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Loma Linda University
CENTER FOR
CHRISTIAN BIOETHICS
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Update

MANAGED CARE: CHALLENGES FACING INTERDISCIPLINARY HEALTH CARE TEAMS

Ruth B. Purtilo

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In November of 1994, the *New England Journal of Medicine* ran an Occasional Note entitled, "The Train is Leaving the Station."[1] In it, the physician author reflects on whether he likes the idea that he and his colleagues are aboard the "managed care express." My comments are on another group of passengers—members of interdisciplinary health care teams [IHCTs]. This article will explore some major challenges teams are facing in the health care system's movement to managed care, and reflect on compromises to cherished ethical goals of health care that could result if the contributions of IHCTs are not fully and accurately taken into account. My assumption is that while managed care approaches are designed to deliver high quality health care, the definition of what constitutes "quality" has not been fully determined. Without that basic definition, other criteria may drive the decisions regarding the direction taken by engineers of the managed care express. More importantly, the contributions IHCTs may make could be overlooked or distorted.

This discussion will be limited to teams in which two or more health professionals from different disciplines apply their skills to direct patient care. Teams can serve many other functions, among them advocacy, education of other health professionals, quality assurance, and community outreach, to name some. However, patient care oriented interdisciplinary health care teams serve two basic functions; one that can be called the *moral* function and the other, the *instrumental* function. Both functions are important in helping to foster the primary ethical goal of medicine: to show respect for persons by providing high quality professional services.[2]

The moral function characterizes IHCTs that engage in professional activity directly, and are immediately geared to the good of the "whole patient." Every interdisciplinary team has this moral function as its focus, but some teams are characterized by *instrumental* functions directly and immediately geared to accomplishing an important technical task.[3] For instance, the cardiac catheterization team's work can be completed successfully without any attention to a direct goal of fostering the person's overall well being. Their activity as a team will include some moral functions, but their conduct will be governed by the need to competently and efficiently insert and secure the catheter.

In short, not all health care teams are equal in terms of the direct ends they serve, though few are solely moral or solely instrumental enterprises. Many have functions that fall some-

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where on a continuum between the extremes of serving moral or instrumental ends. This distinction is significant, especially regarding the question of what constitutes quality in a managed care environment.

INTERDISCIPLINARY HEALTH CARE TEAMS AND QUALITY CARE

Managed care plans operate within a system that integrates the delivery and financing of medical care and related health care services. Since managed care is about delivery and financing, it is reasonable to expect that usefulness in the new health care plans is being measured according to delivery and financing criteria. The language that governs current discussion about the criteria of usefulness in relation to these two criteria is that code phrase, "quality of care." Therefore, the future of interdisciplinary health care teams revolves around the compelling question: can IHCTs deliver quality care?

At the outset of this paper I suggested that the problem with answering that question lies in the imprecise definition of "quality" that currently governs managed care systems. At least three barriers meet IHCTs as they attempt to contribute to an understanding of quality which accurately conveys their perception of their contributions.

The first is internal: teams which long have enjoyed camaraderie are becoming divided in their rush for survival in managed care alliances, an activity that deters them from the more fundamental and life saving task of searching for better understanding of team delivered quality care. The second is that tools presently utilized for measuring quality in the emerging managed care approaches are sometimes blind to the types of contributions IHCTs are making. The third barrier is that cost-effectiveness considerations are becoming disconnected from cost-saving ones, and team contributions are judged solely on money saved rather than quality proffered.

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The Internal Threat of Team Divisiveness

Interdisciplinary health care teams today are becoming divided over threats to traditional team rules of success. One basic ground rule is that each player be highly skilled and responsible in carrying out his or her role. Flexibility among team members for assuming parts of another team member's role signals a highly skilled team, and such activity is decided play by play.

One aspect of managed care that threatens these ground rules is Patient Focused Care (PFC). PFC appears to be team-friendly because someone follows a patient throughout the continuum of care—such as from the hospital to home or nursing home—consistent, on the face of it, with the moral function of IHCTs. However, the PFC idea involves "cross training" of personnel, or de-emphasizing traditional professional boundaries. It suggests that professional "expertise" can be taught in a short course to someone who will provide it less expensively, and that no subsequent compromise of quality will result. No well working team, moral or instrumental, rests on such an assumption. From the teams' perspective, cross training to provide for greater flexibility of services appears to sacrifice quality. In the end, PFC runs directly counter to the premises of a well working team. Rather than beginning by changing team structure, a better approach would be to concentrate on understanding what constitutes quality, then closely assessing the unique expertise of each profession and protecting those functions that lead to quality.

The potential derailing of the traditional assumption that expertise is essential to quality, combined with the anxiety created by restructuring health care, is resulting in entrenchment of professional boundaries rather than enhancement of the spirit of mutual cooperation and adventure this period of change could foster. The surer road would be for IHCTs to make themselves indispensable by virtue of their contributions, but humans tend to act more conservatively and self-protectively when threatened. One untoward effect of the internal strife is neglect—which will become moral complicity—caused by focusing on the wrong task.

Having looked at the internal threat, we turn to another kind of challenge, that of measurement tools which inadequately measure quality of care.

The Threat to Quality Because of Inadequate Methods of Measurement

How *will* quality be measured in an era of managed care? Every indication is that health services research data, particularly outcomes data, will be used. This is designed to identify optimum treatment, distinguishing that from simply more treatment or more expensive treatment; then data from pooled evidence regarding outcomes will be used to further restructure health plans. This strategy deserves high commendation.

But since so much rests on the findings generated by it, a major ethical challenge is to assure that it is an adequate tool for assessing that quality indeed is being measured.

There is reason to doubt that outcomes methodology can assess a team's *moral* contributions. The emphasis on morbidity and mortality in outcomes approaches will measure *instrumental* functions more easily. Take the example of transplant teams. The surgeon's contribution will weigh heavily in affirming the instrumental value of this type of team. Nurses' contributions also will have high instrumental value because they deliver medications and monitor patients for changes in physiological status. Medical technologists, pathologists and radiologists will rate high as well. Less significant (though not totally insignificant) from an outcomes measurement standpoint is that these same professionals also may assume a moral role of, say, attending to patients' anxiety about how much their interventions are costing or the effects of the transplant on a patient's ability to enjoy past pleasures. But now consider team workers whose functions are more directly "moral": social workers, who skillfully guide the golden thread by which numerous disparate services are woven together for patients over many months, or chaplains, who minister to the spiritual and religious needs of patients and families. Their moral functions may lead patients to remember the social worker or chaplain with special gratitude as the ones who made the entire ordeal survivable, but the surgeon's or nurse's contributions as team members with unique *technical* capabilities will be measured higher on an outcomes profile. Patient satisfaction scales could help to alter the present higher valuation of technical over moral functions, but such scales are only imperfectly developed, or not used at all in managed care systems.

In short, IHCTs whose interdependence is not characterized by strong instrumental functions, and professional groups whose members are not skilled in providing highly technical instrumental functions on IHCTs, are more likely to be judged low in terms of outcomes and may be trimmed before the importance of their moral functions can be assessed fully.

Another way reliance on outcomes criteria may affect the opportunity for IHCTs to have their contributions assessed fully is that many health professions disciplines do not have a history of measuring therapeutic success [quality] according to outcomes methodology. Every health professions group is rushing to gather data today, but it could take years of using this methodology to demonstrate their contributions conclusively. Their neglect to collect this type of data may signal unpreparedness and lack of rigor, but more likely, the disjuncture lies in factors other than negligence. For a task as important and momentous as determining which services will be reimbursable in the future, prudence and wisdom would dictate that similar standards of measurement be applied to all groups before decisions are made.

The charge to IHCTs is to engage in delineating accurate descriptions of "quality," as they perceive it, and to show how these particular benefits can be measured in outcomes approaches. The barriers discussed above could lead to decreased quality if teams do not persevere in defining the scope and nature of quality.

The Threat to Quality Occasioned by Reliance on Cost Savings Alone

Finally, let's look at challenges that will arise if cost savings considerations alone replace cost effectiveness ones in managed care systems.

Cost effectiveness criteria, applied correctly, are among the signal strengths of a managed care system. Several recommendations being made about how this goal can be reached have direct bearing on the future of IHCTs. *Cross training* was discussed earlier. *Down scaling the level of professionals* involves replacing physicians with persons trained in other health fields, the assumption being that this practice automatically will cut costs because of relative scales of earnings.[4] This view could mean a secure future for disciplines at the low end of the salary scale, with IHCTs composed of fewer physicians becoming more and more the norm. At the same time, another plausible scenario would be to substitute barely qualified or unqualified persons with appropriate skills, for many types of professionals. For example, a health plan just above the average cost in its bid for a contract may be able to stay in the playing field by substituting an assistant for a physical or occupational therapist. Most patients would never guess. The cost savings motivation for administrators to substitute this level of service may be compelling, especially if there are enough such patients to make an appreciable difference financially. A rival plan, seeing the savings, would follow suit, and a cumulative effect would occur. Because of the way outcomes data are generated, it would take many patients to establish what aspects of care, if any, had been compromised. From the IHCT point of view, team members responsible for this instrumental function would be at risk simply on the basis of cost savings rather than their ability to contribute to high quality.

Down sizing is the practice of cutting the numbers of professionals on a service to save money. Most patients won't know that fewer specialty trained nurses on the intensive care unit team will result in such overload for the remaining nurses that adequate, *but only minimally adequate,* nursing interventions are possible. Everyone who has worked on IHCTs knows that in this case, not only nurses (and nursing care) suffer. Other members are compromised by a stressed link in the chain of interdependent functioning, often to the point that efficiency and quality both are compromised seriously.[5]

In short, the legitimate desire to weed out costs in the system must be weighed against unintended side effects that compromise positive values sought in the cost effectiveness thrust of managed care. Changes made on the assumption that the use of less costly disciplines, or cutting back numbers, will be cost effective will be unsuccessful in the long run. The real contribution of various IHCTs and the relevance of their contributions to a fully developed concept of quality will be possible only if hasty cutbacks are avoided.

WHAT SHOULD MEMBERS OF IHCTS (AND EVERYONE ELSE) DO?

The challenge of coming to a more complete understanding of quality health care, and of understanding IHCTs appropriate role in its delivery, is a task for the whole society. Policy makers and professionals in the health care system can take leadership in coming to a full understanding of quality care in the emerging era of managed care. Some suggestions of specific tasks for health professionals on IHCTs have been made in this paper.

More importantly, however, this is the time for going back to the basics. Health care and the professional delivery of health care services rests on the ethical foundation of respect for the inherent dignity of persons. Any goal, process, procedure, structural arrangement, policy or practice that detracts from that foundation diminishes the value of this age old endeavor. The definition of quality care, who should deliver it and why, must begin with this basic orientation.

This article began with a train story and I think it fitting to conclude with another:

If you have seen the powerful film, *Gandhi*, you probably remember how the young Gandhi, an Oxford trained lawyer, takes a case in South Africa. Upon arrival he buys a first class coach seat on the train and begins to review his portfolio. The conductor enters, and seeing that Gandhi is an Indian, announces that he must leave his seat. Gandhi is dumfounded. When he argues with the conductor that he in fact has a ticket for that seat he not only is removed from the compartment, but unceremoniously thrown from the moving train.

Later, discussing the baffling incident with his lawyer colleagues in Durban, he is told that he was thrown from the train because he had broken the rules—the rules of the game in apartheid South Africa.

In a moving scene he concludes that the rules are wrong! They are wrong because they contradict God's rule—we are all equally children of God; they are wrong because they disregard the high ideals of culture and civilization; and they are wrong because they undermine the possibility for community right here and how.

There are many positive dimensions in our health care system, but there are current and potential challenges. In the long run, managed care approaches must meet criteria that will show them to be consistent with our highest religious, cultural and community ideals.

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Anencephalic Neonates as Live Organ Donors: AMA and CEJA

Theodore D. Masek

Theodore D. Masek, a physician who practices radiation oncology in Rancho Mirage, California, is the head of the Ethics Committe at Eisenhower Medical Center and is active in the House of Delegates of the American Medical Association. He and his wife Julie have three teenage children.

In December of 1994, at the interim meeting of the AMA House of Delegates, the Council on Ethical and Judicial Affairs (CEJA) submitted an updated opinion[1] concerning the use of anencephalic neonates as live organ donors. To understand the AMA policy on this controversial topic, it is necessary to understand the interaction of CEJA and the policy making arm of the AMA, the House of Delegates.

CEJA is one of several councils used by the House and Board of Trustees to produce reports concerning issues in medicine. This council has several unique characteristics that allow it to function autonomously. Its members are elected for a single term by the House of Delegates, upon nomination by the AMA president. On election, members of CEJA are required to resign all other positions in the AMA.

The AMA bylaw 6.4021 states that one of the functions of CEJA is "To interpret the Principles of Medical Ethics of the American Medical Association."[2] When acting in this role CEJA can either offer a report or an opinion to the semi-annual meeting of the House of Delegates. Reports of CEJA which respond to requests from the House or which make recommendations to the House may be adopted, not adopted, or referred, as may be appropriate. Reports may not be substantially amended by the House. Opinions of the Council are also reported to the House. The members of the House may discuss an ethical Opinion fully in Reference Committee and on the floor of the House. After concluding its discussions, the House files the Opinion unchanged. It is appropriate for the House to adopt a nonbinding resolution requesting CEJA to reconsider or withdraw the Opinion. CEJA responds to such requests in due course, after reconsidering the issues presented. No action of the House can prevent the publication of CEJA's opinion in the *Principles of Medical Ethics*. In other words, the opinions concerning ethical issues cannot be modified by the politics of the House. On the other hand, there are no rules that prevent the House from adopting policy in direct conflict with the published opinions of the Council.

In the past the main physician influence on CEJA concerning ethical issues came in the form of discussions of the informational reports at reference committees during the annual and interim meetings of the House of Delegates. The testimony was taken only after the opinion had been produced and, as stated above, could not be modified. The obvious

analogy would be if the Supreme Court gave its opinion and then heard the arguments from the parties involved.

This was the situation in December of 1994 when the Council issued its opinion to exclude anencephalic human infants from the dead donor rule. The report eloquently delineates the arguments against using live human donors for organ transplants. It goes on to exclude this category of persons "because of the fact that the infant has never experienced, and will never experience, consciousness."[3]

The informational report received a contentious reception by many physicians when discussed in reference committee. The House of Delegates was swayed by the utilitarian argument of the Council and voted to file the report. Because many physicians felt that this and several other issues were not given a full debate, and that opposing legitimate ethical arguments were not considered, the Council made a historical decision. The Council agreed to hold a forum at the next meeting to hear from physicians on reconsideration of this issue and other ethical issues that were to be considered by CEJA in the future.

On June 19, 1995 at the annual meeting of the House of Delegates, this new forum was held. The entire council heard testimony concerning ethical issues. The lion's share of the forum was taken up with a discussion of the ethical issues of live organ donors and whether or not an anencephalic infant could be excluded from the protection of the dead donor rule. Of the testimony given that day, only one physician rose to support CEJA's opinion. The Council heard testimony from expert physician witnesses and moving testimony from mothers of anencephalic infants who had survived the neonatal period and died a dignified death at home. The message given at the hearing was that certain actions offend us because they threaten our unambiguous status as human beings.

In his book *Ethics after Babel: The Languages of Morals and Their Discontents*, Jeffrey Stout discusses his concept of "Moral Abomination."[4] His metaphor of cannibalism seems to apply. We find it repulsive to eat human flesh even in situations when no other moral wrong occurs. For instance, if in extreme circumstances a dead comrade is eaten, most feel guilt and remorse. And yet because the comrade may have died of natural causes, no life was taken. A life may well have been saved (that of the cannibal) by taking the comrade's flesh for food. So the balance of utility is favorable. It is not clear that anyone's rights were violated. The fact remains, however, that we define ourselves as human in part by what we do not eat. Our humanity is also defined by the fact that we do not sacrifice living donors for organ procurement.

CEJA will now reconsider the anencephalic issue. Unless it can find a compelling moral argument on why these infants should be excluded from the realm of humanity, it would seem only prudent to maintain the principle of the dead donor rule for all.

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Can Evil Ever End?

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"Always be ready to make your defense to anyone who demands from you an accounting for the hope that is in you; yet do it with gentleness and reverence." (1 Peter 3:15, NRSV)

A recent year was especially difficult for a young physician who is a friend of mine. His father, a family doctor who served a rural community and church for the better part of five decades, died in September of that year. His mother, as much of a saint as his father, succumbed not long thereafter to a malignancy. Just before she died, an intoxicated driver crashed a speeding vehicle into the van in which my friend's two sisters and their husbands were traveling after visiting her in the hospital. His sisters were wounded, one of them badly enough to attend his mother's funeral on crutches. One of his brothers-in-law lost his life instantly. So there was another funeral.

Can the evil of unnecessary pain and suffering ever end?

Clarifying Evil

Six basic and overlapping features of everyday life that are evil in the eyes of some will never end if my understanding of the Biblical view of things is valid. One of these is *dependency*. Another is *finitude*. *Embodiment is* here to stay as well. *Relatedness* is yet another basic feature of everyday life that won't disappear. Neither will *temporality*. The ability to determine in part the direction and shape of one's own life that we call *freedom* is also permanent, though its form and degree will continue to vary greatly.

One way to test the validity of this view is to compare it to alternative points of view. If these most basic features of everyday life are evil as such, how possible and desirable could life of any sort be without them? What would we have if we actually did escape them?

This question elicits two similar answers. The longer reply is that we then would have the non-exclusive identity of undifferentiated unity that is possible only by wholly overcoming in transcendent experience the dichotomies between subject and object, one and many, and potential and actual. The shorter response is that we then would have nothing, or more accurately: "no-thing."

I'm prepared to take my chances on the basic features of everyday life from which, according to my understanding of the Hebrew and Christian Scriptures, it is impossible to escape. To my mind, to be "some-thing" in these ways instead of "no-thing" is not evil. It is good. And splendidly so.

Overcoming Evil

As evidenced by its creation stories, the Bible exudes ontological optimism. This delight in the inherent goodness of ordinary existence is a foundation for reasonable and realistic hope. If the most basic aspects of everyday life are necessarily evil, either in themselves or in what they must always produce, evil cannot be overcome. If that were the case, we would be wise to invest less in attempts to eradicate evil from private and public life and more in efforts to escape it in psychologically soothing ways. This is what some sages recommend.

And yet, regardless of what they say, most people around the world function as though the Bible's more optimistic view of things is true. Some do find it possible to order the whole of their lives on more pessimistic premises. But this is difficult for the vast majority, even though a number do give it an honest try. From a Biblical perspective, this difficulty is an omen of futility, not hypocrisy. Almost like attempts to fall upward, lives arranged on such negative outlooks are difficult because they run counter to the way things really are. As our experience confirms on a deep and daily basis, the most basic features of everyday life are good, not bad. For this reason, it makes sense to hold with the ancient Scriptures that in principle it is possible for the evil of unnecessary pain and suffering to be overcome. This is one basis for hope.

At least two lines of additional evidence converge to make it reasonable to be hopeful. Both are especially evident to Christian eyes in the life, death and resurrection of Jesus the Christ. But both are manifest elsewhere as well. One of these is that actual evil is self-destructive. Just as the one who betrayed Jesus ended his own life, evil annihilates itself. This reality provides little comfort in the short run, particularly when those who cause the evil of unnecessary pain and suffering prosper. But such prosperity eventually and invariably collapses. An exception to this rule has yet to be established. This is a second basis for hope.

A third basis for hope is that goodness out-lasts and out-performs evil, just as the cause of Christ has out-lived and out-matched the rule of the Roman empire that unjustly executed him without even noticing what it had done. As the crucifixion of Jesus demonstrates, the power of good is so subtle and so gentle that it is often mistaken for the weakness that is its opposite. But good ultimately triumphs over evil because in God's steadfast love its resourcefulness and resiliency are so much greater. Those who cause evil are often in a hurry, and rightly so. Their time is short. Those, like Jesus, who embody goodness, can afford to temper their urgency with patience. Time is on their side, as is the way things truly are.

> "False prophecy wrongly claims that God will not let us destroy ourselves. This is a delusion."

Living From The Future

Although Biblical faith is optimistic about the possibility and probability of overcoming actual evil, it refuses to specify when and how this will occur. This depends in part on us. God invites, inspires, encourages and nudges. But God does not coerce. It is vain to yearn for a time when God will unilaterally banish all actual evil and make good solely sovereign without the voluntary consent of those who thereby are governed. We know this has not happened in the past. We have no reason to believe it will happen in the future. As far as we can tell, God does not do things that way.

Our choices do matter. False prophecy wrongly claims that God will not let us destroy ourselves. This is a delusion. We can destroy ourselves. And God will not stop us from doing so. We must face this truth and we must face it squarely. We dodge it at our own peril.

The human race could annihilate itself. But there is no reason why it must. Instead of ignoring God's invitations and admonitions, we could heed them. Instead of continuing trends that are leading us to the brink of individual and communal destruction, we could reverse them, or at least divert and deflect them. Instead of living in ways that make ourselves and others ill, we could arrange things so that we enjoy increasing health and prosperity. All this and more is possible.

To live *from* the future and not merely *for* it: this is our challenge. When we live only *for* the future, we are wistful. We accept things as they are even as we yearn for a better world. When we also live *from* the future, we are faithful. We make genuine attempts to shape our beliefs, values, policies, practices and rituals with an eye to that new and better world, a world of which it truly can be said that "God will dwell with them, and they shall be his people." (Revelation 21:3 RSV)

It can be perplexing and difficult to live in this age by what can be the better views and values of the next. And at times it can feel as though such attempts are pointless. They aren't. Among humans, nothing is more pertinent, nothing more powerful.

"Look at the proud!
Their spirit is not right in them,
but the righteous live by their faith."
(Habakkuk 2:4 NRSV)■

Update welcomes your comments regarding issues raised in this or previous issues. To reach us, write to:

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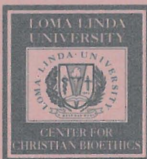

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