The Importance of Management for Understanding Managed Care

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ABSTRACT

This paper argues that the concept of management is critically important for understanding managed care. A proper interpretation of management is needed before a positive account of the ethics of managed care can be constructed. The paper discusses three aspects of management: administrative, clinical, and resource management, and compares the central commitments of traditional medical practice with those of managed care for each of these aspects. In so doing, the distinctive conceptual features of the managed care paradigm are discussed. The paper concludes by arguing that the concept of management implicit in the managed care paradigm affords a basis for building a more adequate ethic of managed care.

Key words: administration, clinical judgement, managed care, managed care organization, management, medical ethics, philosophy of medicine, quality of care, resource utilization

I. INTRODUCTION

The academic literature reflects the tone of the treatment of managed care in the media; both are replete with negative assessments of managed care (Brodie, Brady, and Altman, 1998; Ignagni, 1998). This strongly negative tone has impeded a fair assessment of managed care. Managed care is a complex and heterogeneous set of phenomena involving a spectrum of organizations ranging from comprehensive prepaid integrated systems, such as a nonprofit staff model HMO (e.g., Kaiser Permanente), to administrative shell organizations that primarily handle the business side of medicine, for example, claims processing, reimbursement, and insurance (Christensen, 1995). Given this diversity, treatments of managed care that allege pervasive and pernicious patterns of practice, such as the use of gag
clauses in physician employment contracts, or offer anecdotes about denials of service, have certainly influenced public opinion and policy (Rochefort, 1998), but they contribute little to the fair appraisal of managed care.

The predominance of critical treatments of managed care should not blind us to the fact that there is little or no compelling evidence that the quality of medical care in managed care organizations (MCOs) is drastically different from the care provided in fee-for-service, third party pay arrangements. Although the methods for measuring quality are still primitive (Epstein, 1995; Kassirer, 1993, 1995; Vladeck, 1995), the extant literature tends to show that managed care either improves or equals the quality of care provided in fee-for-service medicine (Blegen et al., 1995; Brave-man et al., 1994; Carlyle et al., 1992; Langa and Susman, 1993; Miller and Luft, 1994; Retchin and Brown, 1990; Riley et al., 1994; Sisk et al., 1996; Unvarhelyi et al., 1991; Ware et al., 1986). These findings suggest that a reexamination of the concept of managed care is overdue.

Managed care has a variety of organizational instantiations, but at bottom it is an organizational arrangement that institutionalizes a particular view of health care. As with any institutional arrangement, one can ask whether the guiding purposes of MCOs are ethically sound and whether their organizational structure promotes defensible ethical goals (Reiser, 1994). MCOs are complex organizations and their impact on American health care has been so remarkably rapid and extensive (Jensen et al., 1997) that understanding their operative logic is imperative. By collecting multiple points of medical decision making into a more integrated and consolidated grouping, managed care represents an epochal change in the way that health care is organized. The challenge is to understand the central features of the concepts of management that underlie these developments. I begin the task of demarcating the philosophical aspects of managed care by arguing that its conceptual key is the concept of management.

II. THE IMPORTANCE OF MANAGEMENT

Although the common view is that medical decisions are naturally confined within the privacy of the physician-patient relationship, this location represents a particular historical choice. Like all choices it has both advantages and disadvantages. Of the many features characteristic of managed care, I single out the way that managed care provides a unique conception of and locus for management decisions. I discuss management over and against the idea of management associated with the traditional physician-patient ethic. I agree with Morreim (1991) that approaches based on the
old medical ethics that do not come to terms with the new understanding of health care introduced by managed care are doomed to failure; however, a fuller survey of the concept of management itself is needed before a positive ethic of managed care can be constructed. Taking this descriptive step, of course, does not itself assure that such an ethic can be developed, but it is a necessary first step toward such an ethic.

The location and kind of management decisions in health care are not conceptually fixed, but represent choices about the way that the sick receive care. These choices are historically and socially conditioned and, so, reflect local empirical circumstances. That said, there are, however, certain general features of management that are essential. This is apt to be overlooked, because the term managed care is itself ambiguous, including capitated, staff, and PPO arrangements, various contracting, incentive, payment, reimbursement, specialty referral arrangements and restrictions, as well as significant differences in the kinds of services that are included or covered. These complications can be bracketed or held in suspension in order to analyze the concept of management at a higher level of generality. This allows us to bypass many of the messy complications associated with the actual situation of managed care today. Three distinctive kinds of management are especially important in managed care: clinical, resource, and administrative management.

III. CLINICAL MANAGEMENT

Clinical management might seem to involve only the professional decisions made within the physician patient relationship. Historically, management decisions in medicine were primarily made within the physician-patient relationship. This locus not only gave a primacy to clinical over administrative, resource, or other types of management, but defined a distinctive way of understanding clinical management and decision making. The focus of clinical management in the traditional physician-patient relationship was the technical knowledge that the physician employed in the direct care of patients.

Traditional physician-patient relationships begin with the presentation of a problem by a patient. This presentation means that clinical management depends on a universe of patient complaints that are filtered through a patient-oriented interpretive framework. As a consequence, problems or complaints that are not explainable in disease language are understandably regarded as less than fully legitimate. This legitimating role of disease language was captured in Talcott Parsons’ (1975) conception of a special
social role, namely the *sick role*. In this view, sickness is a role that an individual adopts when confronted by an experience of illness that compromises the individual’s ability to carry on some part of the normal range of functions that make up the individual’s normal life. As such, sickness is an intrusion into an individual’s life which warrants a response having two elements: a distinctly social response associated with the sick role that allows exemption from normal role-related activities and a medical therapeutic response associated with seeking care from a health professional. Diagnosis or the attribution of disease to the illness is the distinctive feature of the therapeutic response that occurs within the physician-patient relationship.

The attribution of disease to the patient’s state or condition is a hallmark of a *medical* understanding of clinical management. This attribution provides the explanatory basis that justifies treatment. Of course, treatment can not always be founded on an adequate understanding of causal mechanisms, but rather is based upon a complex practical judgment that is focused on the alleviation of pain and suffering, restoration of functioning and capacity, and the attainment of a sense of well being for the patient. These three goals form the normative teleological framework for medicine within which practical elements, such as problem presentation, diagnosis, and treatment, define the traditional understanding of clinical management. In this traditional view, clinical management consists in the application of a (clinical) scientific understanding of the illness, the diagnosis of disease, and the application or recommendation of a treatment to a particular patient. The development of the biomedical and clinical sciences and the diagnostic and therapeutic technologies resulting therefrom supported and solidified this paradigm. They also created social and structural changes in medicine that, paradoxically, made it more difficult to sustain this understanding and that undermined it in subtle but undeniable ways.

The traditional understanding of medical care is thus based on a scientific and technological paradigm that augments the judgment of the individual physician with information provided not directly by the patient or elicited by the physician through observation, but through laboratory and radiological testing or consultation with specialists. The dyadic physician-patient relationship that was so central to the traditional view was historically expanded from a single relationship to a series of relationships, but the effect of this expansion was not appreciated until the development of managed care. During the twentieth century, treatments increasingly moved away from common supportive care of the sick person to scientifically based treatments administered by trained professionals. Medicines were based not on commonly available substances that could be compounded
locally, but developed by a specialized pharmaceutical industry through extensive research and clinical trials. These developments changed medicine from a cottage industry delivered by isolated and solo practitioners into an increasingly institutionalized and technology dependent social system.

The increased ability to diagnose and to treat illness that developed in the twentieth century involved a corollary fundamental social transformation of medicine, which changed the paradigm of the traditional physician-patient relationship. Patients increasingly had relationships with more than one physician even in the diagnosis and treatment of a single uncomplicated illness. Some of these relationships were virtual, such as, relationships with the radiologist who interpreted the radiographic findings and the pathologist who supervised and interpreted the laboratory tests. Other relationships increasingly involved allied health professionals, such as radiological or laboratory medicine technicians or nurses. These developments were supported by complex institutional structures that required increasing levels of administrative and resource support. The net effect of these developments was to increase the cost of medical care, a point recognized as early as the 1930s (Committee on the Costs of Medical Care, 1932). Beginning with Blue Cross and Blue Shield, employer-paid indemnity health insurance supported these developments and did so in a way that preserved the appearance that clinical management within the traditional physician-patient relationship was primary. It did so, in part, by supporting a fee-for-service reimbursement system that effectively hid the economic costs of medical care from both physician and patient. As a result, the advances of scientific medicine and the benefits of biomedical science and technology were channeled through the traditional physician-patient relationship where the economic realities of medical care were marginalized.

In the traditional paradigm, clinical management focused on the welfare of the individual patient. Within this privileged relationship, the patient could be assured that clinical considerations rather than economic ones would predominate. However, this form of medical care delivery systematically ignored allocational inequities. For those able to enjoy this form of medical care, cost did not appear to be a compelling consideration. For those paying for medical services, mainly employers and, after the enactment of Medicare and Medicaid, the federal government to an increasing extent, as well as those individuals not covered by health care insurance, the benefits of a fee-for-service, third-party reimbursed system of care became less and less compelling. Nevertheless, the traditional medical paradigm persisted even as the material conditions supporting it eroded.
It is not surprising that so much of the literature critical of managed care claims that MCOs compromise the pursuit of patient welfare, because the concept of clinical management in managed care rests on a different conceptual footing. In the traditional physician-patient relationship, patient welfare is usually taken to be non-problematic and properly defined in the physician-patient relationship. Even though the introduction of patient autonomy and informed consent circumscribed professional judgment, patient welfare continued to be seen as properly shaped by clinical judgment in the individual physician-patient relationship. The scope of professional expertise, and thus the domain of clinical management, is thus taken to be congruent with the physician’s distinctive knowledge of clinical and basic biomedical sciences as these are applied in the practice of medicine. After the development of informed consent, clinical management had to accommodate patient preferences regarding diagnosis and treatment, but this accommodation did not resituate the definition of patient welfare. Managed care, however, does relocate this key concept by introducing a view of clinical management that cannot be confined to episodic, dyadic relationships.

Although the dyadic physician-patient relationship was the focus of the old paradigm, it is important to remember that medical care is a social process delivered in many other settings and relationships besides the physician-patient relationship. Clinical management is thus best thought of in terms of a social model rather than the individual physician’s professional judgment whose natural home is the traditional physician-patient relationship. Ironically, even in the biomedical model, the distinctive and defining knowledge or expertise that the physician exercises in clinical judgment is utterly dependent on the accumulation of specialized technical knowledge and the integration of vast amounts of information which could never be attained by any single physician. Consultation and referral is thus an inevitable result of the traditional paradigm. Given that patients actually receive care in so many other health provider relationships, it is a fundamental mistake to oversimplify the ethical and conceptual aspects of clinical management by assuming that the traditional paradigm provides the defining framework. The traditional paradigm emphasized the diagnosis and treatment of acute illness which has had the effect of impeding a more complete description of alternative types of physician-patient relationships and types of health professional patient relationships and their epistemological praxes. While some types of physician-patient or health professional relationships involve decisions that are primarily technical, such as surgical interventions, other types rely on a broader form of professional medical praxis, as in the case of primary care or a general inter-
nal medicine physician performing a diagnostic workup. Still other types of decisions may not be grounded in any specialized body of strictly professional knowledge at all, for example, the compassionate care of the dying or the treatment of common cases of anxiety or grief. If this is true, then clinical management is a more complexly variegated praxis than was expressed in the traditional paradigm. The ascendancy of managed care may be partly due to its ability to exploit the opportunities associated with this complexity by restructuring and redefining the relationships within which patients receive health care. From a managed care perspective, then, clinical management would involve a potentially myriad range of responses to the care needs of patients. Such a perspective encompasses a fundamentally enlarged range of responses than was typically associated with the older view of clinical management.

A fee-for-service system of reimbursement, for example, reinforced the tendency implicit in the traditional paradigm to focus on discrete episodes of care. As a result, the traditional paradigm relied more heavily than is typically acknowledged on the psychological influence of the physician on the patient. The failure of this influence is more commonly discussed under the rubric of adherence or compliance than is its constituent elements. Although the physician could write “orders” or give advice, ultimate responsibility remained with the patient who could enter or exit the relationship at will, follow or ignore physician’s directions. Importantly, the old paradigm stressed the physician’s agency, but marginalized the patient’s (MacIntyre, 1977). The old paradigm of clinical management did not sufficiently analyze the contribution of the patient to the process of diagnosis and treatment. For example, only upon being brought to the physician’s attention could the diagnostic framework based on the language of disease be deployed, and compliance with doctor’s orders is a necessity once treatment is prescribed.

In contrast, managed care’s understanding of clinical management elevates the patient’s role. Continuity of care is achieved not only by offering preventive and screening services or services such as stress reduction or counseling or by requiring access through a single, primary care provider who can positively plan care with the patient, but also by developing mechanisms to implement services at sites and under circumstances that are most convenient for patients. These approaches to managing the range of clinical services that might prove beneficial to patients go far beyond what the old paradigm encompassed. Managed care’s understanding of clinical management supports the development of a more systematic approach to continuity of care than the individual physician in traditional medicine ever could. For one thing, the physician only knew the patient in
terms of the individual encounters. Since the patient initiated the relationship and demanded a full measure of fidelity from the individual physician during the course of treatment, the patient could affect the services provided and could seek care from other physicians thereby potentially undoing the commitment to true patient welfare. Managed care generalizes the concept of the care provider to the MCO itself thus providing a systems perspective on clinical management. As a result, care can be monitored across individual physician-patient encounters, and services that best meet observed patient needs can be designed, implemented, and evaluated. MCOs are thus potentially better able to match the best or most appropriate service and service provider with the patient’s specific health care need. A critical question is whether these new forms of clinical management and delivery of health care services can garner patient trust (Gray, 1997; Newcomer, 1997). Ultimately, trust may need to rest on the commitment not only of the individual health care professional or organization, but on the way the overall delivery of services broadly respects and incorporates patients’ own values. As Paul Menzel (1990, pp. 3–19; 1992, 57–58; 1993, 290) has observed, this is especially important as placing limits on treatment becomes more commonplace. Implicit in these points, however, is a different, and, one might even say, enlarged, conception of clinical management. Managed care thus enlarges the idea of clinical management by decoupling the concept from the dyadic physician-patient relationship.

IV. RESOURCE MANAGEMENT

Resource management is a kind of management that involves strategically matching present and future patient needs with appropriate services. In traditional forms of medical care, resource management decisions were distributed widely across many players with different interests. Because MCOs are structured to provide comprehensive services, they can assume responsibility for patient care in ways that individual physicians never could. The traditional commitment of the physician to the welfare of the individual patient basically excluded consideration of alternative needs (Agich, 1987). This focus on the welfare of the particular patient without regard to competing needs or resource limits is a defining feature of the traditional understanding of the physician-patient relationship. In this view, the needs of the present patient are paramount. The needs of other patients are suspended from consideration except under unusual circumstances – for example, the allocation of high cost or especially scarce treatments...
such as organ transplantation. As the services offered in the traditional physician-patient relationship became dependent on expensive diagnostic and treatment technologies, costs increasingly became a factor, but they were marginalized by cost shifting and third-party payment. Managed care’s seeming obsession with cost is thus an understandable reaction to a system in which consideration of cost was marginalized.

All clinical decisions have resource implications, even those made within traditional physician-patient relationships, but the systemic implications could not readily be incorporated into traditional understanding of clinical decision making. The concept of resource management is broader than the problem of meeting an individual patient’s particular needs; it includes reference to other patients and the infrastructure of health care institutions, personnel, as well as equipment and supplies. In a general way, all treatment decisions are decisions about how society’s health care resources are used and managed. Traditional professional ethics, however, focused on decisions made in the direct care of individual patients in relationships that were isolated or disconnected from one other. These isolated relationships could not afford a vantage point from which to survey the implications or costs of individual clinical choices. In this regard, managed care makes the concept of a system of care central in a way that the traditional paradigm could not. All MCOs, no matter what their formal or administrative structure, involve the aggregation of multiple points at which services are delivered. By consolidating providers, managed care is able to deploy the mechanisms and processes of utilization review, practice guidelines, and outcome measurement in a way that could only seem foreign and intrusive from the perspective of the individual physician-patient relationship. The process of introducing accountability for resource use and outcomes, of course, did not originate with managed care, but managed care has accelerated a process begun by third-party indemnity health payers (Brook, 1997).

Contemporary medical care is technologically complex; it can be provided only if all of the components required are available. Efficiently managing the constituent components and financial resources essential to contemporary medical care was not promoted by having diverse, dispersed and, potentially, divergent management points. Individual physician-patient relationships were only able to thrive because they stood upon a broad and mostly plentiful background of available and appropriate resources. As costs escalated, the need to better match patient needs to available resources became socially compelling. Developing, maintaining, and matching resources for the range of medical care needs is, however, a critical management function that requires a degree of organization
not envisioned in the old paradigm. This positive aspect of resource management is too frequently overlooked, because concern over rationing has overshadowed the affirmative side of resource allocation and use.

The resource prerequisites for the care of individual patients in multiple physician-patient relationships are virtually impossible to manage from within the individual relationships and patient care encounters. MCOs, through their organizational structure and contractual relationships with physicians (as well as other health care providers), are potentially better able actively (or proactively) to manage the resources needed for the care of patients. Resource management, regarded positively, involves prudent planning for future needs and opportunities. To manage resources, then, one needs a set of goals or objectives as well as reliable measures of the services needed. The efficient delivery of services in this view is valued not simply to save money, but to create service opportunities and allow a better match of resources with needs. Clearly, the ethical deployment of resources requires a well-founded conception of the MCO’s mission and goals without which allocation choices will lack a justified coherence. Even if the early success of managed care is based on the easy wringing out of inefficiencies in medicine’s utilization of resources and even if managed care has been driven by a concern for profit, the question of which structures and processes best enable an ethically sound management of resources remains as an important empirical and policy question (Christensen, 1995). Ultimately, it is a question that will need to be grounded in an ethical theory. The theory needed, however, is not the theory of professional medical ethics that was so central in the old paradigm, but a social theory of resource allocation (Menzel, 1990, 1992) coupled with a theory of institutional ethics.

Resources can only be effectively managed at a level that can view and evaluate the multiple competing claims on resources. Such evaluation requires an assessment not only of need, but also of the ways to meet the identified needs. Interestingly, the provision of incentives to physicians to practice medicine in an efficient fashion has met with resounding complaint, though the problems with incentives to reduce costs cannot be attributed to their conflict with ethical obligations as is often thought (Agich, 1987, 1990). In the traditional paradigm, the pursuit of individual patient welfare was prized without regard to cost or other considerations (Levinsky, 1984). That paradigm screened out or marginalized concerns about the implications for other patients of resources utilized in the care of any one patient. Third-party reimbursement of fee-for-service care was unable to raise these concerns to prominence. The result was an understandable escalation in the cost of medical care. Awareness of the cost
implications of individual clinical choices and management of resources, of course, are less easily addressed in direct patient care settings, because the social nature and context of resource use and management cannot readily be grasped from that vantage point. Indeed, noticing or attending to patterns of resource utilization is an important, but often misunderstood component of the resource management introduced by MCOs. Too often, this function is thought to be tainted by the objective of limiting care, when limiting care may be more accurately regarded as the byproduct of a more complicated and comprehensive look at the deployment of resources to meet patient needs.

Resource management decisions were, of course, made before managed care, but managed care thrusts the question of objectives and goals to the forefront of medicine. Before managed care, resource management was a piecemeal effort at best without a consistent vision of the interrelationship of various sectors of medical care and the actual needs of patients. Managed care’s attention to resource management highlights an important concern that was either peripheral or of incidental interest in the clinical care of individual patients. Noting this, however, is not an endorsement of MCOs, but rather a comment on the fact that managed care has brought the responsible management of health care resources to prominence as a central concern for an ethic of health care and not just a concern for public policy.

V. ADMINISTRATIVE MANAGEMENT

Two aspects of administrative management are especially salient in the context of managed care: administrative functioning and administrative guidance/leadership. Administrative functions, such as the maintenance of medical records, the tracking and follow up of tests and x-rays ordered for individual patients, and paying the costs associated with office space, utilities, equipment purchases, and support personnel, became increasingly important as the care of patients became ever more complex and reimbursement mechanisms proliferated. In the traditional paradigm, these matters were handled within the physician’s practice. The locus of administrative functioning migrated from the practice of the individual (or group) of physicians to the organization as physicians abandoned solo practice and accepted positions or affiliations with MCOs. It is thus natural that administrative concerns now permeate the daily delivery of patient care. Physicians are noticing these effects more than other health professionals who have always functioned under the (professional or administrative) direction of others.
Administrative functions also involve an executive component that inevitably involves distinctive kinds of influence. This influence is not necessarily contrary to medical ethics, but we do not have a reliable analysis of the myriad ways that administrative functions corrupt or promote good patient care in MCOs. It would, however, be a mistake to assume that any influence is problematic as such. The problem is not that administrative functions affect patient care, but that we do not adequately understand how these functions and processes affect outcomes. It is remarkable that there is virtually no significant ethical analysis of the values that should affirmatively guide the administrative coordination of health care while reams are written on negative effects.

Because MCOs have greatly enlarged the ambit of administrative decision making in health care, they make attention to administrative functions, processes, and structures essential. Unfortunately, as a product of the backlash against managed care, administrative decision making is often regarded as a pernicious element introduced by managers intent only on producing profits and unconcerned with the welfare of patients. As a result, we are much more aware of the deleterious aspects of administrative intrusions into patient care than we are about the positive aspect of well-run health care organizations. Similarly, we are far more aware of the products, namely, the rules, guidelines, or contractual provisions of MCOs, especially as they limit physician or patient autonomy, than we are of the actual ways that sound administrative processes can improve the delivery of services. Given the rapid development of managed care in the last decade, we need to ask what values should guide or animate managed care.

Extending the reach of administrative management into everyday clinical encounters introduces a formal accountability into the delivery of health care that was lacking in traditional medical care, but we actually know very little about the ways in which administrative and organizational values shape the process aspects of patient care. The important task is to understand the actual processes by which administrative actions or inactions affect patient care and to develop a normative framework within which to assess the relationship of administrative processes and functions to the quality of care. It is thus premature to insist on the primacy of either administrative, clinical, or resource management when we do not adequately understand their vital and dynamic interrelationships.

There is no logical reason why the administrative structures and decision making of MCOs should undermine ethically sound clinical processes. However, it does seem clear that some MCOs appear to be ineffective at promoting an ethically sound practice of medicine, so the question
about what works well and why is hardly academic and will not be answered adequately without first coming to terms with the complexity of management itself. Good administrative management can realistically direct institutional and professional development in ways that promote rather than impede ethically defensible goals. Acknowledging this aspect of administrative management is a necessary first step toward a sound ethical analysis of managed care. Yet, it must be admitted that such an analysis is foreign to bioethics. It seems foreign mostly because of the persistence of the old paradigm which privileged clinical management over administrative or resource concerns. The development of managed care, however, has reminded us that contemporary medicine is a complex business that involves equally complex institutional processes.

VI. CONCLUSION

Typically, when management is discussed in the managed care literature, it is regarded negatively. Critics of managed care seem to assume that administrative and resource management can only corrode patient care. The unstated assumption seems to be that clinical management could and should be isolated from the effects of these kinds of management. However, collapsing other types or levels of management into the domain of clinical management is the result of a basic, but serious conceptual mistake. This mistake is, at least in part, related to the dominance of the old paradigm that gave precedence to a limited range of clinical management decisions by subsuming them within the professional role of the physician. An analytically sound assessment of health care management is thus made more difficult, because it is entangled with a concept of medical care that privileged the individual physician-patient encounter above all other types of health care. Such a bias has delayed ethical discussion and analysis of the innovations that managed care has brought into American medicine and has delayed the important task of developing an organizational ethic to guide managed care.

I do not deny that managed care has introduced conflicts into medicine, but the deep question is not the conflicts in individual physician-patient relationships, but the organizational framework itself (Barnato, et al., 1998; Emanuel, 1995). Although it is yet not clear what is the best expression of ethical standards for a managed care organization, it is apparent that mainstream approaches which aim to preserve the integrity of physician-patient relationships are conceptually inadequate to the task (Mariner, 1995). The proliferation of managed care has made the construction of a positive ethic
of managed care important. Any such ethic will need to incorporate administrative and resource management into a richer analysis of clinical management than has heretofore occurred. Some recent commentators have rightly stressed the organizational aspects of managed care by arguing that they have potentially important ethical implications (Christensen, 1995; Christensen and Miles, 1997). The foregoing analysis shows why the attention to these aspects of managed care is unavoidable.

NOTES

1. An early version of this paper, co-authored with Heidi Forster, JD., was presented at the National Conference on the Ethics of Health Care Organizations held at the University of Virginia, Charlottesville, Virginia, September 25-26, 1998.

2. Other goals besides increasing market share, gaining competitive advantage, or maximizing profits, are also evident in managed care, making the conceptual assessment of managed care complicated. For example, some MCOs are clearly committed to defensible goals including increasing access, providing a fuller and more effective range of services for patients, and delivering high quality health care. This fact makes it understandable how some MCOs can be committed to ethically defensible goals at the same time that other MCOs seem to be fundamentally committed to securing competitive advantage or lowering costs in order to increase profitability. I set these complications aside in this paper in order to lay out the philosophical underpinnings of the core concept of management.

3. It is arguable whether this choice is either optimal or ethically justified. It is certainly defended within Hippocratic professional medical ethics, but this medical ethic itself has no privileged claim to theoretical primacy (Veatch, 1981). In this paper, however, I only describe the significant paradigm shift that the managed care revolution represents.

4. I avoid these details for methodological, not substantive reasons. It is conceptually and ethically relevant that managed care is exemplified in a remarkable variety of forms. Some MCOs are comprehensive integrated systems, such as a nonprofit staff model HMO, and others are “virtual” organizations consisting of administrative shells that simply process claims and provide second opinion and utilization review (Christensen & Miles, 1997; Clancy & Brody, 1995; Spenser and McGuire, 1996). These latter organizations might seem, at least at first glance, to be nothing more than the insurance or payment side of medicine and, so, to be extraneous. Indeed, from the point of view of traditional medical ethics, medicine involves the direct care of patients whereas financing patient care, including the establishment of contracts with providers and payment for services, is the incidental business aspect of medicine that is often seen as competing or conflicting with legitimate professional interests. I agree with Kate Christensen (1995) that the structural characteristics of MCOs are ethically important and need to be observed in any sound analysis of managed care. Nevertheless, I intentionally abstract from these different structural forms of MCOs in order to focus on the limited but important background concept of management in managed care.

5. When medicine was primarily a practice composed of stable, individual physician-patient relationships, clinical management understandably had prominence over other management considerations. With the development of complex systems and industries
essential to contemporary medical care, including hospitals and the pharmaceutical industry, and the deployment of diagnostic and treatment technologies requiring the coordination and cooperation of multiple health professionals, clinical management, at least as defined in terms of the management of the medical problems of an individual patient by a physician, became a component in a much larger and more complex health care industry. As specialization increased after World War II, medical care was increasingly delivered, at least for those individuals who enjoyed employer paid indemnity health care insurance, in a series of relationships with specialist physicians and health care institutions with whom patients had only episodic contact. The loss of continuity did not itself change the ideal of clinical management, but it loosened the grip of the ideals associated with the traditional understanding of clinical management. In the traditional paradigm, clinical management was understood as the prerogative of the physician who applied clinical scientific reasoning in the diagnosis and treatment of disease. In the paradigmatic physician-patient relationship, the patient’s vulnerability to exploitation was diminished by the physician’s commitment to the ethic of beneficence. Of course, all clinical decisions involve the management of a patient’s care, but not all care is provided in physician-patient relationships and not all care involves a strictly medical process of diagnosis and treatment. Some clinical decisions involve accommodating the effects of illness or disability in ways that involve adaptation to sickness rather than its curative treatment. This latter kind of clinical decision certainly had a place in traditional physician-patient relationships, but they were hardly central to its understanding of clinical management.

6. This is a conceptual, not an empirical point. The idea of resource management involved in managed care requires an orientation that is far broader than that involved in the classic physician-patient relationship. Making this point does not mean that I believe that individual MCOs adequately institutionalize this perspective in ethically defensible ways.

7. These points are not lost on organizations, such as the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), which view administrative and business concerns as essential to the way that health care institutions deliver quality health care and respect patient rights. The new interest in organization ethics in medicine is now a concern alongside the more traditional focus on patient rights in the accreditation process (Joint Commission for the Accreditation of Healthcare Organizations, 1997; 1998).

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