HUMANIDADES MÉDICAS

Academic and Ethical Implications of Health Reforms Based on Managed Care: Some Critical Reflections*.

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Dr. Pedro Rosselló, Governor of Puerto Rico, has frequently expressed his pride regarding his achievements in the reform of what was known as the Puerto Rican public health system. Today, that system is almost totally privatized and the health reforms implemented have adopted the managed care approach as its distinctive innovation. To solve the bureaucratic and inefficiency problems of the former health government agency, Dr. Rosselló and his staff prescribed privatization and managed care as the best organizational medicine. But as all physicians know, certain drugs and medicines have side effects. Analogically speaking, many political and organizational prescriptions might have social and ethical side effects. Some of those side effects will undoubtedly have implications for academic health-centers. In the case of Puerto Rico, we do not have much data regarding the nature of those implications, mainly because of the short time span during which the reforms have been implemented. Nevertheless, much of what has been evidenced by managed care corporations in the United States experience may suggest what could be the future public debate in Puerto Rico. We heard President William Jefferson Clinton in his 1999 message regarding the State of the Union, warning regarding the need to revise and adopt legislation regulating the operations of managed care Health Maintenance Organizations (HMO's).

I do not have major reservations when managed care is implemented by not for profit corporations who have shown a deep sense of social commitment. But I must say that I have serious reservations regarding the for-profit corporations who see the human frailties and suffering of people as a good strategic opportunity to enrich the vaults of stockholders.

Reflections on some academic and ethical implications. One of the most salient academic implications has to do, among others, with the accessibility to hospital settings for the teaching of clinical skills and for doing clinical research. It is difficult to find teaching clinical settings at the private sector, and if found, there will be much less and it might be more expensive than in the public sector.

Besides those institutional limitations in the logistic of coordinating the clinical settings for multidisciplinary large academic health centers, the health services reforms as implemented pose curricular implications that should be addressed. Let us reflect about some of those implications:

1. First, students in health sciences faculties should be oriented about the changes being made at the health care system. Medicine students, for example should understand that their initial expectations of an independent and autonomous professional practice, traditionally associated with the practice of medicine, might be quite different from what they will find at the moment of incorporation to the job marketplace.
2. Students should understand that the *cost contention mentality* that underpins the managed care approach to health care services has serious ethical implications for practitioners, for the community and for the individual patient. They should understand the political and social reasons why economics has developed into a primary consideration in the reorganization of the health system. In fact, financial considerations have developed a new moral urgency because the changes made might impinge the right of the patients to self-determination and would require a moral reconciliation with the ethical principle of distributive justice.
3. Faculty and students should also understand that the ethical implications of for-profit managed care approach (and even in cases of not for profit types of managed care) will clash with traditional medical and health ethics. The fiduciary relationship between professionals and patients might be impaired because of the visibility of the cost contention emphasis and the difficulties

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this emphasis pose for the health professionals' decision-making process regarding needed costly treatment options. In a litigious society such as ours, the ethical implications of managed care will frequently be transferred to the courts of justice. Students should be well educated in the legal context of the medical practice. In this new market context, defensive medicine will find a new justification because of the restrictions imposed upon both the community of patients and upon the community of providers.

4. Schools of medicine should give priority to primary physicians training in order to ensure that their diagnostic skills and clinical judgment will enable them to be trustworthy gatekeepers. The gatekeeping function assigned to the primary physician needs to be understood not only as part of the strategy to control cost. More importantly, this function imposes the heavy responsibility of not delaying referrals and avoiding hasty decisions regarding the care needed by patients. Rationing services, limiting access to specialist and to high-tech costly technologies, avoiding prescription of expensive medications because of shortage in capitation, are temptations that the physicians should overcome.
5. In the context of privatization and managed care the health academic centers and professional associations should decide if the *Hippocratic oath* and the medical ethics curriculum will be replaced by *Business ethics*. Besides the basic sciences and the clinical sciences curriculum, maybe we should include business administration, accounting, management and entrepreneurial skills as part of the educational experience of health sciences students.
6. The new market driven scenario suggests that we, university professors, will have to redefine citizens as consumers of health services and not as patients anymore.
7. If politicians, corporations, or society insist that cost contention should be the primary concern at the delivery stage of health care services, some university officials might be tempted to think that, for example, a lot of allied health professions should be diminished in numbers or eliminated all together. After all, the reforms seem to be *physician centered* and not *interdisciplinary health team* centered.
8. In the context of cost contention, we should be prepared to hear about persons who, thinking that they are looked upon as mainly an economic burden to society, will conclude that it might be more cost effective for them and their relatives to opt for refusing health care. Even recurring to assisted suicide or euthanasia might be assessed as more cost-effective for them as individuals—and certainly for private corporations. Some citizens might prefer alternative medicine where legal and market restrictions are less cumbersome.
9. Academicians should analyze if managed care is really a health services reform or a business service delivery reform. Are we managing the care or are we really managing the costs? Are we, as a society, maximizing the utility of health services resources or are we optimizing the margin of profits for the insurance companies? Is it legal to obtain astronomical gains out of what has been called the health industry? Is health an industry? If it is legal, does it mean that it is by that fact, also ethically legitimate? In matters of health services, especially those services organized for medically indigent populations, our society should require a sound ethical assessment and justification of what is being done.
10. The schools of medicine and other health sciences should deliberate if it is still valid to continue speaking about a health practitioner as ***a professional,*** or would it be more proper to define him or her as just a salaried employee. If medicine, for example, is to be studied as a skilled trade, then it logically follows that the HMO's corporations of managed care who recruit physicians are authorized to tell them what to tell and what not to tell the consumers, or health plan subscribers. In such a setting, the *locus of loyalty* might be in danger of moving from *loyalty to the patient* to *loyalty to the corporation* that pays the salary of physicians and other professionals. In this new practice context, community health educators, for example, will they be perceived as the advocates of the community or should they become the public relations officials of the HMO's?
11. As long as economical considerations becomes the primary consideration of the current health reforms, there will be a corporate tendency to convert many not for profit institutions into for profit health care organizations. That is the logic of business. It would be difficult to conceive the World Health Organization idea of the *right to*

health as part of the common good. Rather, health will become more of a private good accessible only if there is someone who pays. Remember that capital is motivated by opportunity and profit, not by compassion.

12. As suggested above, as long as the discourse of health services is translated into the health industry type of discourse, there will hardly be a place for ethics. Machiavelli and Adam Smith will replace Hippocrates and Socrates. The *invisible hand* of which Adam Smith spoke in *The Wealth of Nations* will be really the *profit motive* and not the *dignity motive*.
13. Because the public health academic centers will lose easy access to clinical settings for effective teaching and research, they will have to *reinvent* themselves as entrepreneurial institutions. Some large universities systems may be able to acquire hospital facilities for themselves, and will charge for services provided in order to maintain their status of exemplary models of the quality in clinical teaching, research and community services (this time understood as commodities and merchandise). For the new academic health centers, patients served will be perceived as strategic opportunities to survive financially in a competing market of services. Once the logic of the market takes hold of the university planning, by the same token, we may be tempted to treat students of health sciences as consumers of education and professor will be more aptly described as salesmen and trainers in marketable skills. In this context there *might* be no place for liberal arts skills; there might be no place for the humanities and the fine arts as liberating and dignifying knowledge. For the managed competition mentality, liberal and liberating knowledge has no evident marketable value and do not produce revenues for the institution to survive.

We, philosophy professors, know that the value of ethics and humanities only resides in the enrichment of the human spirit; they enhance the quality of life of an educated individual and of his community. A humanistic education can widen the citizens' and the professionals' wisdom to participate in making informed decisions. But other than that, the achievement of the academic goals of a humanistic perspective would not augment the corporations' capital, unless, as I sustain, the university could demonstrate that it is in the best interest of even the health corporations to model themselves upon strong ethical standards. Pragmatically speaking, and supported by my observations of the political, economical and social affairs, I think that it is a good business to be sensible, to be ethical and to be compassionate. As I, somehow cynically tell my students: "ethics pay". If not by *conviction*, let us hope that because of *convenience*, core humanistic values and strong ethical commitments may still have a place in the health academy and at the HMO´s. Those assertions are based upon the fact that people typically trust institutions and corporations that are perceived as manifesting high ethical standards in the delivery of the services and mission of said organizations.

Finally I would say this: the university health programs should make a critical assessment of the reforms already implemented in order to insure that the changes made comply with the highest ethical, scientific, professional and clinical standards. After all, social reforms should be adopted to better serve the best interest of the people. It is not ethically sound to utilize the people to serve the best interests of those who will profit from the type of reforms that only emphasize the financial aspects of said reforms. It is my hope that, if the type of reforms established are to stay for some time, the Government of Puerto Rico will appoint a civil society commission (maybe in charge of the universities) that will periodically make ethical audits of the reforms to insure that the millions of dollars transferred to the private sector comply not only with financial accountability but, more importantly, that the reforms are in compliance with the highest bioethical standards. If this is done, it would certainly supply the ethical empowerment urgently needed by any social reform, especially the one dealing with health services. If the reform of the health services for the *medically-indigent* population is not grounded upon solid ethical values, it may risk itself of being an *ethically indigent* reform.

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