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In The Literature

Resurgent Paternalism

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Chervenak F, McCullough L. The threat of the new managed practice of medicine to patients' autonomy. *J Clin Ethics*. 1995;6(4):320-323.

Sulmasy D. Managed care and the new medical paternalism. *J Clin Ethics*. 1995;6(4):324-326.

Is it possible that managed care has added a new level of paternalism to the medical encounter? Frank Chervenak and Laurence B. McCullough assert in their article, "The Threat of the New Managed Practice to Patients' Autonomy," that managed practice fosters a "resurgent paternalism." They define the managed practice of medicine as the "attempts of payers and providers to reduce and control the variability and, therefore, the cost of medical care."[1]

These attempts by managed care organizations to achieve economic efficiency involve 2 main strategies that threaten the autonomy of the patient, the authors claim. The first is to apply cost-efficiency and cost-benefit analyses to physicians' diagnosis and treatment recommendations. The second strategy is standardizing medical care through practice guidelines, while still maintaining quality. Daniel Sulmasy, in his article, "Managed Care and the New Medical Paternalism," further suggests that managed care organizations offer physicians economic incentives to discourage the utilization of health care services as an additional strategy to contain costs.[2]

Patients often have no idea of the potential threats to their autonomy that these strategies pose. When choosing coverage or seeking care under managed practice arrangements, patients are generally uninformed about financial incentives used to influence physicians' decisions to provide less care. Nor do all patients understand the nature of the cost-effective outcomes that managed care organizations define as valuable. They are also uninformed about the content of practice guidelines that withhold the use of certain diagnostic tools or treatments. Patients are denied not only tests and treatments, but also information that they might have deemed valuable in making their health care choices. They are deprived of the right to exercise their autonomy, and, moreover, they are unaware of this loss. This is the new medical paternalism.[3]

Chervenak and McCullough believe that all rational patients value information concerning their health because information underlies decisions and behaviors and involves what they call the "essential exercise of autonomy." They state, "in the absence of information needed to make fundamental human decisions, autonomy is undermined at its foundations."[4] The authors contrast the "essential exercise of autonomy" with what they label the "nonessential exercise of autonomy." An example of a nonessential exercise of autonomy is allowing patients unlimited choice of physicians. The authors propose that restricting a patient's nonessential exercise of autonomy as a cost-cutting measure is allowable, such as when the patient's choice of physicians is limited to a reasonable number of "approved" physicians.

On the other hand, undermining the *essential* exercise of autonomy is intolerable from an ethical standpoint. It violates a core value of the profession—respect for patient autonomy. It disregards the patient as a person capable of making fundamental decisions. As a case in point, the authors discuss managed care practice guidelines that restrict the use of routine obstetric ultrasound screening.

Chervenak, director of obstetrics and maternal fetal medicine at a major New York hospital, and McCullough, a professor of medicine and ethics at Baylor College of Medicine in Houston, demonstrate the peril to patient autonomy under managed practice in their analysis of the Routine Antenatal Diagnostic Imaging Ultrasound Study (RADIUS). They contend that RADIUS has been applied to defend US practice guidelines that restrict routine obstetric ultrasounds.

RADIUS, a large randomized clinical trial, assessed the effectiveness of routine ultrasound screening for women who were at low risk for poor pregnancy outcomes. It concluded that routine use of obstetric ultrasound did not produce better perinatal outcomes than discretionary use by physician order. Investigators, furthermore, found that its routine practice would add more than $500 million annually to the cost of health care in the United States. In the context of total quality management, a tool employed by managed care organizations to eliminate unnecessary steps in clinical treatment, these findings indicate that routine obstetric ultrasound screening adds no value, only cost, to the outcomes of obstetric management. It can, therefore, be eliminated from practice guidelines.

The authors acknowledge that the principle of beneficence can ethically support elimination of routine obstetric ultrasound screening from practice guidelines. This principle "obliges the physician to act in a way that produces a greater balance of goods over harms for the patient, as those goods and harms are understood from a rigorous clinical perspective."[5] Based on the conclusion of the RADIUS trial, routine obstetric ultrasound screening does not produce a greater balance of goods over harms for the patient. Hence, beneficence supports eliminating its use on a routine basis. If eliminating the ultrasound diagnosis posed risk or harm to the patient in the name of cost savings, the physician's decision to withhold this treatment would dishonor his fiduciary role. Total quality management, therefore, aligns itself with the principle of beneficent care, allowing practice guidelines to eliminate routine obstetric ultrasound screening from treatment of low-risk patients and substitute less costly, equally beneficent care, as defined in terms of epidemiological outcomes, without breaching the integrity of the profession.

The authors maintain, however, that this conclusion is valid only if traditional epidemiological measures, such as perinatal morbidity and mortality, constitute the only relevant outcomes. Investigators have found that routine obstetric ultrasound screening detects fetal anomalies in 16.6 percent of the women before 24 weeks, compared to an abnormality detection rate of 4.9 percent in the group that does not receive routine ultrasound screening. This is a threefold difference in detection frequency of fetal anomalies, which suggests that routine screening can improve the well-being of pregnant women significantly. It provides information about the presence or absence of fetal anomalies that can help a woman decide whether to continue a pregnancy or take another course of action. Denying coverage for routine ultrasounds may be harmful if ultrasounds can reveal useful diagnostic data that women may need to exercise their constitutional right to decide whether to continue pregnancy.

Chervenak and McCullough argue, therefore, that managed practice can jeopardize patient autonomy with its single-minded pursuit of economic efficiency and emphasis on beneficent care. They conclude that, "cost considerations and beneficence can reinforce each other to create a resurgent paternalism as a basic, until now hidden, ethical feature of the new managed practice of medicine."[6]

The authors propose that respect for the essential exercise of autonomy should be given equal importance with beneficence in medical care as a solution to the new medical paternalism. Beneficence and autonomy-based criteria, taken together, should be determinants in defining outcomes of total quality management, ie quality, cost-efficient medical care. This is especially crucial when the essential exercise of autonomy is at risk. Autonomy-based criteria demand that practice guidelines incorporate steps, such as safe and noninvasive routine obstetric ultrasound screening, that contribute to quality, cost-effective medical care. Omitting routine obstetric ultrasounds to reduce costs is paternalistic and therefore, is ethically

unacceptable. Managed practice cannot ignore consideration of the essential exercise of autonomy without the risk of being paternalistic. Chervenak and McCullough's rationale also morally obligates physicians to advocate for guidelines that are based on the essential exercises of patient autonomy. They caution, however, that (1) respect for the essential exercise of autonomy is required only after the clinical quality of a procedure has been determined, and (2) not all seemingly essential exercises of autonomy are truly essential, such as the request for a third-trimester ultrasound to screen for growth retardation.[7]

Daniel Sulmasy develops Chervenak and McCullough's proposed solution in his article, "Managed Care and the New Paternalism," and suggests that patients be asked what they consider relevant knowledge in making decisions about health care services because what patients value is unknown in advance of the patient-physician encounter. He concedes that there is a great deal of waste in medical care, and it should, therefore, be rationed. The responsibility, however, of deciding what must be withheld from practice guidelines should not fall solely on physicians or administrators. Patients should be encouraged to participate together with physicians in an open and public dialogue to decide what should be rationed. He states that while guidelines deal with populations, "autonomy is exercised by individuals, not populations."[8]

Writing in the mid-1990s, these authors believe that managed care exerts a paternalistic force on health care. They agree that respect for the patients' essential exercise of autonomy is key to preserving the trust in the physician's fiduciary and advocacy roles for the patient, and consequently, the integrity of the profession.

References

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8. Sulmasy, 326.

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