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The Catholic Gatekeeper: Physician Ethics in Managed Care

by

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Managed care organizations are playing an increasing role in the American health care system. Currently, managed care organizations serve about 16% of the United States population,¹ with 40% of American physicians involved in managed care.² By the year 2000, it is expected that between 40% and 65% of the population of the United States will have their medical care provided through a managed care system.¹ Much of the public and government attraction to managed care is due to the provision of medical care at a reduced cost compared to traditional fee-for-service medical systems. The primary care physician is instrumental to maintaining this economic advantage in managed care organizations. The primary care physician may also be placed in difficult ethical situations in his/her role as the "gatekeeper." We report some of our experiences in a health maintenance organization.

A significant ethical challenge for primary care physicians involves the management of patient access to medical services. Primary care physicians function in two roles in managed care organizations. They provide care in the traditional role of the generalist physician: management of most disease processes, preventive care services, and screening for illnesses. Their other role is the non-traditional role of "gatekeeper." Managed care organizations attempt to provide medical service at reduced costs by limiting unnecessary tests, hospitalizations, and access to specialist physicians. In this role as gatekeeper, the

primary care physician is responsible for determining which medical services are truly necessary and allowing patients to utilize these services.

Conflicting Interests

A possible conflict of interest arises when the gatekeeper physician is either rewarded for limiting patient access to care, or punished for "over-utilizing" medical resources. Most of the incentives and disincentives are financial. Bonuses can be awarded to primary care physicians based either on the profits of the overall managed care organization or on the physician's individual patient profile performance (capitated patient premium allotments vs. expenses for testings, referrals, and hospitalizations). Disincentives for resource utilization may also be in place including the withholding of a portion of the medical group or individual physician's salary, or possible termination of the physician's employment with the health maintenance organization. Many physicians and ethicists have questioned the physician's ability to function ethically both as the patient's advocate for medical care and as the financial agent of the managed care organization.^{3,4,5,6}

Proponents of managed care are quick to point out that these incentives to decrease the utilization of medical services are no more problematic than incentives for overutilization which exist in the traditional fee-for-service model.³ In the fee-for-service model, physicians have an economic incentive to perform more procedures and increase hospitalizations with a resultant increased exposure for patients to potential iatrogenic adverse effects.⁷ By closely controlling access to subspecialists, a primary care provider is able to prevent conflicts in treatment plans and drug interactions. Micheal Reagan also points out that managed care systems, in an effort to keep costs down, examine treatment patterns for various medical conditions and develop patient care guidelines which may improve patient outcome.⁷ Finally, medical cost containment has beneficial consequences for individual insurance subscribers, employers, and society.

The ethical challenge is to objectively assess the medical needs of capitated patients in the setting of financial incentives and disincentives. The primary care physician should decrease excessive medical utilization in order to decrease medical costs and decrease exposure to iatrogenic insults. This role will hopefully be aided by management guidelines which will supplement good clinical judgement. The physician must, however, guard against depriving patients of needed medical services or denying access to specialists when the patients' problems are beyond the generalist's area of expertise. A self-check for physicians which may be helpful is to assess whether the treatment plan would change if the patient had traditional third party insurance.

Another ethical problem resulting from the gatekeeper role of the primary care physician relates to unethical medical practices and procedures which are covered by a managed care insurance plan. Some managed care plans offer medical coverage for abortions and sterilizations. Some also provide coverage to evaluate infertility and most provide insurance coverage for artificial contraceptives. As the assigned primary care physician for a patient in the

managed care organization the doctor is expected to either provide these services or refer to another physician in the plan who will. This can be a serious ethical problem for physicians opposed to these practices.

In order to retain ethical integrity while working in a health care plan that provides medical insurance coverage for these immoral actions, the physician must not formally cooperate with these activities (intend the evil purpose) nor provide immediate material cooperation (directly perform the evil action).^{8,9} Some forms of mediate material cooperation (performing a good or indifferent action that provides an occasion of sin to another) are licit depending on the circumstances under the principle of double effect.¹⁰ It would be optimal to only participate in plans that do not provide insurance coverage for any of these immoral actions. This may soon become nearly impossible in this country with the spread of managed care and the increasing inclusion of nearly all obstetric and gynecologic services by these plans, often including in-vitro fertilization. It is useful to consider, therefore, the ethical dimensions of primary care gatekeeping behavior in these instances.

In regard to abortion, the primary care physician would be asked to refer the patient to a gynecologist who would perform the abortion. This action would be necessary mediate material cooperation since the woman could not see the gynecologist in the plan without an authorizing referral, and thus would not be morally permissible. The same principle would hold true for sterilization procedures for men or women and a referral would not be permitted.

In evaluating the infertile couple, a referral is usually made to a gynecologist to evaluate the male and female partners. The first investigation after the history and physical exam is usually to perform a semen analysis. In most offices, this sample is obtained by masturbation. This action has been declared intrinsically immoral even if performed for medical indications.^{11,12} The gatekeeper physician could eliminate his/her mediate material cooperation with this immoral activity by performing the semen analysis prior to the referral. Semen can be obtained by retaining some of the ejaculate in a punctured condom worn during marital intercourse or retrieved from the vaginal mucosal secretions following intercourse (Sims test).^{13,14} An alternative technique proposed by Dunn is the post-coital semen analysis.¹⁴ In this technique a drop of semen that was retained in the male urethra following coitus is placed on a microscopic slide, covered with a coverglass, and brought to the laboratory for sperm density evaluation.

Artificial contraception can place the primary care physician in the position of providing immediate material cooperation in the immoral action desired by a patient. In the practice of managed care, the generalist physician is usually the physician who prescribes oral contraceptive preparations (estrogen/progesterone combination pills or mini-dose progesterone tablets). Some generalists also place intra-uterine devices or fit women for diaphragms, but these practices are more often performed by a gynecologist. Gynecologists are also responsible in most cases for inserting delayed release progestin devices (Norplant®). With mini-dose progesterone, intra-uterine devices, and Norplant®, a significant contribution to their mode of action appears to be the prevention of implantation,^{15,16} thus they must also be considered as abortifacients in this ethical discussion.

O'Donnell's View

O'Donnell, in his book *Medicine and Christian Morality*, argues that the Catholic prohibition of artificial contraception is based on natural law, thus prescribing contraception even to a non-Catholic would be transgressing natural law and harmful to the totality of that individual. He thus states:

There is no excuse for a Catholic physician to have anything at all to do with procedures which are directly contraceptive. Grave scandal is caused by a Catholic doctor who, in any way, temporizes in this matter. He cannot, without serious moral guilt, advise or recommend contraception to any patient, no matter what the patient's personal convictions may be. Neither may he instruct a patient in the use of contraception, nor refer the patient to any other physician or agency for this purpose without seriously compromising his own moral integrity.¹⁷

In this statement O'Donnell is reiterating the opinion of Pope Pius XI regarding artificial contraception and natural law.

But no reason, however grave, may be put forward by which anything intrinsically against nature may become conformable to nature and morally good. Since, therefore, the conjugal act is destined primarily by nature for the begetting of children, those who in exercising it deliberately frustrate its natural power and purpose sin against nature and commit a deed which is shameful and intrinsically vicious.¹⁸

If a Catholic physician were to practice these principles, then he/she should neither prescribe artificial contraception nor refer to another physician who does. This poses a problem in the managed care setting where a patient is assigned a physician for their health care in a plan that provides for artificial contraception. The usual solution to this problem is for the physician to discuss the reasons why he/she does not prescribe artificial contraception, and if the patient still desires this service, the patient is asked to obtain a new primary care physician within the managed care organization. At our institution, we have instituted a policy for new patients assigned to primary care physicians who do not prescribe artificial contraception. Women of child-bearing years are asked over the phone when making their initial appointment with these physicians whether they will be requesting artificial contraceptives. If they respond affirmatively, they are informed of the physicians' ethical objections and are able to be assigned to an alternative physician if they so choose.

William Regan, JD, analyzed legal implications of denying immoral services at Catholic hospitals participating in managed care contracts.¹⁹ He argued that Catholic hospitals need not provide every imaginable service and especially those services which conflict with tenets of their religion. The same principle of religious liberty should protect an individual practitioner or medical practice from claims of discrimination in providing services to contracted managed care patients.

Managed care will likely be the dominant mode of health care delivery in the near future. It holds the promise of more efficient delivery of health care resources. Ethical principles must be watched closely by the primary care physician, however, to avoid injury to the patient from economically motivated denial of necessary services. Care must also be exercised to avoid compromising

the physician's moral integrity by cooperation with immoral medical actions sanctioned by the managed care organization. If these principles are followed, the Catholic physician will continue to make valuable contributions to the total well-being of his/her patients.

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