THE PHYSICIAN-PATIENT RELATIONSHIP IN MANAGED CARE: A TALE OF TWO PRESCRIPTIONS

Joseph J. Fins, MD, FACP

Traditionalists lament that managed care has changed the physician-patient relationship. They assert that capitation brings new conflicts of interest to clinical care, which cast a shadow over the practitioner's primary fiduciary obligation to the patient [1–4]. If fee-for-service medicine placed the patient at risk for overutilization of medical resources, many voice concern that financial incentives under capitation place the patient at risk for undertreatment [5]; this risk, they assert, is compounded for vulnerable subpopulations [6]. Those who raise such concerns allege that the intimacy of the dyadic relationship between physician and patient has been usurped by distant bureaucrats who dictate care from afar and that clinical autonomy is threatened [7]. Furthermore, they worry that ongoing relationships between physicians and patients will be disrupted as the marketplace reshuffles affiliations and insurance plans [8].

There is a mournfulness for what has been lost as medicine moves from fee-for-service to capitated reimbursement [9]. Much of that regret is justified. But to fairly judge what has been lost in this transition, it is necessary to consider what might be gained as clinical practice moves into an era in which practice patterns, clinical outcomes, and cost are taken into account. It is only through a forthright appraisal of the past and present that we can appreciate the role of professionalism as the physician-patient relationship responds to challenges posed by managed care.

A Tale of Two Prescriptions

To illustrate the common yet distinct features of the physician-patient relationship in fee-for-service and capitated medicine, let us consider two cases involving a single physician and two patients, both of whom require an antibiotic for an infection.* The first case is set in a traditional fee-for-service environment. The second case has a managed care setting. We engage in this analysis to illustrate the emerging tensions in the physician-patient relationship, appreciating that no two cases are representative of the diversity of managed care plans [10] or of the range of practice styles that can legitimately inform the physician-patient relationship [11].

Case 1: A Medicare Patient

A 75-year-old woman on Medicare presents to her general internist with a lower extremity cellulitis. She is unwilling to be admitted to the hospital for intravenous antibiotics but agrees to take an oral antibiotic at home. The physician selects an appropriate agent with efficacy against suspected organisms. An appointment is scheduled for the following week, and the patient is instructed to call the physician if her leg does not improve during that time.

One week later the patient dutifully returns to the physician's office. Unlike her earlier visit, she now looks ill and her infection is worse. Fully expecting clinical improvement, the physician asks the patient if she took the pills he ordered. She answers, "Oh yes, I took two of them. That was all I could afford." Remarkably, the pharmacist only dispensed the two pills.

Due to her worsened clinical condition, the patient now requires hospitalization. She is admitted, receives a course of parenteral antibiotics, recovers, and is discharged home.

Case 2: A Managed Care Member

A 30-year-old single woman presents to a general internist complaining of polyuria and nocturia. This is the first time she has seen this physician under the managed care plan now subscribed to by her employer. She has had several different physicians in the preceding years, as her employer switched from one managed care plan to another.

The physical examination is unremarkable, and the patient is afebrile. A blood sample is tested for evidence of hyperglycemia, and a urinalysis is sent to

Joseph J. Fins, MD, FACP, Director of Medical Ethics, The New York Hospital, Associate Professor of Medicine, Cornell University Medical College, New York, NY.

*These two cases are drawn from actual clinical practice.

a local laboratory to determine if there is a urinary tract infection. The doctor's office has no facility to perform a urinalysis.

The results of the urine tests return late on a Friday afternoon and the patient is contacted by her physician at her home in an outlying borough. The physician informs the patient she has a urinary tract infection and that he would like to start her on an oral antibiotic. She understands this explanation but tells the physician that her local pharmacy does not provide a drug benefit under her managed care plan. The patient explains that she signed up for the drug benefit at a pharmacy that was convenient to her commuting schedule on public transportation and that she did not plan on returning to work until Monday. As no pharmacy in her neighborhood would provide the drug benefit as part of her managed care benefit plan, her treatment would have to wait until Monday.

The doctor urges the patient to make the trip to a participating pharmacy for the medication, warning her that an infection could prove dangerous if left untreated for 2 days. He offers to call a pharmacy in her neighborhood with the $10 to $15 prescription for a course of treatment. She refuses, stating that she does not see the point of paying when she has a drug benefit that provides for free medication. The physician talks with the patient for 25 minutes, trying to convince her that she should pay for the drug herself or have the prescription filled at a participating pharmacy. He explains the risks associated with delayed treatment, including the possibility of an ascending infection to the kidneys, which might require hospitalization. After this discussion, the patient reluctantly agrees to have her prescription filled at the designated pharmacy the next morning. The physician calls in the prescription.

The patient returns the next week for follow-up. Her urinary tract infection is cleared, and she is now urinating normally. The patient neither thanks the physician for his concern nor returns for a subsequent visit.

The Physician-Patient Relationship in Context

Economics and Physician Beneficence

These two cases exemplify some of the changes in the physician-patient relationship prompted by the transition to managed care. The first case depicts a well-intentioned practitioner who tries to respond to a patient's desire to avoid hospitalization. A rational medical decision is made to place the patient on an expensive oral antibiotic, which would be a reasonable therapeutic alternative for the patient's infection. Unfortunately, the patient cannot afford the treatment. An inpatient course of antibiotics would be reimbursable by Medicare, but there is no Medicare drug benefit for outpatient treatment.

Haavi Morreim has written about the ambiguity of the purchaser in the health care marketplace and noted that ". . . one of the most important facts about health care economics is that physicians quite literally spend other people's money" [12]. In the case of this Medicare patient, the point is even more complicated: The well-intentioned physician, in trying to be a patient advocate, is spending money that the patient *does not have*.

At first glance, the physician's advocacy appears to exemplify the highest standards of the doctor-patient relationship. The physician tries to respond to the patient's request to be treated at home rather than in the hospital. He respects patient preferences and provides a good therapeutic alternative. Unfortunately, his clinical decision is not fully informed as to the extent of the patient's poverty, the expense of the drug, and the absence of a viable third-party payer. Because the cost of the prescription is not discussed in the physician's office, the patient has no opportunity to volunteer that she cannot afford the treatment. She does not learn about the drug's high cost until she tries to fill the prescription.

However well-intentioned the physician, the first case represents medicine practiced in an economic vacuum. This outcome illustrates the limitations of viewing the physician-patient relationship as solely dyadic. In economic terms, this is not a dyadic encounter; physician and patient are not alone but part of a complex financing web. The practitioner is neither the provider of outpatient drugs nor the supplier of the inpatient bed that will house the patient when she requires intravenous antibiotics. A failure to realize that the physician-patient relationship does not operate in isolation has clinical as well as economic and broader societal implications [13].

Patient Preferences and Physician Obligations

As the first case illustrates, there is an aspect of the clinical encounter that remains private and internal to the dynamic between patient and physician. This dynamic operates even as outside economic forces dictate the type of care that will be given and received. These interactions center on professionalism and the physician's discrete and specific obligations to the patient. Here, professionalism is exhibited through the special nature of the relationship

between physician and patient, in which important values—other than medication costs and how they will be paid for—are at stake. In this encounter, the physician tries to be sensitive to the patient's desires by accommodating her preference to be treated at home. This respect for her preferences remains laudatory and consistent with traditional expectations of practitioners—economics aside.

The first case also illustrates that a physician's beneficence may not be fully realized if communication is inadequate, as both the patient and pharmacist failed to inform the physician that the prescription had not been dispensed in full. It further demonstrates the limits of physician beneficence when patient resources are modest and when the patient does not collaborate with the physician on the treatment plan. For some reason, after the patient voices her preference to stay at home she becomes a silent partner in the relationship, assuming no responsibility for informing her physician that she cannot afford the medication or for reporting that her infection had worsened. At the return visit, the patient is passive and rightly assumes that the physician will set things straight, and, indeed, the physician admits her to the hospital to treat the infection. Here the burden is placed squarely on the physician's shoulders and his intercession is welcomed [14]. This is not a relationship of parity but rather a hierarchical one in which the physician assumes a paternalistic, protective, even restorative role, although he initially tried to respect patient preferences and autonomy.

Consumers, Physicians, and Managed Care

Consumerism and Professionalism

Turning now to the second case, it appears that the clinical outcome was a good one. The physician and patient spoke, and the patient agreed to go to the pharmacy the next morning for her prescription. This delay neither aggravated her infection nor inflated the cost of care. At this level of analysis, capitation seems to be working. But assessing this case in purely market terms misses the tension between patient consumerism and medical professionalism, which is the subtext of this case.

In contrast to the first patient, the second patient is quite articulate. She is assertive and engaged. She knows that resources are available to treat her urinary tract infection, and she is quite proprietary about her drug entitlement—almost to the point of delaying her care over a few dollars.

Although this scenario appears different from the first, the consequences of this patient's economically driven decision impose similar obligations on the physician to promote nonmaleficence and to protect her from avoidable harm. In the first case, the physician felt obliged to treat the neglected infection and to compensate for the patient's passivity. In the second case, the physician's responsibility was to prevent a delay of treatment that could have similar clinical consequences.

Do the same ethical mandates of professional practice illustrated in the first case apply to the second patient? The second patient is better informed than the first patient. She knows about her drug benefit, is aware of what the $15 might purchase, and chooses to make an informed refusal concerning the timely dispensing of the antibiotics. What are the limits of the physician's responsibility to this patient? More a consumer than a patient, she is still well and essentially unbent by the infection brewing in her bladder. She has turned a medical choice into an economic decision. Is the physician's obligation different because the patient views the physician more as a vendor than as a professional? What should be our expectations of the physician?

The physician could remain a provider in this mercantile drama and let the patient make what seems to her to be a purchasing decision. Yet he knows that the bladder infection could ascend to the kidneys and become a serious pyelonephritis. He can envision this young woman's transformation from a consumer into a very sick patient who may require hospitalization.

The patient's risk of a worsening infection coupled with the physician's professional knowledge confers an obligation that makes this encounter more than a market exchange of goods and services. The physician's task is more normative than commercial precisely because he is a member of a profession with duties and responsibilities that exist ". . . over and above obligations incurred in other human relationships, that both individuals and groups have simply because they are members of a profession" [15]. This makes the physician's task more covenantal than solely contractual. Virtues intrinsic to his role oblige him to *profess* for good medical care on behalf of his patient [16].

Unrealized Expectations

These heightened expectations were difficult to realize because the physician found himself in a practice context that undermined his social status as a professional. If the social standing of the profession is one element of the healer's power [17], the physician found himself in a situation in which both his professional status and clinical authority were eroded.

In this dynamic, the patient's prior experience with managed care had conditioned her to view physicians as vendors more than professionals. This patient had several doctors over the previous years as her company switched managed care plans. She had not been in a physician-patient relationship long enough for a practitioner to demonstrate the fidelity upon which patient trust so heavily depends. Even physician beneficence can be misunderstood in a doctor-patient relationship devoid of trust. The patient did not perceive the recommendation to fill the prescription to be in her best interest but, possibly, as a means to save the managed care plan money.

Tragically, this encounter appears to be another failed physician-patient relationship given the patient's disinterest in maintaining and deepening the relationship. It is especially ironic that the patient's suspicions of her physician and managed care plan undermined his ability to serve as a fiduciary and patient advocate. In this complicated scenario, forces external to the physician-patient dyad influenced the patient's view of her doctor and the doctor's view of his patient. Collectively, this tension between consumerism and professionalism undermined the possibility for patient-physician collaboration. Ultimately, it compromised the therapeutic encounter.

Reconstructing Medical Professionalism in Managed Care

If we acknowledge that professionalism is an integral component of the physician's power to heal, we also must accept that the focus of our professionalism must change as we enter into managed care environments. In this complex context, medical professionalism cannot restrict its focus to the individual physician-patient relationship but must also consider the integrity of systems of care that may potentially sustain or undermine the fiduciary dimensions of the physician-patient relationship.

It is no longer adequate for clinicians to be concerned solely with the microeconomic or clinical dimensions of how they care for individual patients. To provide quality care that is ethically sound and appropriate, practitioners must develop a broader perspective and assume more responsibility for the integrity of the institutions that care for their patients. Physicians can no longer practice their craft divorced from the world beyond the bedside, because much of what they can provide to patients is predetermined by the justness of the systems upon which they depend [18].

Indeed, returning to the second case for an organizational critique, we can appreciate how the system let this doctor and patient down. At the outset their relationship was operating under the burden of discontinuity of care prompted by plan purchasing decisions by the patient's employer. This suggests the need to develop incentives that foster longitudinal relationships so that physician and patient can develop a trusting and healing relationship [19].

The manner in which the second patient was treated also demonstrates organizational deficiencies. Internal to the practice, there was no opportunity for the physician to perform a urinalysis to determine whether the patient had a urinary tract infection while she was still in the office. This would have allowed her to leave with a prescription in hand, facilitating her use of the designated pharmacy. The care she received also suggests the need for improved continuing medical education about outpatient treatment. While it was clinically justified to obtain a urinalysis and culture before starting antibiotics, it may not have been the most effective manner in which to treat this presumptive outpatient urinary tract infection. Empiric treatment would have allowed the patient to leave the office with a prescription and avoid all the logistical complications that followed. This option, however, may have been unappealing, as this was the patient's initial visit to the practice and the physician may have been hesitant to empirically prescribe medication to a patient he did not know.

Other systemic issues to be addressed are why the managed care drug benefit was limited to just a few isolated pharmacies and why there was a need for the patient to pay out-of-pocket for the cost of a justified course of antibiotics [20,21]. Ill-conceived drug benefit packages have been shown to be penny-wise and pound foolish, engendering costs by delayed and inadequate treatment [22].

But even as we redirect our professionalism to systemic improvements, we must be vigilant to maintain the practitioner's primary obligation to individual patients who place their trust in him. This is critical because ultimately it will be the professionalism of individual practitioners who serve as advocates for patients when the system is overly bureaucratic or deficient. In the second case, the patient received timely treatment because the physician maintained a heightened concern for the patient's welfare as a fiduciary. He overcame the patient's discounting of physician authority, dealt with the ill-conceived drug benefit plan, and ensured that the patient received care. In short, he demonstrated his obligation to his patient in a very traditional way.

Unfortunately, old fashioned advocacy could not match the enormity of reconstituting this physician-patient relationship. To build this alliance would require more than the physician paternalistically rescuing his patient with a timely dose of antibiotics. It would require a deeper consideration of the patient's narrative and a practice environment that fostered mutual trust and collaboration between patient and physician as they worked together to realize shared goals of care.

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