

RECORD, Volume 22, No. 3*

Orlando Annual Meeting
October 27-30, 1996

Session 86PD Managed Care and Medical Ethics

Track: Health
Key words: Accident and Health Insurance, Health Maintenance Organizations, Wellness

Moderator: DAVID V. AXENE
Panelists: ROBERT Z. BRUCKMAN, M.D.†
DEBORAH WHISNAND‡
Recorder: DAVID V. AXENE

Summary: The audience will hear the physician perspective on ethical questions resulting from utilization review decisions infringing on physician decisions in providing health care.

Mr. David V. Axene: There will be three speakers, myself, Bob Bruckman, and Deborah Whisnand. Deborah is a senior consultant and director of clinical ethics for Bioethics Consultation Group in Berkeley, California. This group provides ethical-related consultations to hospitals, hospital systems, hospices, long-term care facilities, etc. I first became aware of this consulting group several years ago when I was doing work with the Oregon Health Plan.

Deborah is the editor of the *Clinical Ethics Report*, a quarterly publication. She has a master's in Religious Studies with specialization in ethics from Rice University. She has a master's of Theology from Harvard Divinity School, and she has been certified as a supervisor by the Association of Clinical Pastoral Education. She is very respected in her field, and she has been acting in a bioethical capacity in health care since 1979.

*Copyright © 1998, Society of Actuaries

†Dr. Bruckman, not a member of the sponsoring organization, is a healthcare management consultant at Milliman and Robertson, Inc., in San Francisco, CA.

‡Ms. Whisnand, not a member of the sponsoring organization, is a senior consultant and director of clinical ethics at Bioethics Consulting Group, Berkeley, CA.

Bob Bruckman is a physician. He works with Milliman & Robertson in the San Francisco office, and he consults in a variety of health care management areas. He's trained as an orthopedic surgeon. He's going to be reacting to medical ethics and managed care from a physician's perspective.

I'm with Milliman & Robertson's Seattle office, and I'm going to be focusing my comments predominantly on the actuarial perspective but also on a management perspective.

What I'm going to try to accomplish is to define what medical ethics is. I'm going to try to describe some situations where medical ethics issues emerge. I will talk about why actuaries, especially managed care actuaries, should care about this. I am going to also talk about what the public thinks they know about this topic, and I'll present many questions. Although the current generation of actuaries goes through an ethics course to get their Fellowship in the Society of Actuaries (FSA) designation, I find most of the managed care actuaries that I run into, both in the consulting world and at the managed care company or in a carrier world, don't often think enough about ethics as it relates to what's going on. I will try to open up Pandora's box a bit so that you will better appreciate this whole topic.

Ethics is defined as the study of the general nature of morals and the specific moral choices to be made by the individual in his relationship with others. That's how Webster defines ethics. Medical ethics impacts the practice of managing care in several ways, so when we apply ethics to a medical area, especially to the managed care area, there are examples that emerge very quickly that we need to think about.

First of all, what is the impact of an incentive payment on physician behavior? In other words, if we pay doctors money for not doing things, what are the medical ethical considerations that you need to think about? What is the reasonableness of a third-party payor, let's say an HMO, holding a provider accountable for its behavior? What are the medical/ethical considerations in understanding the viability or appropriateness of capitation? How do you balance profit motives with providing high-quality care?

We can take a look at some of the for-profit managed care companies who have had exorbitantly positive bottom lines, at the same time perhaps negotiating extremely low capitation rates with their provider community, and potentially motivating the providers not to provide high-quality care because they're trying to save a buck. What are the medical ethical issues related to that?

Last, what are the medical ethical issues related to the level of a target profit margin in light of the risk transferred to the provider community? If, for example, the

reasonable pretax profit of a managed care plan on a total fee-for-service basis is 3–5% pretax, and you've now totally capitated the system, from an actuarial perspective, what should the target profit margin be? Should it be less than 3–5% or should it be more than 3–5%? These are examples of issues that I have found emerging in managed care.

- Appropriateness of patient cost barriers and benefit design. There are many organizations that put up a significant cost barrier so the patient won't use the service. Are there ethical considerations related to that?
- The exclusion of a provider from a managed care network based upon previous performance. For example, some of you may profile a group of doctors and say, "Just because Dr. Jones did a bad job last year, he's no longer part of the network this year." What are the medical ethical considerations of that decision?
- The allocation of cost savings between the payor and the provider. How do you decide where the savings should go, to the employer who's buying the plan versus the government who's paying for it? Should the doctor get it? Should the hospital get it? Should the employer get it? Should the employee get it?

It turns out that most physicians respond to incentives the same way nonphysicians do. I often talk about the six Ps of provider influence. First of all, I've found that positive financial rewards—we call those carrots (i.e., when you give a doctor more money because they do what you say)—will change physicians' behavior. Second, if you have a penalty built in where you give them less if they do something wrong, (i.e., sticks), they tend to change their behavior. If you implement practice guidelines, they will change their behavior. If you profile the results and compare one doctor to the next, they will naturally change their behavior. If you put them into small groups there will be peer pressure, and they will change their behavior. If you publicly embarrass them or publicly show commendation to them, they will change their behavior because of the recognition aspect. So those are the stimuli that will frequently change a physician's behavior as they try to treat patients. Each one of those has an ethical issue you have to deal with or at least you need to think about.

It turns out that the greater the incentive that you give, the more the behavior will change. If you have a modest incentive, you don't get much change in behavior. There's this fine line between financial self-interest and greed. If you cross that boundary, and then you end up having some interesting problems.

One of the things that many of us aren't fully aware of is that less than 20% of a doctor's behavior in any situation is based upon hard science. About 80% of what they do every day is based upon their perception of what is the right thing to do

based upon their training, but 80% of the decisions that they make every day are not based on hard science. If they're not based upon hard science, and you build in an incentive to change that behavior, you have to be very careful that you're not driving them in the wrong direction. What safeguards do you need to build into the program to protect the patient? In an earlier session the speakers were talking about the patient's perspective. In managed care there's an ethical issue. What do we do to build in safeguards for the patient so that they can get high-quality, cost-effective health care?

Effective medical directors, utilization review nurses, and other case management staff frequently will challenge the provider on their care plans to minimize unnecessary care. That's what utilization management's all about—challenging the doctors on what they're doing to perhaps encourage them to do something that's more appropriate, more cost effective, etc. How far should they go in challenging that care? How far should they pressure doctors to change their behavior? That is a medical ethical issue. You have to be careful that you don't go too far. Is it always in the patient's best interest?

Fortunately, we have found that efficiency is convergent with quality, and the most efficient systems tend to have the highest quality. The highest quality systems tend to be the most efficient. As we're working towards efficiency, as we're working for high quality, we're often improving the quality of care of everybody involved. But who really knows what care is appropriate? Who's to really decide? Who is the final judge or who should be the final judge in that process?

How much say should the patient have in what happens, especially when they have to pay for a portion of that care? That's a medical/ethical issue. If patients have an out-of-pocket premium payment every month of \$100, plus they have \$10 office visit copayment, how much say are they entitled to have in what happens to them? On the other hand, you have a physician who perhaps is basing many of his or her decisions upon subjectivity instead of hard science. What role should he or she play? You may have a obtrusive medical director who's being motivated by a president who has a stock option on the profitability of the HMO. How far is it safe to push that medical director? There needs to be a standard somewhere to determine what's appropriate. How much say a patient has in what happens often directs which HMO the patient signs up for next year, and if a patient gets pushed around too much at one plan, then he or she might choose one where he or she's not pushed around so much.

We, as actuaries, have been faced with ethics related to incurred but not reported (IBNR) liabilities in financial statements. The valuation actuary has to decide what's best or what's appropriate for the plan. There are many ethical issues related to this.

For example, if the president of a life insurance company or a health insurance company comes down and says your job is on the line unless you take away all the margins in the reserves, we, as actuaries, have a process that we know we can go through. However, there is no code of ethics for medical directors that I've been able to find. If the president of an HMO comes to a medical director and says to deny all the care this week because the HMO can't afford to pay the claims anymore, how far can a medical director go without crossing that level of ethics?

Let's talk about profit and high-quality care. The most frequent criticism that I hear about managed care, and you have to understand I'm coming from pro-managed care, is denying care for profit motives. Why would a medical director ever not allow somebody to have a procedure, or be reimbursed for that procedure? Is it because it's medically unnecessary and it doesn't do any good, or is it because they have a stock option, and if they lower the cost of care, they make more money? Those are issues that you must take a very close look at.

Managed care plans need to make a profit in order to survive. If they don't have profit, they're not going to survive. They won't be able to grow. The market is highly competitive which is driving down those margins, making it harder for them to survive. At the same time, there's a potential for challenging care for financial reasons, especially at a for-profit company with employee stock options. The not-for-profits seemingly can get by that because they don't have stock options. However, there are ways of taking care of people in not-for-profit plans, and so perhaps there can be a profit-based incentive built in another way. How do you associate and relate those two issues? It turns out that if you define quality, it really helps you in that process. In other words, if we had a good definition of quality that we could all buy into, perhaps we could have a better chance of answering that.

One of the definitions that I use in my managed care consulting practice is as follows: "Quality is finding out what's wrong with the patient as quickly and as efficiently as possible and fixing it as quickly and as efficiently as possible." When you fix it, you have a good outcome. When you do it on a timely basis, you have high-quality care. When you found it the first time instead of the 16th time, that's better quality than the guy who had to do "needle in the haystack" tests until he could find out what's wrong with the patient. Finding out today is better than finding out tomorrow. If you define quality that way, you can be sure that you're trying to minimize medically unnecessary events. I'm not trying to maximize profit. I'm trying to minimize medically unnecessary events. With a good definition of quality you can control the profit-driven motive.

It turns out that an appreciation of how much clinically unnecessary care there is helps to sort that out. Perhaps the fact that about 60% of the bed days in this

country are medically unnecessary suggests that you can shorten the length of stay and turn down a few admits before you go after the ones that really count. If you really believe that, you don't have to worry so much about trimming it back for a while.

Let's talk about profit targets and risk transfer. What do the terms "good and sufficient," mean to you? My mentor taught me that sufficient meant more than adequate and good meant not redundant. I don't know what you think good and sufficient means, but when it comes to establishing a profit margin, what is a good and sufficient profit margin? The whole concept of there is no maximum amount that's fair to add as a profit margin is something that has always been foreign to me. Perhaps the fact that I work with a many provider company has helped me understand this more as they're being whittled down to bare bones. What is a fair profit margin? What is a fair target? What is the impact of provider contracting, especially when it transfers significant amount of risk? If you are whittling away each of the opportunities for a profit margin to build up that surplus, then you are making it more difficult for them to assume that risk.

What level can actuaries build in without violating their own ethics? What is fair? What is equitable? It becomes more than what you can negotiate. In my opinion it actually gets to the issue of what is equitable and what is fair? When we put a value on a client for merger or acquisition purposes and do an actuarial appraisal, are we're trying to find out what is a fair actuarial value?

For years actuaries were the people that were the decision makers who actually determine an unbiased estimate of what was appropriate, yet many of us in our profession are being unfairly twisted by the marketplace to do things that are a little jaded, a little bit far from the middle of the road, and a ways from what's fair and equitable. How far can you go in deeply discounting a provider before you've gone too far? How about those who deeply discount the provider, transfer no expense dollars, transfer most, if not all, of the underwriting risk, and maintain higher margins at their level than they had before they did all of that? What are we allowing to happen in our industry? Does the free market permit an anything-goes mentality or attitude even if it negatively impacts the ability of a provider to financially absorb the risk? This is an example of an ethical issue that an actuary should at least think about. We take those ethics courses when we get an FSA, but we often fail to apply it in our day-to-day work.

Regarding patient cost barriers and plan design, it is a fact that the bigger the cost barrier, the fewer the services that will be used. If there's a \$10 office visit copayment versus a \$1 office visit copayment, the patient with less of a copayment will use more services. Therefore, you get to a point where you wonder how big

can a copayment be before we're stopping access to appropriate care? If you're a federally qualified HMO, they say 50%. Whatever the cost of the services, you can't go across 50% of that service. Does that mean you should go that high? What about the quality of care issues to make sure that the patient will be using appropriate care? Plan design is more than trying to get a price that's competitive. Plan design has a great deal to do with quality, yet I find that many of us actuaries aren't even thinking about that because we're trying to blindly lower the price enough by having higher copayments so we can be competitive to make up for our inefficiency at managing the care dollar. How does a managed care plan avoid inadequate provider access yet minimize excess patient-motivated utilization? Perhaps we should quantify how big excess patient-motivated utilization is in order to try to understand what that means. What should a managed care plan do to monitor the underserving of a population? We've built in all the high-cost barriers. What should we be doing to make sure that patients who really need service aren't going without it?

The issue of excluding providers from networks creates a very interesting situation. What level of information is adequate to exclude a provider? How sophisticated does the actuarial analysis have to be to prove that? There are people that are not excluding because they say they don't have enough information. On the other hand, there are people who are excluding with no information. What is the right answer? Is past performance indicative of future performance? Another way of saying that is, do doctors ever learn? If they do learn, then why exclude them? If they don't learn, does that mean that they should be a blacklisted doctor in that community? How much can providers be rehabilitated, and how quickly? I believe that providers can be rehabilitated quite quickly. If they can be rehabilitated quite quickly, how quick should I be to get them out of the network?

There are about 2.6 doctors for every 1,000 people in the U.S. Our most recent actuarial analysis says that with the appropriate use of nurse practitioners and physician assistants we need no more than 1.15 doctors per 1,000 people. It's a nice way of saying that one out of every two isn't needed. Sometimes if one out of every two isn't needed, we might want to exclude a few from the network so that we don't get stuck with a little bit of everybody. In balancing the approach to the oversupply of doctors, is it an ethical issue? Is it a business issue? How do we answer that question?

One of my favorite questions emerged when I did a project with General Electric. Management indicated that they thought that all the money that they saved from their health plan should come to the employer. Then we talked to the doctors, and they said all the money that we save should come to them. Then the employees said all the money should come to them in terms of excess compensation.

Everybody wanted a piece of that action. What is the right answer? Who should get that money? Who should get the rewards? If you put some carrots and sticks into the program to motivate doctors to be more cost effective, do they deserve that money or does somebody else deserve that money? How do you decide? It's more than an arbitrary issue. Is it fair to ratchet down a provider payment in future years once they have managed the system down? What happens when you do that? Ironically, the costs go back up.

The public is our number one source of problems in managed care today because they just don't like managed care or change. Whether it's inertia or people being told what to do, there are many people who really don't like it. Plans rarely provide high quality. All they want to do is make a profit. A frequent statement in the press is "Shortening of hospital stays means termination of care." The Bradley Bill that recently passed invokes a prison sentence to force women to spend two days in the hospital whenever they have a baby. Yet when 81% of all births on the West Coast are discharged within 12–24 hours with the best outcomes in the world, why would mothers want to be sentenced for one more day? I don't understand that personally, yet many HMOs have gone along willingly. Many HMOs don't like it. Shortening a hospital stay never meant termination of care. It meant transitioning care to a more appropriate location, continuing the care as long as it's needed, but it didn't mean stopping care. In fact, one of the statements that I'm using very frequently is that inpatient care is nothing more than an admission of a bad outcome of ambulatory care. Because we couldn't take care of the patient on an outpatient basis, and had a bad outcome, now we have to admit them to take care of them the second go-round. Once they're better, they can go back to the outpatient sector. The public thinks that shortening of those stays means termination of all care, but it's not true. The public believes that capitation always results in the underserving of a population. That's not always true. The incentive to underserve is there, but if you have the right control, it doesn't necessarily have to occur.

The public generally believes that patients, given the right to choose their provider, will always make a good choice. I will tell you that's probably about as untrue as anything can be. Patients are probably the poorest selectors of doctors that exist. They're after a comfortable choice; they're not after the technical knowledge.

Oftentimes we will make decisions based upon bad parameters, and we'll get into a situation that causes a problem. The public also says managed care plans give no provider choice to patients. Has anybody ever seen a provider panel with one physician? I think most provider panels have many physicians. You have a limited number that you can choose from, but you do have quite a bit of choice.

Until managed care can produce complete outcome studies, it is unreasonable to expect provider behavior changes. The public says that until you can prove that managed care doesn't hurt me, I'm not going to change. The fact is that there are no outcome studies to show that what has happened today is good. Why is managed care held to a higher standard to not allow change? It's perhaps a physician rebellion against change. Perhaps it's an inertia effect. They don't want to do that.

In closing, I think that actuaries working in managed care need to carefully consider the guidelines for professional conduct that we're all supposed to know. If you don't know where that is, go home and look at your *Yearbook* and your other publications from the Society of Actuaries and the American Academy of Actuaries and take a good look and read through it. If you're practicing in health care, take a real close look because those of us in our profession at least have guidelines for professional conduct on what we're supposed to be doing. Unfortunately, in the managed care area they're significantly out of date. It's not the normal market situation, and there are tremendous issues to deal with. It's easier outside of managed care than I think it is inside of managed care, and since money and financial incentives are involved, any time money's around, the word financial self-interest shows up, and, potentially, greed. It's going to be controversial. Somebody's money becoming somebody else's money makes it controversial. It's always hard to separate financial self-interest from greed, and I think that we just have to think through those issues.

Dr. Robert Z. Bruckman: I'm going to start right out by doing the unpardonable thing and begin reading to you. Medical ethics got a very big, positive statement about 2,300, or 2,400 years ago, when Hippocrates, who was a physician born on the Greek Island of Kos, developed an oath for his followers, and it has been used more or less since then. The Hippocratic Oath is the foundation of medical ethics. Doctors argue in the lunchroom about much of the material Dave spoke about, but in their souls, they worry about getting caught between the health plan and the patient—getting stuck in the middle where you don't know what your role is, and you don't know where you belong, or you're not sure of who you are and who you're responsible to.

Now, the use of this Hippocratic Oath has actually been increasing. Somebody recently studied it and found that in 1928 only 26% of medical schools actually gave the Hippocratic Oath, while its use in 1993 had increased to 98%. Of that 98%, all of them pledged a commitment to their patients. Forty-three percent pledged to be accountable for their actions—only 43%! Fourteen percent included a prohibition against euthanasia. Eleven percent evoke a deity. Considering which deity was evoked by Hippocrates, I think it's actually quite important. Eight percent

forswear abortions. You know, of course, where that goes. And three percent proscribed sexual contact with patients which means that 97% of us are free to pursue.

From the Floor: So, there's more than one oath, apparently.

Dr. Bruckman: There are probably 50 oaths and interpretations and retranslations, and I'm going to give you two of them. I think it's useful to actually read the oath and think about what's happening as you go through it. This is just about the oath that I swore:

I swear by Apollo, the physician, and Aesculapius, and Hygieia and Panacea, and all the gods and goddesses, that, according to my ability and judgment,

I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parent, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture and every other mode of instruction,

I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others.

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.

Those are two of the hallmarks of the oath.

I will give no deadly medicine to anyone if asked [an interesting problem in Michigan these days] nor I will suggest any such counsel and in like manner I will not give to a woman a pessary to produce abortion [another interesting current issue]. With purity and with holiness I will pass my life and practice my Art.

I will not cut persons laboring under the stone [now, that's a day when physicians and surgeons were separated, as we are again] but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption and further, for the seduction of females or males, of freemen or slaves.

Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. [That's the third tenet of the Hippocratic Oath. That's essential.]

While I continue to keep this Oath inviolated, may it be granted to me to enjoy life and the practice of the Art, respected by all men, in all times. But should I trespass and violate the Oath, may the reverse be my lot.

Now, that's a very complex oath, and it has changed over the years. Not all of it is relevant, but it has three, major foundations on which the ethics of modern practice are built. These are that the physician will maintain confidentiality and that he will do no harm. Now, physicians consider doing no harm the first tenet of the oath. You hear it all the time when doctors talk to each other about what to do for a patient. I will apply measures for the benefit of my patients according to my ability. Now, as far as maintaining confidentiality is concerned, I broke the Hippocratic Oath a week after I'd been in practice as an intern when I encountered my first workers' compensation patient. The state law required that I breach confidentiality, and I argued that was against the oath which I had just sworn, and I was told that I hadn't any choice. That was the law. I began to look at the Hippocratic Oath as a framework of a document not to be taken quite as literally as some might take many oaths.

I'd like to take these three points and move them forward, so that we can see their impact on modern medical ethics and on modern medical practice and the interface with the insurance industry which is, of course, why we're here. The physician has sworn to maintain confidentiality, but federal and state government says that doesn't work. Workers' compensation and Medicaid require that the physician divulge information. The HMOs do too, but with the HMOs you don't have the same

situation because the patient is asked to waive confidentiality when they sign up. In a sense, the physician could argue that's not a problem. The same is true with life insurance. The patient signs a waiver, and that information can be disclosed.

The second tenet is do no harm. Usually that's not a managed care issue. No matter how angry doctors get at the HMO, they rarely think that the HMO is trying to do harm. Usually the argument is whether or not the HMO is doing enough. The problem lies in terms of doing harm with interpreting and evaluating the risk of specific therapy to the patient and also to the plan back and forth. What is the physician's real responsibility? I think this is the crux of the problem and the crux of the issue that I see. It's also the biggest mistake that most (and I use the word *most* advisedly) physicians make in their practice. What is the physician's real responsibility? Is it outcome? Is it advocacy? What are the limitations? As the oath says, "according to my ability and judgment." Let's look at that statement.

I'll ask you this question: Is the physician responsible for a specific outcome? A physician might say he or she is and advises on that basis, but I say no. I say the physician is not responsible for the outcome because the physician only controls availability, quality of advice, quality of technique, and quality of follow-through. The physician is, indeed, responsible for those four factors, but there are issues beyond the physician's control like patient agreement, patient compliance, timing, luck (God, fate, or "the gods"), and, finally, agreement of a third party. One of my friends in medicine used to say that as a patient, if you have a choice between a good surgeon and a lucky surgeon, pick the lucky one. That's probably good advice. So look at those factors. The physician has no control whatsoever over those factors. Thus, the physician really doesn't have control over the outcome.

Is the physician responsible for the outcome of a medical event? The traditional thinking in terms of responsibility is very paternalistic, and you'll see and hear this regularly from physicians. I think that among an intelligent patient base, that's probably the most resented part of an interaction with a physician. I've heard these quotes, and I'm sure you may have also. "Don't worry." "We'll take care of everything." "I know what's right for my patients." I've heard it. I've argued against it. I argue the patient knows what's right for the patient. Many doctors say, "I know more. I know what's right for my patient. Patients cannot understand the complexities of a modern medical decision." Guess what. They can. All they need is to have a few facts and a little bit of understanding, and they can. Physicians think that they have to decide for the patients.

I think I discovered around 1978 that I could liberate myself from that thinking and that I could have patients who were educated because I educated them. They could take responsibility for their own decisions because it was their lives. It wasn't mine.

Patients need to make or take responsibility for their decisions and be accountable for all of their actions. If patients can't take responsibility for their share of the medical outcome, then the medical outcome will fail. Time and time again I've seen that. So the physician becomes responsible for what he or she can control: availability, quality, quality of technical skills, and quality of follow-through.

Let's discuss advocacy. Time and time again I see the physician get involved in trying to be an advocate for the patient with a plan; the physician is fighting for the patient. Who is the patient's advocate? Is it the physician? Who appointed the physician the patient's advocate? Is it the patient himself or herself, or is it a lawyer (advocate)? Think about the training of those folks. It all comes down to a dual moral agency, and the physician is caught between the plan and the patient. The plan wants the physician to do x. The physician wants y. What do you say? That's when we get into gag clauses. That's when we get into those very frustrating times when the physician tries to argue on the patient's behalf. It never works. This dual moral agency is minimized by the physician understanding the level of responsibility that he or she actually has for the outcome. The patient thus becomes his or her own advocate, and if the patient can't become his or her advocate or it's beyond his or her control, then they need to hire an advocate or a lawyer.

Full disclosure completes the process of extracting the physician from this duality problem. What do I mean by full disclosure? The health plan doesn't really advocate the wrong solution, even though the physician sometimes might argue that it does. The choices are usually between satisfactory and best, and that's a legitimate and frequent argument. So the disclosure options might go something like this: I recommend x. The plan will pay for y. I'll authorize x if you wish. I think x has advantages. I think it's best. But if you wish y, you may have to pay out of your pocket or hire an advocate to deal with the plan. In other words, the physician offers both options and an informed choice so that the patient can make the choice. The plan says, "you can't do x." The doctor says, "OK, if you don't want to do x, I'll recommend y, even though I think x is better. However, if you want to do what I think is best, you're going to have to fight for it," and it is very liberating, every time a physician follows that advice, because they can operate without this conflict of dual moral agency. Under these circumstances the plan must not prevent this ethical full disclosure. Gag clauses are irresponsible in my opinion.

The plan has another goal that I think needs to be achieved, and that is to start telling people upfront what they pay for and what they don't pay for. I don't like the term medically necessary. It's not real. Medically necessary is determined by whom for whose benefit? Who decides? I think that's an abrogation of responsibility, and I would like to see a time when the plan defines upfront, when

they sign people up, exactly what they pay for and what they don't. Getting the plans to do that may not be so easy. Specialty societies are another problem. Specialty societies today are coming up with answers to problems that are absolutely clear and without question the proper answer for a complex problem, however, they will not commit themselves to stating that this is the very best because they're afraid to define the standard of care for fear that those that don't follow what they define will get into malpractice trouble. It's a common problem. Virtually every specialty society does it.

I came across this again just the other day. A cardiologist friend mentioned that there's another new drug on the market, another clot-buster that is better than the last one. It's a great drug, but more expensive. The Academy of Cardiology is absolutely convinced that this is the answer. They want to put it in their guidelines. They won't. Intellectually and scientifically they know what the answer is, and they will not make a definitive statement. It would get everybody else off the hook—the doctor, the medical director, everybody else. If doing x is the standard of care, and it's defined by the Academy of Cardiology, then it will become the standard of care, and people can rely on that and, if necessary, charge for it. The Academy needs to understand the financial issues involved as well.

So, to summarize, dual moral agency is the major potential ethical problem created for the physician by managed care. The problem is minimized for the physician by accepting the limitations of the physician's responsibility in modern society, by changing the marketing approach of the HMOs, and by an acceptance of responsibility for defining the standards of care by specialty societies.

I came across a revisited Hippocratic Oath, which I want to share with you, in the January 2, 1986 *New England Journal of Medicine*. It gives a physician's somewhat ironic look at the Hippocratic Oath. It was revised in 1995 by David Scheidermayer.

"I swear by Humana, Columbia, HCA, CIGNA and Prudential and Family Health Plan (FHP) and Wellpoint, and HMO and PPO and IPA, making them my witnesses that I will fulfill according to my ability, and this covenant:

To hold the one who has taught me this business as equal to my corporate president and to give my life in partnership with him or her, and if he or she is in need of capital, to give him or her some of mine, and to regard his or her offspring as equal to my colleague's, and to teach

them this business—if they desire to learn it—for a fee, under contract.

To give a share of my practice management techniques and computer systems and all other business acumen to my children and the children of those who have taught me, and to students who have signed the contract and have taken an oath according to Medicare law, but to no one else.

I will apply dietetic measures for the benefit of the obese, the alcoholic, the smoker, and the drug addict, but in this culture and in this political climate, I will seldom be able to keep them from self-harm and injustice.

I will neither give a deadly drug to anyone if asked for, nor will I make a suggestion to that effect (depending on the outcome of the Oregon Ballot Measure 16). As an internist, I will not do an abortion, leaving that to obstetricians. In fear of malpractice, I will guard my life and my business.

I will not use the knife, but I will try to learn some form of endoscopy.

Into whatever clinics I may enter, I will come for the benefit of the members, required to remain clear of all except capitated care for the indigent.

Things that I may see or hear in the course of treatment or even outside of a treatment regarding the life of human beings, things which one should never divulge outside, I will report to government commissions, immigration officials, hospital administrators, or use in my book. If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and business, being able to retire at age 50 in the sunbelt. If I transgress it and swear falsely, may Milwaukee be my lot.

Ms. Deborah Whisnand: It is really a treat for me to be with you because you're thinking about issues beyond your own discipline, and I applaud you for that. It is a treat for me to be with Dr. Bruckman and Dave Axene, as they are also thinking

about these issues and leading in their industry which is assisting our industry and health care. I will tell you first a very short story about a patient or a health plan member, more properly called, in the Kaiser New England Health Plan. The company that I work with, Bioethics Consultation Group, has been the ethicist for Kaiser for 11 years, and I've worked with the ethics committee in Connecticut for quite some time.

Last spring we had a case come to the committee. It was a ten-year-old boy with a solid tumor, a very unusual tumor, for which he was getting high-dose chemotherapy. He had been in remission for a while, but the tumor reoccurred. He came back to his Kaiser physician who was not an oncologist because the Kaiser physicians are a small group, and they refer out to most specialists. He came back to both the Kaiser physician and to his referral oncologist, and they began to talk with the parents about the possibility of an autologous bone marrow transplant (ABMT).

There are no good tests or no good statistics right now or outcome studies for solid tumors treated with ABMT and high-dose chemotherapy. It was clear that this boy would die at some point from this disease unless a miracle occurred.

One of the doctors wanted to bring this case to the committee. It was, in fact, the Kaiser physician, not the oncologist. So the ethics committee heard the case, unfortunately without the family members in the room. The parents, by the way, were divorced. One lived in Hartford where the committee was hearing the case, and the other lived in Boston. Both parents were well-involved but there was a great deal of friction between the parents, so much so that it had gotten to the point that they could not be in the same room when the doctor gave his report. Needless to say, this wasn't benefiting their son very much. As we sat in the room, we had the oncologist from the University of Connecticut Medical School, the physician, and the manager who was head of the autologous bone marrow transplant unit at the medical school. We also had the Kaiser referring physician. We began to talk about benefits and burdens and the cost of this procedure for this ten-year-old. The case had been referred out to three ombudsmen across the country to get their reaction. All three of those senators had come back and basically said there are no outcome studies that show this is effective, or that will show there will be any change in his life, or that he will survive any longer than he might under high-dose chemotherapy; however, they still recommend that we do the transplant.

The question that the manager of the health plan brought to us was, should Kaiser pay for this? If so, then we set a precedent. This was not the first, but the second case for autologous bone marrow transplant to come before Kaiser Connecticut, and this was still very early in the winter of 1996. We're talking about a small region,

and a small budget. We're talking lots of money. We're talking about setting a precedent. We're talking about a kid whose last chance may be the autologous bone marrow transplant, depending on how you want to interpret the outcome studies in this case. There was no proven data at this point. This is the kind of dramatic case that physicians and health plans are looking at right now.

Your less dramatic case is going to be the mother who brings in the child who fell off a bicycle three days before. This was in Kaiser Massachusetts. The 13-year-old boy started having headaches about a day after the fall. Mom brought him in three days later. She was insistent with the physician in the clinic that the boy get a computed tomographic (CT) scan. The physician checked him out. Every symptom that he had did not indicate that there was any reason to suspect anything unusual going on. Important fact. Mom has a long history of migraine headaches, knows how disabling headaches can be, and is seeing her son in a lot of pain, like he never has been in his life. They talk a while. The doctor says, "Take him home. I'm going to give him this medication for his headache, and call me or come back in if there continues to be a problem." This was Wednesday. Friday, right about lunch, mother shows up with her son again. The physician there taking calls was not the provider physician but sees the patient. He says there's no symptoms in the case that warrant a CT scan. The mother is almost hysterical now because the son has been having headaches for almost a week. He's not dysfunctional, but he was obviously having problems with the headaches. The physician says, "There are no symptoms that indicate we need a CT scan here. I'll give you a stronger drug, even a narcotic, to deal with the headaches." They go home. Before the day ends the physician leaves. Over the weekend the mom calls the emergency clinic and comes in. The on-call physician does what?

From the Floor: A CT scan.

Ms. Whisnand: Does the CT scan. She takes the kid to the hospital and gets the CT scan. When the Kaiser physicians met in a continuing medical education exercise, they talked about this case, and the physician who had seen this boy on Friday said, "What would have happened if my colleague would have given them the same story that we gave them, believing we were correct? What would have happened if the health plan had said we won't pay for CT scans where there is no medical indication it is needed. What if utilization would not allow us to do that? Yet we have a physician, one among us, who feels that it's the appropriate thing to do?" These are the kinds of questions coming before physicians every single day. Physicians are becoming aware of the dilemma that they're in. Doctors are obligated ethically to the patient that sits in front of them, to the physician group or the health plan of which they are a member and at-risk financially. There's a triple moral agency; a moral agency to themselves and their family in terms of

maintaining a lifestyle that they are now well-accustomed to, and I do not say that with any kind of flippancy at all.

I want to share with you the broader context philosophically for the conflicts that we are describing to you. What we're looking at in our estimation as ethicists is a very fundamental shift in the philosophy out of which health care services and medical practice are being done. This affects every single part of who we are, not just our business decisions (although that's what's driving it largely), but the decisional, the emotional, the behavioral aspects of the providers, and those who are employed by the providers who are going to service them in some way.

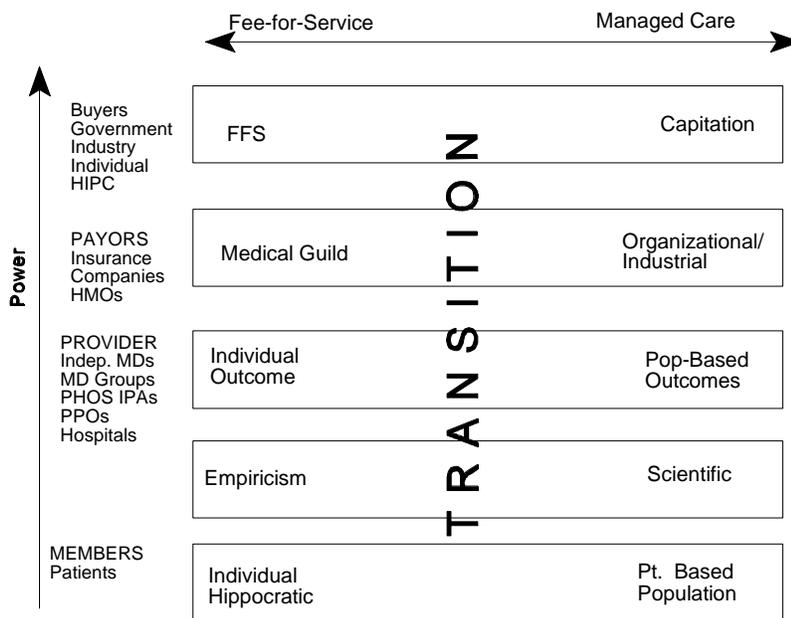
I won't spend a great deal of time on changes. We could talk about who's creating this change in health care. The ones I want to highlight for you, though, are first, medical price inflation. We could talk about the spiral, and how out of hand it's gotten. The bottom line is the payors are saying, "We won't pay anymore; we can't do it." Employees are suffering. Benefits are often becoming so costly that wages are deferred or employees are losing benefits. The competitive marketplace is currently driving the values of the health care delivery. That's extremely important. I'm not against that and it's not a bad thing, that is the primary force. That is allowed to happen now because we do not have a consensus in the U.S. about health care. What I'm talking about here is who should get it, or how it should be delivered. We don't have a universal plan, if you will. Whether you like it or not, a universal plan in the other civilized countries of this world does indicate that there's a moral consensus that all people deserve at least the bare minimum of health care. You'll see that issue being dealt with in some of the states such as Oregon and others that have tried to tackle that. The third factor here is that we are moving from a strictly Hippocratic value base to a population/evidence-based approach to medicine.

Again, the shift is driven by the payors. Value equals medical outcome plus patient satisfaction divided by cost. In the past quality has often been defined as medical outcome. Did we get the medical outcome we wanted and was the patient satisfied? Everything is divided by cost; everything that's on the table. When I began training ethics committees 12 years ago, the rule was the ethics committee never talked about cost or insurance coverage. You couldn't be ethical in health care if you considered money. Now you can't be ethical unless you put it on the table. It is an important factor. The shift or the change is being driven by the providers.

Chart 1 shows how complex the layers are in health care delivery now. The top of the chart is the most powerful. Those are the payors and the buyers—those who are paying the bills, like government, industry, aggregated groups, and in some cases,

individuals. The bottom shows those who have the least power now. Those are the health plan members or the patients. Looking left to right we see the progression, if you want to call it that. It's a spectrum. It's just the indication of where we're moving. The employers, and the payors want to pay for something that we can show them works. They don't want to pay for health care that's not proven. I don't believe we're ever going to be able to prove everything we do in health care, as has well been indicated, but employers are going to the now private companies that are doing all the studies and asking them to show how these companies rate. Can these providers deliver what we want, and for what amount of money?

CHART 1
LAYERS OF HEALTH CARE DELIVERY



The Medical Guild is important. That's the physicians. Medical Guild refers to the way that physicians have practiced for a long time, and that is they were strictly autonomous in many ways. They were responsible for patient care, as has been discussed by Dr. Bruckman. In many ways they have assumed more than they needed which was also indicated, but now they're having to join groups. They're becoming members of different plans, like individual practice associations (IPA) and preferred provider organizations (PPOs). They're having to organize. A Kaiser physician pediatrician who's now in the Kaiser national office, was speaking to some medical directors of children's hospitals from all over the country. She said, "These last few years I've realized that although we've had a group model in Kaiser, and we thought we were doing managed care, and we certainly were doing more of it than other providers in the country for a long time, basically the physicians were

practicing alone. That is, they still could pick up the phone at any time and call the benefits department and say, "You will cover this surgery for my patient," and the benefits department would say "Yes, we will." They were pretty much separate. They did contract together with the health plan, but they still were responsible, as Dr. Bruckman has pointed out, and felt that responsibility as individuals.

There's a shift in terms of ethics and in terms of values. It is moving from measuring value or benefit in individual encounters. What Dr. Bruckman was describing to you is the individual bind on individual providers. There's also an individual patient involved in each one of these. The provider got a sense of satisfaction, (whether it was a nurse, a lab technician, or whoever) of having done the best thing for the patient. There's individual interaction. We are no longer measuring benefit or value that way. We're now being asked in the health care arena to measure value according to things such as the performance of the health plan and the success of the physician groups. Think about your own orientation. Has your orientation been judging in your field as actuaries individual outcomes and/or population group outcomes? I think in many ways you all have come from a different arena and may not appreciate, unless you stop and think about it, how difficult the switch is for someone who took the Hippocratic Oath. It pertains to individuals—one physician treating one patient. We are changing, in a fundamental way, the entire orientation of providers. They cannot think only that way. When I talk about a shift from a Hippocratic to a population-based approach, I'm not saying leave the Hippocratic Oath. We can't leave it. We still have to focus on the individual patient's needs, but that individual patient is now nested in a group. Let's discuss the kind of group.

The Hippocratic approach has been well-described to you, but there's also the scientific and the population aspects. I won't spend much time on the Hippocratic aspects because it was just done so well for you. I will present the autonomy tradition which is very important. That has given rise to, in terms of patient care, patient's advance directives, living wills, proxies, and those sorts of things.

We can exercise our autonomy to refuse or consent to any procedure as long as we're a competent adult, or on behalf of those who are not. There's the autonomy of the physician to refuse to give care that he or she feels is wrong or inappropriate. The autonomy tradition is focused on individuals, and nonmaleficence (that is, doing no harm). There's the promise to do what's in the best interest of the patient and to uphold confidentiality. Also, the contract obligation which is the fidelity that the provider feels, and out of that grows that advocacy. As I was hearing Dr. Bruckman refer to the advocacy, I was thinking about the continuing medical education session that I had with the Kaiser Massachusetts doctors. One of their strong premises is they will not give up their advocacy for their patients. It's so

interesting to hear another physician talk about that in a different way. They want to maintain that in some way. How will we do that in our new system of managed care? Obviously, individual patients, individual treatment, individual diagnosis, and prescriptions in fee-for-service structures fit this very well.

The scientific-based paradigm is one that physicians have had for some time, specifically since World War II, in what we might call the Medicare era. In the time that followed World War II technology and science contributed wildly and dramatically to health care. Physicians began to be seen as scientists. We didn't always call them that, but they began to be seen as scientists. If my child came up with a particular disease that needed a particular treatment, I would go in to my physician and say, "Do you do this?" If he didn't, I would ask, "Who does it best?" We looked for the best scientists, the best technician, if you will. The scientific paradigm is based on population-based research and looks at outcomes for groups and evidence grading. Of course, the best is going to be double-blind, clinical, randomized trials.

We were talking earlier about the practice guidelines being developed in some places in the country. In the practice guideline, Group Health of Puget Sound has evidence grading as their top level. There are certain guidelines and certain places in the guidelines that dictate they must have absolutely the highest level of evidence grading. They have to justify when they have other types of evidence grading which will inform their practice through practice guidelines, through the scientific studies. In addition we have probabilistic reasoning. You heard David say that only 20% of hospitalizations are needed. There's some care that's given that we simply can't prove, but there's a predicted value that we have to take in as we look at scientific data and not just empirical data. The population-based paradigm looks at population groups. Again, this is second-hand for you; it is not second-hand for practitioners in health care delivery.

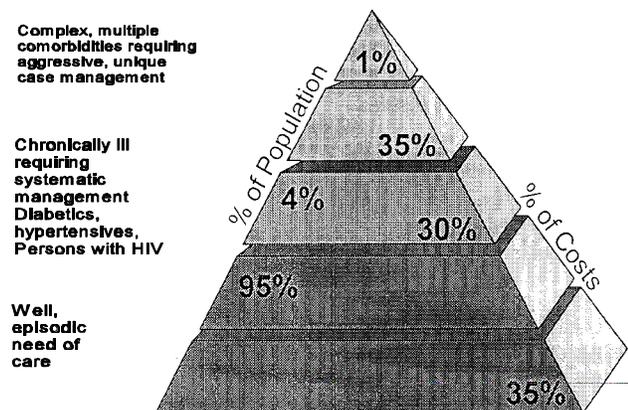
Think about the fact that every physician goes in and sees one patient. They may see several of them in an hour, but everything is judged for that one encounter with that one patient. Now they're being asked to add a whole new perspective, and for many of them it feels like they're being asked to give up forever what they've sworn to be their oath and their loyalty. There's a huge emotional shift for them. We began to look at aggregations of patients demographically and epidemiologically; that is, by disease types. We began to look at the trade-offs, for example, between treatment and prevention. This means big decisions for health plans. How much do we put on prevention and training or prevention and screening of the healthy? How much do we put on treatment of those who are ill?

What we begin to do is move from the individualistic ethics that we looked at in the Hippocratic-based paradigm to a new kind of ethic or utilitarianism. How do we produce the greatest good for the greatest number of people, for example, in my health plan or in my practice? If I'm a cardiologist, and I have several capitated contracts for these patients in my community, how do I produce the greatest good for them while still practicing in good conscience when I go in and see one patient? Will I feel satisfied that I've done the best thing for that patient? There are new ethical conflicts, and, of course, you hear that there's some financial base.

Distributive justice ethic is what it's worth. There are some values even in the statement that the purpose of distributive justice is to distribute resources among populations to equalize health status. Some people would disagree with that, but that definition, that kind of understanding of what health plans are about, and what physician groups are about, are the questions that they're asking in a different way.

Chart 2 is going to illustrate to you one of the ways that we are beginning to see the health care arena make sense of these conflicting ethics and make sense of how to treat a patient and still maintain an obligation to the health plan, or IPA, or the family? What we're looking at is the tools that are actually part of medical practice. These data are based on Health Care Finance Administration (HCFA) 1995 National Medicare. We have a population group that we're looking at. It is pretty well translatable. The percentages will change a little bit. On the left side you see numbers in the pyramid, which are percentage of population. On the right side, you see percentage of cost. Let's start at the bottom. Ninety-five percent of the patients in this are the healthy that need episodic care. Most of us in this room probably fit in this category unless you already know you have a chronic disease. Most of us are in this category, and use 35% of the resources. We're again looking at this structure epidemiologically. We're looking at how to understand cost.

CHART 2
THE SHIFT TO EVIDENCE-BASED AND POPULATION-BASED MEDICAL CARE



There are questions about the financing of our health care for the healthy. How much do we spend on screening before we catch something and it becomes an acute incident? How much do we catch before there is an incident that puts patients in a chronic phase or in the hospital which costs more money?

Some things are as simple as access. How much does Kaiser spend for access for a San Francisco clinic for someone who lives in Marin? They have an office in San Francisco, so they go to the San Francisco clinic. They want in and out. They have to get back to their office. They want to make sure there's easy parking, easy access off the freeway. How does this compare to access in Greenfield, Massachusetts? Needless to say, access in Greenfield is a little different. There's a great deal of snow in the winter. There's plenty of parking. It's on a little field, practically and up on a little hill. The kind of questions about expenditures, resources, and how to unlock them for the healthy becomes important.

The 4% in the middle of Chart 2 are the chronically ill. My examples here are people like diabetics or those with hypertension. You can also add asthmatics, and people with HIV, that is, those who are not specifically AIDS symptomatic yet. Thirty percent of the resources are spent on them. This is the level at which we are seeing managed care succeed the best because this is the place where you can have practice guidelines, utilization reviews, and outcome studies for the group. You can feel confident that the individuals within those groups will not suffer very much. We're seeing costs go down as we're managing these populations in the chronic area. The top group reflects about 1% of the population, and 35% of our resources are spent here. These are the acutely ill. These people may have several co-morbidities such as Alzheimer's with chronic heart disease, or you may have an AIDS patient with several symptoms.

Questions also arise about two invisible groups on this pyramid—the transition groups. Dave Lawrence is the head of Kaiser Health Plan. He's extremely concerned about these invisible groups because we need to pick them up before we end up spending more money on them. We also need to pick them up because now we're seeing people come back down from the acute phase to the chronic phase. As for AIDS, we're seeing some results with long-term medications that put people back into chronic phases. They're no longer acutely ill. Those people are in the middle. Most of us, when we have a disease label, see ourselves as acutely ill. We're looking at how to change behaviors and understandings. We're just looking at the physician or the practitioner. We're not even talking about helping patients and consumers understand that they are now one of a group. How do I maintain my advocacy for myself, if you will, or get what I need? Also, is it possible for me to be responsible as a member in a health plan in terms of what I demand? If my daughter ever develops a disease, I want the best for her, but I'm a real believer in

managed care and in looking at population groups. The emotional conflict is high not only for the providers, but also for the patients and health plan members.

Let's try to summarize some of the value conflicts here. Understanding the shift becomes very important. We found in working with physicians that they begin to understand that they're not being asked to sacrifice their patients; but they are being asked, unfortunately, to take on more conflicts and value questions. The institutions and organizations really want to help doctors do that. They must understand now the trade-offs, good versus bad, benefit versus burden, value versus loss, and gain versus loss of the health status of populations within resource constraints. You may say, "I've dealt with this all along." That's my perspective. Health care providers at every level have never thought of it this way. They've never thought about resource constraints.

When I work with some groups in the military, especially providers and administrators in the Navy and the Air Force, we talk about Hippocratic, scientific, and population aspects, I'll ask them to think about what they do every single day, in their role as a health care provider. I'll ask, "How many of you put yourself primarily in the Hippocratic field?" The people that raise their hands for Hippocratic are all physicians. They're primary care providers. They're family physicians, or sometimes they are pediatricians. Your specialists float down into the scientific arena because they're watching techniques or keeping up on techniques. I'm being heuristic here, but these are generalizations.

I get the health plan managers in the population group. I get the administrators. I get those doctors who sold out and have gone into administration. I get preventive care doctors. They group heuristically and unbelievably fast. One of my words to health care groups is that you really need to have all of these perspectives represented at the table on every single decision you're making in your organization because these three are here, and they need to be heard, and they need to be balanced. Somehow those trade-offs maximize, while we're also maximizing the health status of individuals in the Hippocratic matter.

The core problem, as we have heard it from physicians, is that this shift to a population-based paradigm is forcing them to feel like they are making ethical decisions about quality when they don't have outcome measures. They feel like they're forsaking their individual patients, especially when they don't have the input of the other stakeholders. They're making decisions about who gets certain treatments, who gets certain interventions, and who gets certain medications. Those of us who are the consumers, when we were on the consumer side, are not able to give that input. This is extremely difficult for a physician who walks into a room and knows there's a gag order on something. He cannot tell them about y

because it won't be paid for. The physician has to tell them about x. Think of a community where a health plan is large. How many of those health plans are bringing in representatives of specialized groups, or advocacy groups, or the employers that are paying for the health plan and saying, "Now, you help us decide." Do you want your employees to be able to get autologous bone marrow transplants, if they have end-stage cancer disease such as breast cancer, or do you want us to do fertility work? Taking responsibility even beyond the patient into the stakeholders themselves such as those who are paying the bills, is not happening, but it is a problem.

Core conflicts are lifted up by physicians in particular. We don't know what an increased diagnostic risk means yet. We do know that there are some people who won't fall in the curve over practice guideline. We don't know what that looks like, and physicians are very scared about that. We don't see a big, red flag yet. There will be people who will be missed. Will it be any different in numbers? We don't know. There are explicit cost concerns. You may say so what? For providers who've sworn to care for people, this is extremely difficult. It is a conflict for them to measure everything in terms of how much of their budget will get cut next year? How much of my raise, if I'm the department head in a hospital, will depend on how I manage my budget this year? That's what's happening in hospitals.

For some 2,600 years, in the Hippocratic tradition, there has been trust between the patient and the physician. That is the grounds for advocacy, confidentiality, and fidelity. Now the trust issue is between physicians, as physicians are forming groups and deciding how they're going to monitor themselves. How do I, as a physician, monitor you so that I know you're not spending more or making a decision that I would never make? At the same time, how am I going to allow myself to be monitored by those same rules? Remember, these are people that have not been monitored; they've been autonomous. Not only can they not make every decision, not only do they have to answer to utilization, but they have to get with their peers, in whatever kind of physician group they get in, or whatever kind of contract they make, and look at each other and deal with this. They are at risk, and they have to do this.

Kaiser knows I use them as an example all the time. The Kaiser New England Health Plan recently bought a community health plan, which is four times as large as Kaiser New England, and these groups are merging. This is what's interesting. Kaiser bought them, and yet all the Kaiser physicians are very afraid because when they go now to start their compensation negotiations, the Kaiser physicians are outvoted four to one. There are many problems. How are they going to decide issues about quality care for you and me when they're also fighting for their lives in terms of their financial future? These folks have very difficult dilemmas.

Let's discuss some of the benefits. The first thing about the benefits that you need to remember is the benefits of Hippocratic-based care are individual. If the physician, the nurse, or the chaplain feels good, the patient feels good, and things go well. The benefits in a population-based scheme are not experienced by individuals. You're also asking people to now have benefits that they don't experience individually on a day-to-day basis. They may experience it at the end of the year if they get a bonus or if their department gets more money, etc., but it's not experienced individually, and that has been the basis of their vocation. We are beginning to see these are slightly improved population outcomes. In other words, science is working, and we're seeing it work. We are beginning to see in some health plans the net health of the group is going up. We are beginning to see more bang for our buck, and improved efficiency. We are beginning to see where physicians have made it past the resistance to trust one another to achieve improved collegiality. We don't know how far it's going to go, but I'll lift them up as benefits.

There is increased individual risk in some of the limited incremental situations. This is risk both for the patients, and for the providers depending on their contract. The other burden is managing demand by patients for a high-cost marginal benefit. If I am a health plan member, and my lawyer is standing outside saying, "You're going to do this for my son," what do I do? How do we manage what we call demand management as a whole new area in health care? The individual patient advocacy, as I mentioned earlier, is nested in the patient interest, and this is a very difficult bind.

This is the world that we ethicists live in. We work with people, trying to, in some ways, lay the groundwork for you to come in and give them data and information. But first we help them name the values as a health care organization, and then as individuals. What are the conflicts, and how are they going to try to work with those as they get the data they need from you.

Mr. Cecil D. Bykir: I am curious as to what happened to the ten-year-old boy with the solid tumor.

Ms. Whisnand: Two things happened that were interesting. After the committee heard the case, we found out that there was another set of insurance. The father had insurance that we didn't know about. Even though we've been dealing with this for years, we also found out that the boy had been on the front of the Hartford newspaper cutting the ribbon for a children's health care facility about a year before. He got the coverage.

Mr. John D. Dawson: I tend to believe that when employers are developing their benefit designs, they're deciding what they're going to pay for and not necessarily

deciding what care is going to be delivered. I have a real-life situation that I was asked to comment on for one of the brokers that I work with so that they could get back to their employer. It is a situation where a big insurance company, who I will not name, and a very well-known hospital had a disagreement over a young patient who had a stroke. The patient was still numb over half of his body when he was discharged. The hospital said we can't discharge this person. The insurance company said we won't pay for it. The patient went home, and the spouse was terrified. What are we supposed to tell the employer in this case? Whose responsibility is it? My belief is it's the patient's responsibility to say I'm staying here if I believe I need to stay here. That's not necessarily the right answer.

Ms. Whisnand: The employers feel like it's the health plan and the hospital's responsibility to make those decisions. They don't want any part of it. It's going to be a while before that conversation occurs. The only places that we've seen that occur have been in places where we may have a state such as Oregon or you may have a system in a smaller, kind of contained area where they've tried to bring in the primary forces that would pay and the primary consumers. Our group really feels like these people need to be represented at the table and that the payers need to understand they have some other responsibilities besides just paying the bill.

Dr. Bruckman: I'm going to give you a physician's perspective, and a managed care physician's perspective as well. First of all, it's not a great example, although I understand that it disturbs you. A patient needs to remain in the hospital after a stroke until he or she is stable. At that point, if the person can swallow, and if the vital signs are stable, there's no reason to keep the person in an acute hospital setting. You have a situation where the hospital was trying to cover itself rather than treat the patient. That's a problem. I suspect the plan understood that, second, there are other levels of care that could have been used rather than just sending him home—there's acute rehabilitation, or skilled nursing facility care. All these levels are set up to treat post-stroke victims, and a young person with an acute stroke probably should have gone to an acute rehabilitation facility rather than home. There were step-down options that you haven't discussed.

Mr. Axene: My reaction to that from a managed care plan perspective would be that the care was probably assumed to stop when the patient was discharged, and the patient was really concerned that he or she couldn't handle the situation. It sounds like there was no home health care planning and process at all. I view the culprit in that situation as probably the payor who did not plan the care properly. You mentioned carrier, but if this was indemnity coverage, it's very typical in an unmanaged care system. I would say it's despicable for a managed care plan to have acted that way. I know that the people that we often see in the marketplace

would plan the transitional care until the patient could sustain himself or herself at home or at work.

Mr. Robert B. Hardin: My client base is mostly large employers, and each of you, in one way or another has said that they need to be involved in this process differently. My sense is that they do not want to be involved. They read a great deal about unnecessary care, and they're interested in managed care organizations to reduce unnecessary care. They're not necessarily interested in providing the best care. The difference between best and satisfactory might be important. Maybe everybody doesn't drive a Cadillac, and just because you don't produce Cadillacs, doesn't mean you're not a good physician. If you really believe that my client should be involved in this process or I should be helping the client because I have some ethical responsibility to get them involved in this process, how can I go about this? The people I work with are finance, and human resource people. They've outsourced much of their capability to even think about these things. How can we get these payors involved? How should we be doing that?

Mr. Axene: It starts with education. There's a book by Kubler-Ross called *On Death And Dying*. I find this to be probably the most valuable book in doing managed care consulting. The first stage is denial, and eventually there's recovery, I find that employers are denying the fact that they need to get involved, so I've found that education is really important. Wherever the money is, is where many of the decisions are made. I would start with an education process. People don't care. If there's a union and somehow they find out that the employer doesn't care, it's amazing how quickly the employer starts to care. I start with education as a process, and I have found a relatively warm reception to that once they understand that efficiency or cost is directly convergent with quality. They can reduce cost by appropriately educating their work force. I have found that they are open to do that if they see a reward for the education process. In fact, there are some large employers today that are only establishing managed care options for their employees because they care about the quality of care.

Dr. Bruckman: That seems like a leftover attitude from the days when they were just presented a bill for medical costs and paid it and said nothing. If they want to be involved in driving and determining the cost of the benefit, then I think they have to be involved in creating and defining what it is.

Ms. Whisnand: We are seeing creative groups in different communities around the country begin to do this. They are initiated in all kinds of ways, some are advocacy groups in the community, and some are small payors that organize and want to be at the table. Others are large payors who need to be there, too. Most of the time it's our responsibility. We are beginning to see it happen. Maybe some knowledge

about where it's happening and how companies are doing that in a positive way would be helpful.

There is no easy or good answer to your question right now. I can name several others exactly like this. At this point the entity calling the shots is the payor or the insurance company. There's no doubt about it, unless legal people are brought in. That's what's happening, I think you know that, unless the stakes become really high in terms of suit.