes not only ethically suspect but also legally negligent.

A landmark and still very illustrative case in the annals of managed care case law is *Wickline v. State of California* (1986). Lois Wickline was admitted to a hospital in California in the late 1970s for a peripheral vascular procedure. Following that procedure, her physicians recommended an additional eight days in the hospital for postprocedure care and observation. Wickline's insurer was Medi-Cal (California's Medicaid program), which denied her physicians' request for eight days of additional hospitalization, approving a four-day stay instead. At the end of four days, Wickline was discharged. She subsequently developed complications that necessitated readmission and eventual amputation of her leg. Wickline did not sue her physicians, whom she regarded as her advocates, but rather Medi-Cal, whom she blamed for the abbreviated initial hospital stay. In a lower court, Wickline won her suit and was awarded several hundred thousand dollars. Medi-Cal appealed that decision, however, and in a 1986 ruling the appellate court reversed the lower court's decision. The ruling of the appellate court was noteworthy in two respects:

> Third-party payers . . . can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical . . . care are arbitrarily ignored or unreasonably disregarded or overridden.
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> However, a physician who complies without protest with the limitations imposed by a third-party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the healthcare payer as the liability scapegoat when the consequences of his own . . . medical decisions go sour.

The first paragraph indicates that a third-party payer—whether an MCO or a government program such as Medicaid—could be sued if its cost-containment policy resulted in medical harm, especially if the treating physician's legitimate objections were arbitrarily ignored or overridden. The second paragraph is clearly aimed at physicians working in managed care settings and emphasizes that the physician's ultimate obligation is to the individual patient and not passive acceptance of the third-party payer's cost-containment policies.

Since *Wickline v. California*, a number of other cases (e.g., *Boyd v. Einstein, Hand v. Tavera, Fox v. Health Net of California*) have involved the legal liability of physicians in the managed care setting or the legal liability of MCOs (Gosfield 1995; Moskowitz 1998). Although each of these cases is different from *Wickline v. California*, the common theme is that adverse patient outcomes resulting from cost-containment policies can place both the physician and the MCO at legal risk. MCO executives also need to be aware of yet another case, *McClellan v. Health Maintenance Organization of Pennsylvania* (1995), in which the court ruled that the MCO in question had an obligation to select and retain only competent physicians.

Notably, despite the cases cited here, MCOs have been relatively protected from lawsuits in state courts for medical negligence because of the 1974 Employee Retirement Income Security Act (ERISA). The purpose of ERISA was to prohibit state regulation of employee pension plans and other employee benefit plans, including health benefit plans. Because most Americans in MCOs are enrolled through their employer, ERISA has effectively barred most MCO enrollees from suing their MCO for medical negligence in state courts (although it has not prevented patients from suing their MCO physicians in state courts). In their decisions in the cases of *Pegram v. Herdrich* (2000), *Aetna Health Inc. v. Davila* (2004), and *Cigna Healthcare of Texas Inc. v. Calad* (2004), the US Supreme Court ruled to uphold ERISA, continuing MCOs' immunity from medical liability, at least in many of the situations commonly encountered. The issue of whether ERISA should be overturned or amended remains the subject of ongoing and intense political debate.

ETHICAL GUIDELINES FOR PHYSICIANS PRACTICING IN THE MANAGED CARE SETTING

Physicians practicing in the managed care setting should consider the following recommendations:

- The physician–patient relationship is the cornerstone of the practice of medicine, and physicians should view their primary obligation as the provision of humane, high-quality care to their individual patients.
- Physicians are not obligated to provide care that is clearly useless. In addition, physicians have a responsibility to choose among the least costly of effective therapies.
- Any decisions regarding the allocation of healthcare resources should be made on a broad, policymaking level and not at the bedside of individual patients. Physicians have a responsibility to participate in these resource

allocation decisions, bearing in mind the ethical principle of distributive justice.
- Physicians should be truthful in their dealings with patients and families. All information that might affect patient care should be disclosed, including (1) relevant diagnostic and therapeutic options and (2) all physician–MCO financial relationships that might affect patient care.
- Physicians should be truthful in their dealings with MCO management and refrain from attempts to game the system.
- Any financial incentives and disincentives should be limited in magnitude and ideally should be based on the performance of a sizable group of physicians rather than that of a single physician or a small group of physicians. The physician's personal interests should never result in the withholding of care that is medically necessary or medically advisable.
- Physicians have an obligation to maintain their professional competence and seek appropriate consultation for patient care issues outside their realm of expertise.
- Physicians should serve as advocates for a system of healthcare that (1) is based on humaneness, high-quality care, and optimal outcomes for patients and (2) does not place restrictions on access to medical care that is necessary or advisable.

ETHICAL GUIDELINES FOR MCO MANAGERS

In many respects, recommendations for MCO managers parallel those made for MCO physicians. For example, recommendations regarding truth telling, the fair and equitable allocation of healthcare resources, and limitations on financial incentives and disincentives are germane to both physicians and MCO executives. Additional recommendations for MCO managers include the following:

- Refrain from engaging in misleading advertising or selective marketing, no matter how great the temptation.
- Establish and maintain systems within the MCO that aim to protect patient confidentiality.
- Ensure high-quality patient care by (1) selecting and retaining only high-caliber healthcare professionals, (2) working with physicians to establish diagnostic and therapeutics guidelines that are evidence based, and (3) providing performance-based feedback to physicians that is meaningful and accurate.
- Establish appeal procedures that are fair and free of punitive overtones.

- Consider carefully how the organization might contribute to the social good, including medical education, medical research, and care of the indigent or uninsured.

A BLUEPRINT FOR THE FUTURE: THE TAVISTOCK PRINCIPLES

Although this chapter's ethical recommendations to physicians and those to MCO managers overlap considerably, a common perception is that each constituency in the healthcare universe (physicians, MCO executives, or others) tends to view healthcare issues through its own particular lens, hampering meaningful discussion and interdisciplinary cooperation.

In 1999, a group of interested parties, including physicians, nurses, healthcare executives, economists, and ethicists, convened to develop a set of mutually agreed-on ethical principles. Called the Tavistock Group because they initially met near Tavistock Square in London, these parties proposed the following seven principles (Davidoff 2000):

1. *Rights*. People have a right to health and healthcare.
2. *Balance*. Care of individual patients is central, but the health of populations should also be our concern.
3. *Comprehensiveness*. In addition to treating illness, we have an obligation to ease suffering, minimize disability, prevent disease, and promote health.
4. *Cooperation.* Healthcare succeeds only if we cooperate with those we serve, with each other, and with those in other sectors.
5. *Improvement*. Improving healthcare is a serious and continuing responsibility.
6. *Safety*. Do no harm.
7. *Openness*. Being open, honest, and trustworthy is vital in healthcare.

The Tavistock principles are similar in spirit to the principles outlined by the Woodstock group nearly a decade earlier. The tone of shared values and productive cooperation embodied in both sets of principles may one day replace the rancor and divisiveness that has all too often characterized discussion of the US healthcare system. Only time will tell if the for-profit MCO model will be able to adhere to these principles while simultaneously generating the level of profits that investors in other businesses typically expect. Healthcare reform and the political controversy surrounding it have introduced an additional measure of uncertainty to the current US healthcare system. However, no matter what model of healthcare delivery prevails in the future, healthcare professionals of all stripes and at every level must make sure that the ethical underpinnings of patient care are honored.

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