Managed Care And The Imperative For A New Professional Ethic

A plan to address the growing misfit between traditional medical professionalism and emerging health care structures.

by David Mechanic

PROLOGUE: In his landmark work, The Structure of Scientific Revolutions, Thomas Kuhn put his finger on the notion that science was a social enterprise and that scientific innovations were best thought of as responses to cultural imperatives rather than ordered steps in a ceaseless march toward the “truth.” Along the way, Kuhn observed that prevailing notions in science gave way to new ones only after young scientists, acutely aware of the inadequacies of the outdated theories of their mentors, were able to persuade enough of their peers that there was something drastically wrong with the established order. Thus was born the now hackneyed term “paradigm shift.”

In this paper David Mechanic argues similarly that medicine is being pulled in one direction by members of the old guard, who rail against managed care and its effects on traditional notions of medical professionalism, and in another by broader trends that call out for a new professional ethic that takes account of a broader set of responsibilities for physicians. These emerging demands on physicians will require fresh thinking.

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ABSTRACT: Physicians complain about the growth of managed care structures and strategies and their effects on treatment autonomy and medical professionalism. Organizational changes and a competitive marketplace make the traditional view less relevant today. New concepts of professionalism are needed that recognize constraints and include patient advocacy within a framework of procedural justice, responsibility for population health, new patient partnerships, and participation in an evidence-based culture. Such changes require more focused efforts in medical education to support the new professionalism.

A large variety of managed care structures, strategies, and approaches have developed and expanded over the past decade. These range from the traditional staff- and group-model health maintenance organizations (HMOs) and individual practice association (IPA) networks to preferred provider organizations (PPOs), point-of-service (POS) options, and other entities that combine various management features.1 Physicians have been exposed to varying combinations of incentives and controls, including capitated payment, transfer of financial risk, utilization management, profiling, bonuses and withholds, and quality assurance initiatives.

Many physicians are unhappy with the evolution of these managed care innovations and how they could affect physicians’ status, income, and autonomy to follow their best professional judgment. Although physicians may have experience with different combinations of these structures and incentives, they express much hostility to the range of innovations they perceive as “managed care” and as injurious to their conceptions of their discretion and professionalism.2 For example, in comparable surveys of young physicians carried out between 1991 and 1996, physicians increasingly reported that they did not have the freedom to “carefully review patients’ medical histories and test results”; “care for patients who require heavy use of time and resources”; “order tests and procedures whenever they want to”; “care for patients even when they are unable to pay the fees and charges”; “spend sufficient time with the patient”; and “hospitalize patients who, in their opinion, require it.”3 Other recent studies of physicians report comparable findings.4

Jerome Kassirer captured many physicians’ feelings when he noted that discontent was attributable to “frustrations in their attempts to deliver ideal care, restrictions on their personal time, financial incentives that strain their professional principles, and loss of control over their clinical decisions.”5 The growth of managed care structures, particularly more-explicit strategies such as utilization review, affect physicians’ perceptions of their clinical autonomy. The 1996 study of young physicians reported that 69 percent of respondents indicated that their degree of professional autonomy fell short of their expectations and that they complain much more of
a lack of freedom than earlier samples did.5

Because of a growing misfit between traditional concepts of medical professionalism and emerging health care structures, I argue the need for a new professional ethic and efforts within medical education to provide socialization consistent with health care changes. This notion is not new, but it is difficult to accomplish. The new professional ethic, I maintain, acknowledges physicians' responsibility to allocate resources but to advocate on behalf of patients within this framework, depending on a clear structure of procedural justice. It accomplishes this through carefully thought-out principles for care allocation, guidance from evidence-based medicine, and concern with prevention and public health. Strong patient advocacy in a context where principles of fairness are transparent, I believe, offers the most promising context for "muddling through" as we cope with new complexities and dilemmas.

**Failures in medical socialization.** Physicians face adjustments to changes in the marketplace and practice organization within a context of negativity among their colleagues. Physicians express much hostility to managed care, and even doctors in training are introduced to managed care in negative ways. In a 1997 survey of medical students, residents, faculty, and deans, students reported that specialty faculty, peers, and residents were most likely to have negative influences on their attitudes toward managed care.7 Only 12 percent of deans reported that their schools required students to complete a clinical rotation in a managed care setting, and only about half reported that their schools offered clinical experience in such settings. Fourth-year students and residents reported that they spent only about 5 percent of their clinical efforts in managed care settings. Medical education as it is now oriented appears to offer an unconstructive perspective for the types of practice circumstances young physicians will face. Specialty faculty, in particular, appear to offer poor models needed for a new professionalism.

**Need for a new professionalism.** I perceive a growing disjunction between the traditional concept of medical professionalism and the changing circumstances of health care provision. It is no longer generally accepted that the rigorous selection and training of physicians and their service orientation and ethics by themselves justify the trust, control, and autonomy that physicians enjoy.8 Medicine is increasingly seen as an occupation competing with others in jurisdictional disputes, each attempting to gain authority over spheres of work.9 Medicine, it is argued, gained legitimacy and used its power to dominate other health occupations, control entry, restrict competition, and dictate the terms of its service—ensuring high remuneration and encouraging relentless spending increases.10
In other words, the medical profession was a craft union. This view has now gained wide currency in support of corporate medicine’s challenges to medical sovereignty.

Corporate medicine has taken from physicians much control over forms of organizational practice and payment, the uses of technology, and the division of labor. It does so with the assent of employers and government because it has demonstrated capacity to contain the growth of medical costs. Thus, the context of medicine has altered radically from what it was just a couple of decades ago. There is more competition, and the income aspirations of physicians as solo entrepreneurs have been superseded by the profit seeking of large corporations. Levels of organizational decision making from national corporate offices to lower-tier organizations associated with health plans now affect physicians in many important ways.12

Many other forces have changed traditional arrangements. Although rationing was always implicit in the practice of medicine, rationing processes have become more transparent and rigorous, and doctors now must weigh treatment decisions more consciously in light of costs. Patients are better educated than before and come to physicians armed with information from the media and the Internet, expecting more participatory relationships. Finally, the complexities resulting from growth in knowledge and technology, the magnitude of information, complex reimbursement incentives, and new expectations and demands require innovative approaches to communication, coordination, and quality assurance.

**Key Elements Of The New Professionalism**

Among the most important elements of the new professionalism are new forms of patient advocacy, responsibility for population health, the forging of new patient partnerships, and participation in an evidence-based culture.

- **Role of patient advocacy.** Americans dislike the idea of rationing, and much of the public’s discomfort with managed care focuses on potentially being denied care they want. Physicians have always had to weigh patients’ interests against their own needs and other considerations, but the incentives of managed care now put physicians’ and patients’ interests in more obvious conflict. Although in theory the basis of trust can be transferred from individual doctors to organizations—for example, we trust that airlines, banks, communications companies, and other service organizations will hire competent and responsible personnel, without insisting on individual personal relationships—most patients view their care primarily through their relationships with their physicians and place an exceedingly high priority on their doctors as their agents.13
An effective new professionalism must retain this important advocacy role despite the increased tension resulting from new economic incentives and allocation responsibilities. The dilemma is how to fairly represent patients' interests while distributing care equitably to a population. Many advocates want to make allocation rules explicit, constraining physicians' discretion. Important countervailing reasons are the large variations in patients' circumstances, needs, and preferences and the difficulty and uncertainty in making explicit comparisons. I argue that what is needed is patient advocacy within a structure of procedural justice.

Conditions for fairness. HMOs and other managed care organizations have depended more on marketing slogans than on explaining carefully the terms of the contract, the trade-offs required, and the basis of the types of limitations they will impose. Patients have to understand that plan membership may allow lower costs but only in return for accepting some limitations on choice or on the type and amounts of care provided. Norman Daniels and James Sabin suggest four conditions for fairness in imposing restraints. First, the rationales for limiting access to new technologies and other treatments should be accessible to the public. Second, "reasonable" reasons should be provided for such limitations. Third, plan members and their doctors should be able to challenge decisions and argue for their revision through dispute-resolution mechanisms. Fourth, there need to be public or voluntary mechanisms to ensure fidelity to these principles. Within such evolving structures and some other constraints discussed below, an acceptable level of physician advocacy can be retained.

Appropriate physician incentives. Physicians need protection for "clinical neutrality" within organized systems of care. Such protections also are needed within fee-for-service (FFS) arrangements that typically encourage overuse of health services. Some protections in FFS, however inadequate, have evolved by regulation. Nevertheless, patients seem more concerned with the threat of underuse than of overuse. Some modest financial incentives for physicians may encourage thoughtfulness in making decisions, but if they become large and greatly affect the physician's remuneration, they can influence decisions too sharply toward underprovision.

A practice style in which physicians pursue every expensive intervention, however small and uncertain the benefit, is not sustainable in the long run. In contrast, increasing the level of services where the evidence supports it is also needed. The development of Health Plan Employer Data and Information Set (HEDIS) measures and other efforts in quality assurance are beginning to address this challenge, but current efforts are imperfect and require much work.
There is no gold standard for defining appropriate incentives, because they will depend on the size of the risk pool, quality assurance procedures in place, the extent of stop-loss insurance, and other considerations. Complex incentive systems that reward quality as assessed by peer review, patient satisfaction, and retention, balanced with reasonable utilization targets shared among a physician pool of reasonable size, provide an approach under which incentives can support good professional practice. We still know far too little about what might be optimal or how to make such incentives work well in practice.

Advocacy limits and protections. There are limits to how much time, hassle, and risk physicians reasonably can expend in battles to get patients what they need, and this has always been the case. Anecdotes suggest that some clinicians are unwilling to resist managed care decisions they believe to be harmful because of the hassle factor and fear of network exclusion if they protest too much. Nevertheless, this is an important professional obligation. Physicians also have an obligation to inform patients of their best judgment and assist in whatever way they reasonably can to reverse decisions they believe to be harmful. Protecting such advocacy and making it the accepted norm is an important agenda for physicians and for their professional associations.

Plan cooperation. There is reason for some optimism that reputable health plans will respect such advocacy and cooperate in making it more possible. The managed care industry has been tarnished by its defensiveness and has little public trust. The American Association of Health Plans (AAHP), for example, now takes a more proactive stance in affirming a code of conduct for health care plans. The public backlash and the continued threat of state and federal legislation encourage the industry to work cooperatively with doctors and other professional groups and seek accommodation. Physicians should aggressively promote and pursue these opportunities to design new arrangements that protect advocacy.

Counteracting drug ads. New advances and more aggressive direct marketing of drugs and medical devices to a better-educated, more articulate public increase patients' demands. Resisting some of these new expectations will be a challenging task, and physicians will need support from their colleagues and organizational mechanisms to sustain reasoned decisions to withhold requested care. Doing so in a credible way will be helped by an evidence basis for decisions, the availability of patient facilitators/representatives to help mediate differences, and the availability of outside independent review when differences cannot be resolved. But most important in many instances is the strength of the physician/patient relationship.