

---

# Can Ethics Committees Work in Managed Care Plans?

by Michael Felder

---

*The evolution of health care financing and delivery has created many ethical challenges. The history of ethics committees in managed care organizations is a short one. The author describes the formation of a committee and includes information on its composition and role within the organization. Perhaps the most challenging and most valuable contribution the committee will make is in reviewing existing policies and formulating new policies which have ethical implications.*

## Background

The nature of health care delivery has undergone fundamental change over the last several years. A rapidly growing number of patients receive their care from institutions categorized under the broad rubric of managed care organizations, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Such plans differ from traditional indemnity insurance carriers. In the past, indemnity carriers were passive bill payers having no direct relationship with the delivery of medical care and thus, no relationship to the ethical dilemmas presented daily to care providers. Managed care organizations, on the other hand, arrange for or provide medical care and thus have inserted themselves into the physician/patient relationship. As a result, managed care organizations must deal with the ethical dilemmas familiar to physicians and other health care professionals. Plan managers and physicians also face new ethical dilemmas unknown to providers in the past. These arise from a plan's multiple functions as insurer, marketer, and allocator of limited resources (the premiums of members). Managed care organizations have only recently begun to recognize the need for some formal way of considering the variety of ethical issues in their universe.

The traditional forum for clinical ethical dilemmas has been institutional ethics committees in hospitals or long-term care institutions. Clinical

ethical dilemmas within the context of managed care, whether relating to institutional or to ambulatory care, generally have not had a suitable forum for discussion. Nor has there been a designated venue in most managed care organizations for reviewing the ethical implications of corporate policy or managed care as a whole.

Over the last year or two, academic research centers and regional ethics centers such as Midwest Bioethics Center<sup>1</sup> and the Hastings Center have begun addressing value dilemmas in managed health care. Their efforts are aimed at assisting managed care plans in developing an institutional forum and expertise in ethical discussion and problem solving. As CHP's bioethicist, I have attempted to do the same for this organization.

CHP is a health maintenance organization that provides care to members and nonmembers in upstate New York, Massachusetts, and Vermont. Currently, CHP provides care in CHP owned and operated health centers as well as in a growing number of fee-for-service physicians' offices." After joining CHP in January 1991 as a practicing family physician and plan-wide bioethicist, I was

---

*Michael Felder, DO, MA, is a family physician and planwide bioethicist for Community Health Plan (CHP), an HMO with members in New York, Massachusetts and Vermont. He is the founding chairperson of CHP's Ethical Issues Committee.*

asked to establish and chair the CHP Ethical Issues Committee (referred to as the *committee* in this paper). Since its inception, the committee has been in the national vanguard in dealing with ethical issues in managed care.

---

*The primary goal of an ethics committee is to contribute to the cultivation of the "ethical life" of the organization, to attempt to infuse the plan with a raised level of "bioethical consciousness."*

---

Many in the medical field do not think the ethics committee model is appropriate for managed care organizations. This paper will illustrate how such committees can be adapted to, and prove useful in, the managed care setting. The intent of the paper is not to provide normative guidelines for other institutional ethics committees but to provide information which might prove useful to other organizations.

Drawing on our committee's experience over the last five years, I will describe the mission and structure of the committee, how it functions, highlight some of its work, review some beneficial results as well as problems faced, and identify issues and challenges we anticipate for the future.

The primary goal of an ethics committee is to contribute to the cultivation of the "ethical life" of the organization, to attempt to infuse the plan with a raised level of "bioethical consciousness." This goal necessitates inclusion on the committee of high-ranking plan managers and physicians. These administrators will, in turn, use their bioethical knowledge and sensitivity in dealing with other committees within the organization and in

making administrative decisions and policy.

### **Mission**

The CHP ethics committee and management agree

1. to identify and consider the significant ethical issues that may affect CHP's health care program
2. to understand the implications of these issues as they affect CHP's staff, members, and patients
3. to develop and recommend policy as appropriate to assist CHP in carrying out its "Founding Principles"
4. to anticipate and address heretofore unidentified ethical issues that may result from advances in medical technology
5. to serve, when requested, as a consulting body on bioethical issues which affect the disposition of a patient's individualized care or a specific component of CHP's program
6. to actively educate the staff, members, and patients on ethical issues affecting health care

### **The Structure and Agenda of the Committee**

#### *A. Organization*

Given its mandate to lend guidance to the organization's administration, the committee departed significantly from the classic ethics committee by answering to CHP's board of directors, rather than being a subcommittee of the department of medicine.

#### *B. Committee Membership*

The committee is an eighteen-member multidisciplinary group with representatives from medicine, law, nursing, behavioral health, clergy, and health care administration. Six members are physicians, three of whom are active in clinical practice. One of the physicians is the planwide medical director. Other members

include the chairman of CHP's board of directors, an Orthodox rabbi, Catholic sister, nurse, physician assistant, two counseling social workers, university professor, lawyer, two members of CHP's risk management department, and one member from the communications department. There are seven women and eleven men. Most committee members are also CHP members; three have no affiliation with CHP other than the committee.

### C. Meetings

The committee meets monthly (eleven months of the year) for two hours. Approximately ten days prior to each meeting, members receive a packet containing the previous meeting's minutes, a detailed agenda for the upcoming meeting, readings (usually ranging from fifteen to twenty-five pages) and a two-to-four-page memorandum from the chair on the current project, trends in the bioethics literature, other bioethics topics of interest, and so on.

Meetings vary significantly from month to month. Considerable time is often devoted to substantive comments on a position statement, or time may be spent identifying ways in which the committee can more successfully "reach out" to other sectors of the organization.

It has typically required four-to-eight months of literature review, fact-gathering, deliberation, dialogue, and writing for the committee to develop a position statement which reflects the broad consensus of the committee.

### D. The Agenda

Since managed care plans frequently have several hundred thousand to several million patients, a plan ethics committee would find it unwieldy to consider urgent case consultations as hospital ethics committees do. CHP's committee rarely considers individual cases. Because of its size, structure, and needs in the area of ethical review, CHP's committee generally spends most of its time addressing policy and educational issues, rather than case consultations.

Review of existing organizational policy re-

quires that the committee have at least one member who knows an existing policy and who has sufficient sensitivity to ethical issues to identify ethical implications; that the organization is willing to have policies reviewed (realizing that ethically troublesome areas may be discovered); and that the organization is willing to risk offending the original policy maker and to formulate and implement new policy. None of this is simple. Retrospective policy review is the most challenging, labor-intensive function of a managed care ethics committee, and it may occasionally test the organization's commitment to an ethics committee.

Since the majority of the committee's efforts are devoted to policy formulation (usually resulting in a position statement), CHP believes these statements will be more acceptable if the committee is not seen as a "watchdog." Therefore, the committee solicits input from the administration, physician management, and individual physicians, as well as committee members, to identify topics for review. For example, when CHP faced for the first time the prospect of hiring an HIV-positive physician, the committee was consulted. On the other hand, a review of the role of spiritual advisement in managed health care was prompted by a case consultation and one of the committee members.

While the committee has never faced an administration attempt at censorship, we have sometimes aroused the reaction from other CHP committees that our efforts duplicate their efforts, or review of a particular topic has been perceived by another committee as meddlesome or unsettling. Recognizing the inevitability of some such problems, we nonetheless try to establish and support good lines of communication within CHP and make concerted efforts to avoid duplication. For example, when the Committee appointed a subcommittee to develop and implement a comprehensive planwide educational program on advance directives, we so advised CHP's Health Education Committee to ensure that we were not duplicating their work. In an organization as large as CHP, guarding against duplication is a difficult task which requires ongoing effort.

Almost every topic the committee has covered has culminated in a position statement or brief paper. Some of our policy statements are rather exhaustive while others are more reflective and schematic. Statements vary depending on their intended audience. A project on advance directives, for example, resulted in publications written for patients, for physicians and for non-physician clinical staff. A "conflicts of interest" position statement was addressed to the departments which most closely interact with representatives of the pharmaceutical industry. A statement on provider financial incentives was addressed directly to the board of directors.

To help fulfill the committee's commitment to education, articles by the committee chair and recording secretary appear regularly in a CHP publication for providers. The committee is now considering distributing position statements to be inserted and maintained in each *Clinician's Handbook*.

### **Achievements**

After clarifying its mission and gaining some knowledge of the fundamentals of bioethics, the committee addressed a number of topics. We have developed policies and/or position statements on

- CHP and the HIV-positive health care worker
- advance directives, including a comprehensive planwide effort to educate CHP's staff and patients
- a framework for analysis of "medical futility" in individual cases
- whether accepting continuing medical education from pharmaceutical industry-funded programs creates a conflict of interest for clinicians
- the propriety of participating in industry-sponsored research (consideration of this question led CHP to establish our own institutional review board)
- what the relationship between individual health care professionals and pharmaceutical industry representatives should be
- needed changes in the function and composition of CHP's Pharmacy and Therapeutics

and Formulary Committees

- the role of spiritual advisement in the health care professional-patient relationship
- ethical financial incentives for physicians
- defining "experimental" therapy as a contract exclusion
- the ethical dimensions of prostate cancer screening

In a number of individual case consultations,

---

*It should be increasingly apparent that good ethics is good business.*

---

the committee has also examined issues with planwide applicability, such as record keeping of highly confidential HIV information, management of terminally ill patients, the effect of religious and/or cultural differences between health care professionals and their patients, application of the concept of "medical necessity," and whether to participate in surgical contraception of a mentally retarded woman.

### **Challenges in Forming a Committee**

Having no template to guide us when we instituted the committee, we learned through experience and can offer other committees advice based on that experience. First, it serves no useful purpose to try to convince senior management that an ethics committee can generate income or directly save money. Rather, such a committee must be perceived as a natural outgrowth of the maturity of the industry, a way to show that the plan is willing to shoulder its share of the burden of implementing formal medical ethical discourse and adopting acceptable standards of business ethics. It should be increasingly apparent that good ethics is good business.

In developing a managed care plan ethics committee, confusion and disagreement over its appropriate role and position within the organization can be avoided by involving senior management and leadership of existing committees in the

creation of the ethics committee and definition of its charter.

To function successfully, an ethics committee must forge constructive relationships within the organization, and it must remember that its role is advisory rather than operational. Nonetheless, to be taken seriously and to be effective, the committee must make formal, unambiguous recommendations, while accepting that they may not always be followed. An ethics committee must strive to understand the "managerial ethos" by soliciting input from senior management on how the committee might be helpful to them. Management and the ethics committee would benefit if management will articulate the nature of resource utilization decisions. As the committee formulates policies and position statements, it is important that the committee keep in mind and periodically assess the broad impact of those policies.

Thought must be given in advance to how senior management will deal with the discomfort bound to occur when the committee develops a position which is at odds with the recommendations of another committee or senior management itself. Careful consideration needs to be given to ways of avoiding confusion of ethical issues with allocation, legal, and communication issues. The committee needs agreement from management to avoid pressure on the committee to capitulate to an effort seeking approval for a policy which the committee believes may be unethical. This pressure is likely to increase as plans feel the need to position themselves favorably in an increasingly competitive marketplace. Setting the rules early on is vital to the committee's ability to function no matter what pressures arise.

Bioethical concerns are inherent in many areas of organizational decision making and have been considered by many other committees in the past. Committees within the organizations will need to understand that the entire plan can profit by accepting a blurring of boundaries between the ethics committee and other committees in areas such as technology assessment, utilization management, and legal affairs. Teasing out ethical

considerations and focusing on them alone will give them an importance that will benefit the plan and its membership, as well as augmenting the efforts of other committees within the organization.

### **Future Challenges**

There is an inexhaustible supply of issues appropriate for discussion and analysis by managed care ethics committees. I will mention a few that a committee might select.

The committee could provide the venue for an appeals process for primary care practitioners on behalf of their patients who have been denied care the primary care practitioner believes should be made available. In managed care, health care professionals need to be encouraged to advocate on behalf of patients since they understand and can articulate patients' needs better than anyone else. Providing access to the ethics committee for this type of appeal should reassure physicians that there will be no reprisal, no "deselection" (the current euphemism for being fired) simply for patient advocacy. Similarly, plans might consider such an approach for working with physicians who "conscientiously object" to an established policy.

With the rapid development and application of biomedical technologies, it may be appropriate for an ethics committee to participate in technology assessment. Moreover, through the committee, issues of justice and resource allocation for the entire plan membership can be considered.

Other emerging areas within managed care which would benefit from bioethical examination by an IEC include the burgeoning fields of "evidence based medicine," the use and/or abuse of outcome measures, and terms such as "best practices" and "quality care" (for which our assessment capabilities are still severely limited), the content and use of "report cards" for individual physicians as well as entire health care plans, a question of physicians' rights as well as their accountability, limits of confidentiality (given the increasing use of computerized medical records), and so on.

IECs are unarguably of value in managed care organizations. In the case of CHP, there are several reasons why the administration values the ethics committee so highly. First, management depends on the committee to relieve the burden of careful review from administrators who have insufficient time, inclination, skills, and/or expertise. Second, management appreciated that the committee's position statements reflect the considerable efforts of a diverse group of committee members. For our committee, that diversity has ensured a more exhaustive bioethical review than would come from any other committee or individual within the organization. Third, management is reassured by the notion that the committee's recommendations and policies are impartial. While many malign health care insurers' ulterior motives, the committee's work is thought to be devoid of such motives.

The function of the CHP ethics committee was succinctly expressed recently by a high-level administrator, who said, "The ethical issues committee is the soul of the organization." And as such, it is largely responsible for developing the "ethical life" of CHP. .

### Conclusion

The CHP Ethics Committee demonstrates that there is a distinct and distinguished role for ethics committees within managed care organizations. A plan benefits from policies developed through the deliberations of a well-rounded ethics committee versed in the foundations of bioethics, a committee which can maintain its ethical perspective despite competing financial concerns. Success hinges on the committee's ability to understand management's viewpoint, as well as the viewpoints of the plan's patients and both professional and nonprofessional staff. However, assembling, supporting, and educating an ethics committee, ensuring adequate dissemination of the committee's final reports, and general support

of the committee require strong commitment at the highest level of plan administration. With that support, an ethics committee can positively affect the ethical climate in the plan and ultimately, the care offered to the plan's members.

### Endnotes

1. See "Ethical Issues in Managed Care: Guidelines for Clinicians and Recommendations to Accrediting Organizations" for a discussion of ethical issues likely to face a plan ethics committee and applicable ethical principles.

2. "Value Dilemmas in Managed Health Care: The Hastings Center Initiative." This six-part initiative, begun in 1995, includes discussions of resource management, emerging values in corporate health benefits, technology and outcomes assessment, as well as other managed care issues.

3. An excellent discussion appeared in the article by Stanley Reiser entitled "The Ethical Life of Health Care Organizations," *Hastings Center Report* 24(6):28-35, 1994.

### References

- Biblo, J., Myra Christopher, Robert Potter, and Linda Johnson. 1995. *Ethical Issues in Managed Care: Guidelines for Clinicians and Recommendations to Accrediting Organizations*. Kansas City, Missouri: Midwest Bioethics Center.
- Felder, Michael. 1992. "An Ethics Committee for a Health Maintenance Organization: An Oxymoron? Certainly Not!" *HEC Forum* 4(4):261-67.
- Felder, Michael. 1996. "Bioethics and the HMO." Accepted for publication in *HMO Practice*. (To be published in Spring, 1996).
- Reiser, Stanley. 1994. "The Ethical Life of Health Care Organizations." *Hastings Center Report* 24(6): 28-35.
- Rodwin, Marc. 1993. *Medicine, Money and Morals*. New York: Oxford University Press.
- Ross, Judith Wilson. 1993. *Health Care Ethics Committees, The Next Generation*. Chicago: American Hospital Publishing.
- Scott, R. 1995. "Organizational Aspects of Caring." *The Milbank Quarterly* 73(1): 77-95.
- Sims, Ronald. 1994. *Ethics and Organizational Decision Making*. Westport, CT: Quorum Books.