First Annual Nicholas J. Pisacano Lecture

Words *Can* Hurt You: Some Reflections On The Metaphors Of Managed Care

Edmund D. Pellegrino, MD

There are few honors I have cherished more than the invitation to deliver the first lecture in memory of Nick Pisacano. Nick was a man of many roles: compassionate physician, devoted family man, extraordinary teacher, formidable public speaker, staunch friend, ceaseless advocate for family medicine, and an unreconstructed bibliophile who threatened the structure of every house he lived in with the ever-growing bulk of his books and bookcases. Nick was a lover of the classics, too, of Cicero's mellifluent rhetoric, of Cato's mordant moralism, and of Horace's vibrant verse.

What facet of this multigifted, multitalented man should I choose to commemorate? I was pondering this question when a former patient called to tell me that he needed my help. His university had decided to go the "HMO route," and he was asked to choose a "case manager." Because my patient was a mere professor of literature, he could not be expected to comprehend this administrator's neologism. So, I explained that he was being asked to choose a primary care physician, a family physician, or general internist, i.e., a personal physician. He was astonished to learn that the "case manager" euphemism was not mere persiflage but a serious request.

What would Nick have said to this contortion of the English language? Nick was, as you all know, enthralled with words. He hunted down their origins and meanings feverishly. He respected their power to change human behavior, to inflame, to invoke, to soothe, and even to generate revolutions. Nick understood the enormous latent power of words. He knew that they can hurt more than "sticks and stones" and that their deliberate misuse is moral maleficence of a high order.

If Nick were with us today, as I suspect he is in spirit, I think he would share my revulsion for the metaphorical atrocities now displacing the once honorable title of "physician." Those metaphors are drawn from business, industry, economics, commerce, and the marketplace. Like all metaphors, they identify one thing by another. To be sure, metaphors are the yeast of creative writing; however, they also pose a great danger. Used too often, and unthinkingly, we soon mistake the metaphor for the reality. We forget a metaphor is only the product of and a stimulus for the imagination, not a substitute for reality.

The greatest peril I see in all the talk about health care reform is that physicians and even patients might begin to believe that physicians really are "case managers," "fundholders," "gatekeepers," or "clinical economists" and should relate to each other in that way. If they do, physicians will surely lose the final moral moorings of their professional integrity. Physicians might then feel exempt from their traditional ethical imperatives and place the blame on the system for their own moral defection. Needless to say, to protect themselves against such physicians, patients will have to adopt the precautions of the marketplace. Instead of trusting in the physician's ethical commitments, they will have to be guided by the principle of *caveat emptor*.

For all generalists — family physicians, general internists, and pediatricians — these concerns about metaphors are not the trivial fears of a word-infatuated pedant. Generalists are the last defenders of the substance of what it means to be a physician. They are not defined by a procedure, an organ system, or a diagnostic device. They are simply "physicians" who see patients before they are dispersed among the specialists and after they return from that diaspora still in need of someone to put it all together.

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From the Center for Clinical Bioethics, Georgetown University Medical Center, Washington, DC. Address reprint requests to Document Delivery Service, Kennedy Institute of Ethics, Georgetown University, Washington, DC 20057.

Primary care physicians are the prime targets for manipulation by "managing" care. Without managing the generalists, these systems cannot achieve their goals of efficiency and cost savings; yet only through generalists can the well-being of the sick be protected against the system. This paradox is the moral burden of the generalist, and it cannot be shifted.

In the national debate about health care reform, this fundamental contradiction in roles and responsibilities has been neglected.[1-3] Most plans talk in generalities about preserving the physician-patient relationship, protecting patient participation, avoiding discrimination, etc. These are important obligations, of course, but they are derivatives of something more fundamental, i.e., the need to preserve the physician's primary advocacy for the patient. Embedded in the word *physician*, which we are in serious danger of discrediting and even discarding, is the expectation that physicians can be trusted above all else to act for the good of the patient.[4]

Any system of managed care, by its nature, places the good of the patient into conflict with three other goods: (1) the good of all the other patients served by the plan; (2) the good of the plan and the organization, themselves, as expressed in the limits they place on care; and finally (3) the self-interest of the physician. The last conflict is not a new one. Physician self-interest has always been with us. It must be confronted in any plan. The other two conflicts, however, are created by the very idea of a managed system that depends on deliberate manipulation of physician behavior to contain costs by a variety of means, e.g., employing physicians who will accept lower reimbursement, engaging in utlitization review, or limiting access to expensive procedures. Some of those restraints might preclude unnecessary care. When they do, they are in the patient's interests and morally sound. When needed care is denied, however, as it almost must be in any rationed system, a moral dilemma is created. Some other good replaces the patient's good as moral guide.

How should these three loci of conflict be confronted? When obligations are in conflict, how do we resolve them? What is the obligation of the individual physician? What is the role of organized medicine? What is the special role of generalist and especially family physician? As we ponder the answers to these questions, it should become clear why, either consciously or by default, we must resist the metamorphosis of words from "family physician," "primary care physician," "internist," or "pediatrician" to "primary care case manager," "fundholder," "gatekeeper," or "clinical economist." We must face the reality that, public sentiment being what it is today, we are and will increasingly be in externally managed systems. We must be very clear about who and what we are, and we must resist being called something else. We can capitulate and be shaped by those systems, or we can try to shape them in accordance with the dictates of medical ethics.

How Do We Confront the Conflicts of Obligations?

It is important to realize that most of practical ethics consists in resolving conflicts of obligations. To resolve moral conflicts usually requires an ordering of obligations in accord with some governing principle. In the case of medicine, we do have an ordering principle, a moral standard, something not so clearly available in other states of life.[5] That standard is the covenant of trust we enter every time we ask a patient, "How can I help?" In doing so, we implicitly promise to be competent and to use our competence in the patient's best interests. We make this promise to a person who is usually anxious, in distress, and dependent on our knowledge and good will. We invite trust, and we promise fidelity to that trust. The patient's final safeguard is the physician's character, and this character is measured by the degree to which the physician remains faithful to the covenant of trust.[4]

The Good of Other Patients

Physicians who elect to work in a managed care system, however, assume an additional obligation, i.e., to serve the goals of the system — to save money and redistribute resources — and thus serve the good of all the other members in the plan, as well as the survival of the plan itself. When limits on care prevent the unnecessary use of resources, the good of all is served. Under these circumstances, the moral obligations to serve the good of an individual patient and the good of the other patients in the plan are congruent. Ineffective, dubiously effective, or harmful treatment is in the interest of neither the individual nor the group.

When necessary and effective care is denied, physicians are in a position of genuine ethical conflict. Under these circumstances, in effect, physicians are being asked to deny something they think is in their patients' interests. This is a violation of the covenant of trust that binds physicians to use their medical knowledge for the patient's benefit. They have no choice but to disclose the reasons for denying care and to outline the other options even if these options are not part of the patient's benefit package. Depending upon the degree of need, the effectiveness of the treatment in question, and the treatment availability, physicians might or might not be obliged to provide the care or, at a minimum, to be an advocate for the patient in an attempt to obtain the needed care through whatever mechanisms are available.

Physicians have no choice but to put their patients' needs first if they are to adhere to the covenant of trust to which they are bound in their relationships with *their* patients. This covenant is not a license to make arbitrary treatment decisions or to ask for any, and all, treatments. However, whether physicians are obliged to observe the rules of the plan or, instead, to advocate their patients' causes despite the plan depends on how the requirements of the plan affect the welfare of patients. This situation is true with both implicit and explicit rationing schemes.

In implicit rationing, a central authority imposes an overall budget limit but leaves microallocation to the physician's clinical judgment. In explicit rationing, the central authority establishes fixed rules, clinical guidelines, and limitations on what services can be made available. In both cases the physician's moral obligations must begin with the principle of avoiding harm and conferring benefit on the patient. Thus, the putative effectiveness of a treatment must be balanced against the harm done by omitting it. When a treatment is highly effective and the loss of benefit is great, the physician is under obligation to provide the service. If the harm of omission is slight or unlikely or the benefit marginal, the obligation is reduced.[1]

Clearly there is no moral equation into which we can fit a set of numbers and get a computerized resolution of this conflict. Attempts to quantify this process or to standardize ethics beyond these general guidelines are logically unsound and dangerous. The proper resolution of the moral conflict depends on the physician's moral sensitivity at the bedside at the moment when the choice must be made. This obligation is one that physicians cannot escape. Ultimately, physicians write the orders and are responsible for the good or the harm those orders produce.

This same order of priorities applies to the ethical conflicts between the good of the patient and the good of the plan or health care organization. Clearly a health care organization cannot succeed or survive if the physicians in it do not fulfill the roles assigned to them. Physicians who accept employment in managed care plans incur an obligation to serve the goals of the organization, e.g., cost savings, productivity, efficiency, and in some plans, making a profit for investors. In this situation, the physician confronts two sets of obligations, each legitimate in its own right but with the potential for conflict with each other when they must be met simultaneously.

As before, the conflict can be resolved morally only by the primacy of the principle of the good of the patient. The requisite moral algebra involves weighing the effect of omission of a test, procedure, consultation, operation, or hospitalization in terms of harm done or benefits lost. The patient and society are dependent on the physician's clinical acumen and moral sensibilities. The only alternatives are ever stricter regulation of the physician's decision making or an altering of moral priorities from emphasis on the patient to emphasis on the system. The dangers of either alternative, i.e., overregulation or subverting ethics to fiscal exigency, should be obvious.

This last point is especially pertinent to the third locus of conflict, that between the good of the patient and the physician's self-interest. Managed care and managed competition deliberately set out to change physician behavior by incentives and disincentives according to the theory that if each of us serves his or her own self-interest, the interests of all will be served. The health care marketplace is notoriously insensitive to the usual rules of commodity price, supply, and demand. Moreover, any system that deliberately generates ethical conflict through incentives to serve economic or other nonpatient-centered, nonethical goals is morally untenable. It makes no difference whether the incentive is a year-end bonus, salary

increase, promotion, renewed contract, prestige, or a prize for the best utilization review. Clearly, conflicts of financial interest should be resolved in favor of the patient and not the physician.[6]

To be sure, conflicts between patient and physician self-interest exist within the present fee-for-service system, but they are not contrived deliberately to reward the physician for doing less. When fee-for-service conflicts occur, they are the physician's direct responsibility. The physician is free to resolve the conflict in the patient's favor. Overutilization for private gain is a moral defect for which the physician is clearly responsible. In managed care, the physician is not responsible for generating the conflict but *is* responsible, nonetheless, for its resolution. Furthermore, the measure of freedom allowed in effecting a resolution is much narrower than in a fee-for-service situation.

Physicians, like all other humans, have legitimate self-interests, e.g., an interest in earning a reasonable income, maintaining security for themselves and families, and enjoying a certain amount of leisure. What distinguishes medicine as a profession, however, is the expectation that, within broad limits, self-interest will be restrained if it threatens harm or loss of benefit to the patient. Precisely where and how the balance between self interest and its effacement is struck cannot be formularized. As before, the alternatives are trust on the one hand, or rigid regulation on the other.

Prevention of conflict is a better solution. Physicians have a moral obligation to avoid systems that operate through manipulation of incentives and disincentives — particularly fiscal incentives. In this respect, explicit rationing by some authority external to medicine, such as government rather than insurance plans, seems preferable; but as large health care organizations sign up large numbers of patients, their power increases to the point where physicians might have no choice other than to join. The alternative is to have no patients or not enough to sustain a livelihood.

One suggestion for avoiding conflicts of obligations is to shift the focus of competition from cost containment to quality.[7] This idea is appealing, but it is untested and it sounds unrealistic. How do we measure quality? To be sure, where there are good outcome studies, we could use adherence to clinical guidelines. Morbidity and mortality data have utility as well if we can correct for differences in risk, severity, and complexity of different patient populations. Before giving prizes for good utility reviews or other seemingly objective data, the pitfalls of competition, even on the basis of quality, need far more critical scrutiny than they have yet received.

Obligations of the Organized Profession

I have spoken thus far about how individual physicians should confront conflicts in their moral obligations. Conscientious physicians, however, should not be left alone to carry the entire moral burden. Medicine is a moral community.[8] We are united by a shared oath to a common commitment to serve the well-being of those who seek our help. This is a covenant of trust in which the whole profession participates. We are all discredited when one of our members violates this covenant or when we abandon the conscientious physician to confront an unjust policy alone. There are a number of things we are bound to do collectively to maintain ourselves as a moral community. Here are a few of them:

We must first assert in unequivocal terms that we are physicians first and not functionaries in a managed health care plan. We must resist being called case managers, fundholders, or gatekeepers. Our signal should be clear that our prime concern is competent care guided by the well-being of the patient, that well-being is the moral standard to which we will appeal to resolve conflicts among our obligations.

We must remain stewards of the quality of care that results from every health care policy, rule, or regulation. We must document and collate instances of harm and advocate patients' interests within our organizations, with the public, and with legislative authorities. In some instances, when a policy is clearly detrimental to patient well-being, we will have to confront the difficult decisions of collective refusal.

We must insist on the integrity of the physician-patient relationship and of medical ethics, neither of which can be dependent on social whim or governmental fiat. The integrity of medical ethics is to be protected to preserve not the physician's prerogative but the safety of the patient. Medical ethics must not be tailored to fit the needs of the marketplace or the ideology of health care reform. Some would do this tailoring because they take ethics to be a self-serving

enterprise[9]; others do so out of a mistaken motive of resolving conflicts.[8] No matter what the motive might be, medical ethics cannot be made to serve any purpose except to protect the patient.

We must oppose systems that use financial and other incentives to modify physician behavior in ways that can redound to the patient's harm. The physician's focus must be quality care. Efficiency is a focus only to the extent that it promotes quality of care.

Our objections and recommendations with respect to any policy must rest on the primacy of the patient's good, not the potential or actual loss of prerogative, income, or autonomy for the physician. We must be willing to expose our ethical behavior to public scrutiny and establish mechanisms for setting standards of ethical performance in cooperation with the community, which managed health care systems as well as we, as physicians, serve.

Finally, we must encourage, support, and participate in studies of therapeutic efficacy. If we are to argue cogently about the impact of policy on patient care, it must be on the basis of outcome studies. With good outcome data, clinical guidelines become ethically justifiable. Without such data, guidelines become arbitrary and can be made to serve the fiscal well-being of the plan and not of the patient. At the moment, the data only show that patients might be at increased risk of harm in managed care systems or might receive less than optimum care.[10-12] Clearly, more extensive data are required.

The Special Obligations of Generalists

The ethical obligations and conflicts I have outlined apply with special force to the generalist: the family physician, the general internist, and the pediatrician. They are the primary targets of care management because they are the point of contact for the patient with the whole system. If primary care physicians make the decision to deny service, consultations, tests, and operations for the sake of saving money, their moral complicity is inescapable when harm comes to the patient as a result of those decisions.

Generalists also face the responsibility of informing the patient about the full range of indicated treatment — even if it is denied by the plan — and the reasons that indicated care is being denied. The generalists are held legally and morally responsible if serious harm occurs to a patient as a result of their failure to provide a needed service. Generalists will be criticized by both the patient and the specialist if they do not discriminate carefully between loyalty to the plan and loyalty to the patient. Generalists are in the best position to ask what delayed or denied treatment means. In large part, generalists are the "ethical gatekeepers" in the health care system.

Generalists will be under increasing pressure to encroach on the specialist's domain and become marginal specialists. Already insurers have refused to sanction specialist referral until the generalist has exhausted the "simpler measures." For example, some plans expect the gatekeepers to "use up" their talents in psychotherapy or in psychopharmacology before referring for expert psychiatric help. Only when their efforts fail are the gatekeepers allowed to order expert help for their patients. This approach might seem attractive to family physicians and general internists eager to be all things to all people, but delay in access to the specialist could result in increased morbidity, mortality, or severity of illness. The generalist must resist being turned from being a good generalist into a marginal specialist. It would be a strange paradox if a system justified on grounds of universal accessibility were to end up denying access to what the patient genuinely needs.

Twenty-five years ago, the American Board of Family Practice took a courageous step when it undertook to establish family practice as an independent specialty. Perhaps you will take another courageous step and lead our profession back to its original ethical purposes by shaping health care reform as it should be shaped — by ethics and not by economics, politics, or the managed care ideology.

Words are not simply the names of things. They convey ideas that shape our actions and give them moral content. Shall we be physicians? Or are we to undergo a mindless and morally irresponsible metamorphosis into case managers, fundholders, gatekeepers, or clinical economists?

At this point, Nick would have had a word of caution for me. He might well have taken it from one of his great favorites, the Roman poet Horace, who warned all would-be writers about the waywardness of words once uttered or published: "What is not published can then simply be

destroyed, but beyond your recall is the word you have uttered."[13] I have uttered too many, but I hope not in vain. Physicians are not and should not be case managers, gatekeepers, or fundholders but simply physicians — a word we must restore to its original meaning.

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