

Managed Care: Some Basic Ethical Issues

Not a few critics utter prophetic indictments against managed care organizations, programs, or plans. However, my ethical concerns are aimed at certain policies and practices in many managed care organizations (hereafter MCOs), rather than at MCOs as such. MCOs are not, I believe, inherently or intrinsically evil and unredeemable. Nevertheless, an ethical audit reveals troubling deficiencies. Many, perhaps all, are correctable, but they must be corrected before we can certify that MCOs are ethically acceptable in practice as well as in principle. Some actually result more from our societal ethic of health care than from managed care as such.

Defining the Health Care Crisis

There is a rough consensus that our current health care system—or non-system—is flawed and needs to be reformed. This consensus has not, however, been translated into concerted, unified social action for a particular solution, largely because our various perceptions of the fundamental flaw(s) differ so much.

Some—I am one—hold that the system is morally flawed and even unjust mainly because more than 41 million are uninsured at any one time, 15 to 20 million more are uninsured some time during the year, and millions more are underinsured for health care that costs more and more.

Others, by contrast, identify the escalation of health care costs as the basic flaw, with health care expenditures now consuming about 14 percent of the gross domestic product, a much higher figure than for any other country, including those providing universal access.

People thus disagree about possible solutions to the health care crisis, not only because they find hard choices painful, but also because they perceive the problem(s) and causes of the problem(s) quite differently. Nevertheless, without reaching closure in our public debate, radical changes are already underway. We have a de facto public policy—a shift to managed care—as our latest societal effort to control national health care costs. The evidence is still mixed about how well MCOs can contain health care costs in the long run,¹ and about whether cost savings result from increased efficiency or reduced access and quality. However, they represent the main 1990s

strategy for cost containment, even though many believe that true cost containment will also require other structural changes.² In 1993 almost 80 percent of U.S. citizens received health care insurance through their employers, and 51 percent of those were enrolled in managed care programs, a substantial increase over the 29 percent enrolled in such programs in 1988.³ The percentage in MCOs has continued to increase and reached 70 percent in 1995.

The term “managed care” has been used so widely and so loosely that it is now almost meaningless. It covers a diverse set of organizational and financial arrangements from tightly-bound group practice health maintenance organizations (HMOs), to looser affiliations of physicians and hospitals linked by payment formulas, to traditional forms of practice managed through third party restraints. It covers both not-for-profit and for-profit arrangements. Whatever the specific arrangement, all types of managed care attempt to control costs through modifying the decisions of physicians and patients in order to promote a more rational—not necessarily more equitable—use of resources. To accomplish this goal, MCOs use various devices, such as case management, utilization review, and financial incentives for physician choices.

Our de facto policy of managed care is largely driven by concerns about the costs of health care. Its proponents tend to see cost as the major problem in health care, rather than access, availability, or quality. Ethical difficulties emerge in part because managing costs through MCOs that limit and constrain physician decisions does not fit well with the traditional conception of physicians as advocates for their patients’ medical needs. Physicians’ judgments about appropriate care for their patients obviously have a major economic impact—after all, physicians are responsible for 75 percent of all health care expenditures. In order to control these costs, MCOs expect physicians to temper their health care recommendations both because they appreciate that health care resources are limited within the MCO and because they have financial incentives to do so.

It is not surprising that ethical concerns about managed care include damage to the physician-patient relationship, and particularly patient trust, by MCOs’ financial incentives for the provider to limit

care, incentives that create serious conflicts of interest, and by their limits on physician and patient choices, as well as by rationing health services without the kind of public accountability that justice appears to require.⁴ We can begin to explore some of these basic ethical issues by considering how the shift to managed care both shapes and reflects a shift in language, especially in our metaphors for health care.

Thinking Metaphorically

We often approach health care through various metaphors, perhaps in part because it concerns fundamental matters of life and death for practically everyone but frequently in quite mysterious ways. We thus try to understand it through something less mysterious. For instance, we may view physicians as parents, or nurses as advocates, while we interpret health care itself as a war against disease. David Eerdmann suggests that imagination involves “reasoning in metaphors.”⁵ In each use of metaphor we see something as something else, for example, we view human beings as wolves or life as a journey.⁶ Metaphors, more precisely, are figurative expressions that interpret one thing in terms of something else.⁷

Several times over the last fifteen years I have explored our socio-cultural metaphors as one way to interpret what is actually going on and to suggest what should go on in health care. Often, most recently in the second edition of the *Encyclopedia of Bioethics*, I have noted the significant tension between the previously dominant (but still persistent) metaphor of “medicine as warfare against disease” and the new contender: “medicine as business or commerce.”⁸ Both the military and market metaphors appear in our ordinary language, concepts, and practices. And both illuminate and distort what is and what ought to be.

The military metaphor first became prominent in the 1880s when bacteria were identified as agents of disease that threaten the body and its defenses. It still pervades our day-to-day language of medicine, health care, and health policy. It is so familiar that it requires little explication: The physician as the captain leads the battle against disease, orders a battery of tests, develops a plan of attack, calls on the armamentarium or arsenal of medicine, directs allied health personnel, treats aggressively, and so forth.⁹

The military metaphor has many positive implications—for instance, in supporting a patient’s courageous and hopeful struggle against disease and in galvanizing societal support to fight against disease. But it is also problematic, especially because of what it implies for allocating resources for and within health care.

First, under the military metaphor, society’s health-care budget tends to be converted into a defense budget to prepare for and conduct war against disease, trauma, and death. As a result, the society may put more resources into health care than it could justify under a different metaphor—perhaps even without regard for the cost.

Second, within the health-care budget, the military metaphor tends to assign priority to critical care over preventive and chronic care.

Third, in setting priorities for research and treatment, the military metaphor tends to target killer diseases, such as cancer and AIDS, over chronic diseases.

Fourth, medicine as war concentrates on technological interventions, such as intensive-care units, while downplaying less technological modes of care.

Fifth, the military metaphor supports overtreatment, particularly of terminally ill patients, because death is the ultimate enemy, just as trauma, disease, or illness is the immediate enemy. “Heroic” actions, with the best available weapons, befit the military effort that must always be undertaken against the ultimate enemy. Death signals defeat and forgoing treatment signals surrender.

Some of the military metaphor’s negative or ambiguous implications for health care could be avoided if we interpreted war within the limits set by the just-war or limited-war tradition, rather than as an unlimited crusade or holy war (as the U.S. is inclined to do in warfare). Unfortunately, then, our invocation of the military metaphor often fails to recognize moral constraints on waging war.

The military metaphor thus has serious limitations as a guide for health policy. And because of various sociocultural forces, including what Eli Ginzberg has called the “monetarization of medical care,”¹⁰ it is not surprising that the market metaphor has become increasingly prominent, especially in efforts to control health care expenditures. Consider the shifts in language and orientation from patients to con-

sumers, from physicians and other health care professionals to health care providers, from health care to the health care industry, from care to costs, and from the healthy patient to the healthy bottom line.

Under the market metaphor, as George Annas observes, “health plans and hospitals market products to consumers, who purchase them on the basis of price.”¹¹ Medical care is considered a business, with marketing through advertising and competition among profit-motivated suppliers, and its central theme becomes consumer choice. The market metaphor reconceptualizes medicine—“emphasis is placed on efficiency, profit maximization, consumer satisfaction, the ability to pay, planning, entrepreneurship, and competitive models.” Business ethics replaces traditional medical ethics.

Many critics of this metaphor worry that the language of efficiency will virtually replace the language of care and compassion for the sick along with equity in distribution of health care. The poor and uninsured have no place in the market metaphor. And patients now often fear undertreatment as hospitals and professionals seek to reduce costs, in contrast to their fears of overtreatment under the military metaphor.

Despite such worries, the market metaphor has become more and more pervasive and more and more accurate as the structure of health care has changed and as concerns about costs have widened and deepened. Indeed, the structural changes have been so thorough that it may even seem odd to view the language of markets, business, and commerce as metaphorical in contemporary health care. But metaphorical the language still is, at least to a great extent, because health care is now viewed largely through the image of markets, business, and commerce even though it retains many of its traditional features. Hence, major tensions have emerged. Furthermore, health care has often been a business, or had business features, without being viewed through the metaphors of business and the market. What is new is the interpretive lens.

Yet many uses of the market metaphor for health care mistakenly appeal to ideal markets rather than real U.S. markets, where, as Annas notes, there is a high degree of regulation, “major industries enjoy large public subsidies, industrial organizations tend toward oligopoly, and strong laws that protect consumers and offer them recourse

through product-liability suits have become essential to prevent profits from being too relentlessly pursued.” When extended to health care, the market metaphor conceals many of its public aspects, and it distorts the imperfections of the medical market.

In short, both military and economic metaphors illuminate certain aspects of health care, but they may not be adequate, even together, to guide and direct health care. Whether any particular metaphor is adequate to guide our policies, practices, and actions will depend at least in part on the values it highlights and hides, such as justice, fairness, equity; care, compassion, solidarity; liberty; and, yes, efficiency. An adequate metaphor must also somehow fit our real world, at least its emergent possibilities.

We should, Annas argues, “reframe” our debate on health care reform by replacing both our dominant metaphors, which together produce a “sterile debate” and which we cannot simply combine because their entailments are largely incompatible. Indeed, he suggests, the Clinton health care plan failed in part because it tried unsuccessfully to combine these two metaphors while also introducing other metaphors. Hence, Annas claims that we cannot even begin to think seriously about health care reform without a new metaphor that can enable us to “look deeper than money and means, to goals and ends.” Neither the military metaphor nor the market metaphor can suffice, because each narrows “our field of vision,” and each is now dysfunctional as well as mythical.

What we need, Annas suggests, is an *ecological metaphor*, which involves such words as “integrity,” “balance,” “natural,” “limited (resources),” “quality (of life),” “diversity,” “renewable,” “sustainable,” “responsibility (for future generations),” “community,” and “conservation.” Such a metaphor could help us accept limits, value nature, stress the quality of life, worry about posterity, seek sustainable technology, emphasize prevention, and debate the merits of rationing. While the military and market metaphors only reinforce the detrimental American characteristics of wastefulness, obsession with technology, fear of death, and rampant individualism, the ecological metaphor would enable us to confront and perhaps modify these traits. Specifically in application to medicine, “the ecologic metaphor can encourage an alternative vision of resource conservation, sustainable

technology, acceptance of death as natural and necessary, responsibility for others, and at least some degree of community. It can also help move us from standards of medical practice determined by the law, an integral part of the market, to standards that provide a greater role for ethics and ethical behavior in the practice of medicine.”¹²

Still others have proposed nursing, a subset of health care, as a metaphor for the whole of health care, because it attends to caring more than curing and to hands-on rather than technological care. While the metaphor of nursing is also inadequate by itself, it could direct the society to alternative priorities in allocating resources for and within health care, particularly for chronic care.

The process of altering sociocultural metaphors is complex and uncertain, particularly when such metaphors as warfare and business appear to be relatively accurate descriptively (that is, within limits, they illuminate how we think and act), even though they are problematic normatively (that is, they distort how we should proceed). In contrast to Annas’ proposal, we can rarely totally replace dominant sociocultural metaphors. Most often we retain such metaphors for some purposes but not others. Despite their systematic entailments, metaphors never convey all of the secondary subject, such as war in “medicine is war.” For instance, even when that metaphor was dominant, medicine was not primarily an undertaking of the federal government as warfare is.

In the film, *Il Postino*, the postman tries to learn how to use metaphors to win the love of a young woman. The poet Neruda observes at one point, “You [just] invented a metaphor.” “But it doesn’t count,” the postman responds, “‘cause it just came out by accident.” Neruda then notes, “All images are accidents, my son.” Any metaphorical construal of health care is a historical accident—it could have been different. But in particular times and places some metaphors just fit—they make sociocultural sense and even become part of and shape our operative conceptual frameworks in health care. Neither the ecological metaphor nor the nursing metaphor does that at this point. Even though I distinguish descriptive and prescriptive uses of metaphors, a metaphor will rarely become pervasive and persuasive in sociocultural discourse unless it seems to fit what is already occurring, or at least emerging as a possibility, and unless it coheres

with many of our important values, which, of course, may shift over time, at least in their salience or weights.¹³

Conflicts of Obligation, Conflicts of Interest, and Threats to Trust

Consider the following case as a way to explore some of the basic ethical issues involved in managed care. It was prepared by physician Elena Gates, who is Associate Clinical Professor of Obstetrics and Gynecology at the University of California in San Francisco:¹⁴

The faculty obstetric practice at a large urban medical center is in the process of negotiating contracts for prenatal care and delivery. Most of the health plans with which the group has contracts are interested in shortening the length of stay for delivery. One of the plans makes the following offer:

The plan will reimburse \$1400.00 per patient for prenatal care and delivery (about 30% below their current reimbursement rate). As an incentive to achieve a shorter length of stay, the plan will raise the reimbursement rate to \$1500.00 per patient if the group is able to bring its length of stay for uncomplicated births down from 1.8 days to 1.3 days.

This health plan brings with it about 25% of the total number of obstetric patients cared for by the faculty practice each year. Declining to contract with this plan would clearly hurt the practice (as well as the teaching program at the medical school, which benefits from the faculty private practice in terms of patient volume).

As they discuss the health plan's offer, several members of the group indicate that they feel that obstetric length of stay can safely be decreased as part of the overall effort to responsibly decrease the cost of medical care. They are pleased at the opportunity to increase reimbursements. Other members of the group are concerned about what appears to be clear conflict of interest: get the patient out sooner and take home more money. One individual points out that if such an incentive were agreed to, it would have to be disclosed to patients. There ensues a discussion about how best to rationalize such an incentive plan to the group's pregnant patients. No acceptable approach is arrived at. A fundamental disagreement remains between those who believe that accepting the health plan's offer is reasonable and those who feel that it is clearly inappropriate.

Ethical Conflicts. Some of the participants in this case worried about apparent and real conflicts of interest and conflicts of obligation. Medical fidelity or loyalty traditionally assigns priority to the patient and his/her interests in two basic ways: (1) the professional effaces self-interest to some extent (though he or she is not expected to sacrifice it altogether) in any conflict with the patient's interests, and (2) the patient's interests take priority over others' interests, such as third parties' interests. In practice, the priority of patients' interests has never been so complete. For instance, physicians are not expected to care for all patients without remuneration. And conflicts of obligation and interest are not new in medicine or in other professions. They often concern the meaning, limits, and weights of obligations of fidelity and loyalty.

Conflicts of *obligation* occur when a physician has an obligation to the patient and an obligation to persons or entities other than the patient. Such conflicts can occur in two ways. On the one hand, a physician may have an obligation to the patient and an obligation to the MCO (among other entities). These obligations to the patient and to the MCO may not in fact conflict, according to one interpretation, because the physician's contract with the MCO may specify his/her obligation to the patient so that it does not conflict with the obligation to MCO. However, in reality, especially when traditional expectations undergo change, patients may and often do believe that traditional physician obligations to patients still stand.

So there may be a conflict between traditional profession-based obligations to patients and new organization-based obligations. Similar conflicts have emerged in other organizational settings, such as the military, prisons, certain companies, and sports medicine. They also arise in the context of research and teaching and anywhere else the physician is a "double agent."¹⁵

On the other hand, a physician may experience a conflict between an obligation *to do X* for the patient (an implication of the traditional or customary relationship with and obligation to the patient), and an obligation *not to do X* for the patient (an implication of the obligation to the HMO). It is thus both obligatory to do X and obligatory not to do X. Here the physician faces a genuine dilemma. This second conflict of obligations frequently grows out of but is not reducible to the

first. And it may appear in certain rationing schemes adopted by HMOs.

Managed care organizations ration health care in the sense of limiting access to some forms of potentially beneficial care on the basis of cost. Rationing may occur, for instance, when a primary care provider, who serves as a gatekeeper to various forms of health care, determines that a particular patient's medical complaint does not merit referral to a costly specialist. Such a judgment may reflect the particular rationing scheme the MCO has designed to serve its own goals in health care without substantial input from physicians or patients.

Constraints on physicians' abilities to act on behalf of their patients pose serious ethical problems for medical gatekeepers and others. Physicians may be unable sometimes to act effectively on behalf of their patients without "gaming the system," but such actions may threaten, perhaps unfairly, the MCO's allocation pattern. Hence their dilemma.

Conflicts of *interest* appear when, in addition to his or her obligation to the patient to protect the patient's interests, a physician has a personal (often financial) interest at odds with fidelity or loyalty to the patient. Here the patient's interests conflict with the physician's own financial interests. Conflicts of interest do not necessarily involve breaches of obligations. As Rodwin notes, conflicts of interest refer to circumstances, situations, states of affairs, and conditions that create incentives of some kind—we're especially interested in financial incentives—for professionals to breach their obligations of fidelity, their fiduciary obligations, to the patient or client.¹⁶ They provide the incentives for acts, but are not themselves acts. They create the risk of breached obligations.

Of course, conflicts of interest also mark fee-for-service medicine, not only in such practices as fee-splitting, self-referral and the like, but in its very temptation to overdiagnose and overtreat for additional fees. The incentives offered to physicians to limit services are attempts to correct the problems of fee-for-service medicine. After all, since the incentives of fee-for-service are partly responsible for the runaway costs, reverse incentives could conceivably curtail those costs. "Only one thing was overlooked," Rodwin observes, "reward-

ing physicians for using resources frugally does not eliminate financial conflicts of interests. It creates new conflicts with different effects.”¹⁷

For example, most Health Maintenance Organizations (HMOs) hold back a portion of the primary physician's income—ten to thirty percent with the higher figures appearing in for-profit HMOs. Part or all of that amount is returned at the end of the year, depending on the overall financial condition of the HMO and, in some cases, the particular physician's productivity and frugality. Such an arrangement clearly creates an incentive for physicians to limit their care to patients and thus establishes a troubling conflict of interest. It is all the more troubling when the financial incentives are direct and substantial, when, for instance, the particular physician's salary is substantially affected by his or her productivity and frugality rather than by the overall productivity and frugality of the practice group.

Two critics charge that MCOs in effect pressure “doctors to exploit patients' trust for financial gain.”¹⁸ But, as the earlier obstetrics case suggests, given the surplus of physicians, financial survival itself may be at stake, not merely financial gain. And, as is often true, what appears to be “self-interest” also involves the interests of others such as family members and dependents.

Is this conflict of interest more problematic than the one in fee-for-service? Echoing a point Haavi Morreim makes in *Balancing Act: The New Medical Ethics of Medicine's New Economics*, I would suggest that the patient is in a very different position when the physician has incentives to *restrict* or *limit needed* procedures than when the physician has incentives to *provide unnecessary* procedures. When physicians have incentives to provide unnecessary procedures, patients can seek a second opinion about the appropriateness of any recommended diagnostic or therapeutic procedure for a particular condition. However, when physicians have incentives to restrict or limit needed procedures, patients may never become aware of a needed treatment because no one has ever mentioned or recommended it.¹⁹

We cannot assume that effective financial incentives will reduce only the wasteful, unnecessary, and marginally beneficial diagnostic and therapeutic procedures, and that practice guidelines will ensure that physicians can reliably identify such procedures. Incentives

strong enough to produce desirable results may be too strong to avoid undesirable results, especially in view of the uncertainty that pervades medical practice.

Threats to Public and Patient Trust. Some forms of managed care clearly threaten public and patient trust. Trust is confidence in and reliance upon others to act within moral limits both in general and in particular contexts. To the extent that control reigns, trust is reduced. We either trust or distrust others when we cannot control their actions. In the absence of control (or the presence of only limited control), we are vulnerable, we put ourselves in another's hands, and we could be let down. These are situations of trust or distrust. Most situations involve some mixture of trust/distrust and control.

In January 1996, *Time* magazine had a major article on managed care in its "Business" section, and, in noting various controversies, observed "Yet the most fundamental question raised by the new medicine [managed care] is one largely missing from the public debate: Can you still trust your doctor?"²⁰ Under the market metaphor, trust tends to be displaced by *caveat emptor*. In an effort to provide patients with some control, in the absence of trust, one neurologist has established a company, American Medical Consumers, which intends to provide "personal medical advocates" to negotiate care on behalf of patients. He notes that patients must be willing to confront their physicians: "Since the trust is already gone, why not? You've got nothing to lose."²¹

The Publicity Test

In this context, both physician conflicts of obligation, for example, in rationing, and physician conflicts of interest need to pass the publicity test or the public disclosure test. This test can be hypothetical or actual or both.

Hypothetical Disclosure. Some modern versions of the publicity test build on Kant's principle of universalization—can you conceive your maxim of action to be universal and can you will it to be universal without contradiction? Some maxims of action cannot be conceived or willed as universal without contradiction. For example, Kant argued that a maxim that one may lie to protect one's interests cannot be universalized without contradiction. Some modern formu-

lations of this test require that we imagine whether our action and its rationale can pass an audience of reasonable people. Hence, Sissela Bok proposes a publicity test in determining whether the presumption against lying can be rebutted. She asks agents to consider whether an imaginary audience of reasonable people would concur with their proposed lie.²²

Such a test is important, but it may not be sufficient. For instance, largely because of concerns about public confidence, an American College of Physicians (ACP) position paper warns against “excessive or inappropriate rewards.” While encouraging professional guidelines, it allows physicians to make their own individual decisions whether to accept gifts and honoraria, but recommends that they ask themselves, in the process of making their decisions, whether they would be willing to publicly disclose their financial arrangements. Physicians do not actually have to disclose their acceptance of such gifts and honoraria to anyone—not to patients, colleagues, professional groups, or the public. The ACP merely asks physicians to imagine the public’s reactions to hypothetical disclosures in deciding what is appropriate. They never have to subject their decision to an actual test of public response.²³

Actual Disclosure. Beyond her proposed imaginary audience, Bok also recommends that we also test maxims of action by considering the responses of actual people. For both rationing plans and conflicts of interest, public disclosure and patient disclosure are essential (but again not sufficient).

The participants in the obstetrics case presented earlier were unable to reach a decision about whether to accept the offer of \$1,500.00 with a goal of reducing maternal hospital stays following uncomplicated deliveries from 1.8 to 1.3 days. Some argued that such a policy, with its incentive, would have to be disclosed to patients, and yet they were not able to agree on how to explain and justify it to their patients. Having actually to explain and justify a policy or practice to some public, especially one directly affected by the policy or practice, often exposes its moral deficiencies.

In addition to disclosing the rationing scheme and conflicts of interest created by financial incentives, physicians in MCOs ought to disclose the benefits, risks, and costs of procedures that are covered as

well as any that might be beneficial to the patient, even though they are not covered in the plan, as in the following case: Two sets of materials are widely used for hip joint replacement: The more expensive one will last indefinitely, while the less expensive one will last about ten years and then need replacement. The group performing hip joint replacement surgery in one MCO is now limited to using the less expensive one that will wear out in about ten years. A physician in that MCO has to decide whether to tell a patient in her early seventies that his group uses only the inferior but less expensive materials but that another group, a few miles away, uses the superior but more expensive materials.²⁴

Many MCOs have “gag clauses” in their contracts with physicians to prevent just such disclosures. According to Neil Weisfeld, deputy executive director of the Medical Society of New Jersey: “It’s more like managed silence than managed care.”²⁵ According to many physicians, these restrictions on disclosure interfere with their obligations, both ethical and legal, to give patients adequate information about the costs, risks, and benefits of various procedures. Furthermore, the Council on Ethical and Judicial Affairs of the American Medical Association declared that doctors should inform patients of “all relevant financial arrangements,” including any incentives they receive to limit care.²⁶ And the California Supreme Court, in the *Moore* case, held that the “concept of informed consent is broad enough to encompass . . . whether a physician has an economic interest that might affect the physician’s professional judgment.”²⁷

Defenders of “gag clauses” in MCO contracts often justify them on grounds of patient trust and confidence and because of confidentiality. But note the shift: It’s not trust and confidence in physicians or the MCO to act within moral limits, at least as traditionally conceived, and it’s not confidentiality of patient information. Often these gag clauses stress that the physician “shall take no action nor make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, plan sponsors or the public in Choice Care, or in the quality of care which Choice Care enrollees receive.”²⁸ U.S. Healthcare insists that its almost identical clause is intended to protect patients from being put in the middle of economic disputes between doctors and the company.²⁹

The traditional medical-ethical norm of confidentiality is now invoked not to protect information about the patient, but to protect information about the MCO from the patient and others. For instance, another clause in the U.S. Healthcare contract states that the physician “shall keep the Propriety Information [payment rates, utilization review procedures, etc.] and this Agreement *strictly confidential*.” This is closer to trade secrets and the like than traditional medical-ethical confidentiality. Thus, however much their language resembles traditional medical confidentiality, MCOs justify these “gag clauses” largely by invoking business protections, such as trade secrets and proprietary information. This fits with the shift from a military metaphor to a market metaphor.

By contrast to MCOs’ concerns about publicity, Gerald Winslow argues, with specific reference to rationing, that the “demoralizing effect of publicity depends not so much on the practice of publicizing the rule as it does on the types of rules that are publicized. . . . In the end, we cannot eliminate many of the distressing costs of rationing medical care. But publicity should help us bear these burdens together.”³⁰ In arguing for a publicity test—actual as well as imaginary—I do not suppose that it answers all our problems. But, whether in self-referral or in accepting financial incentives to reduce services, “secrecy increases the ethical taint.”³¹ In addition, when patients know about their physician’s conflicts of obligation and conflicts of interest, they can take more vigorous actions, exercise legitimate options, make appeals, and so forth. It is only fair for people to know what kind of game they are playing, and it is particularly crucial to inform them when the rules of the game have changed. Disclosure is absolutely essential—morally necessary (though not morally sufficient). After all if patients have legitimate expectations about physician conduct, based on codes of medical ethics, past experiences, and so forth, then they have a right to assume that those traditional, customary obligations of fidelity and loyalty persist unless they are informed differently. Medicine has not traditionally been a matter of *caveat emptor* but of trust, and *caveat emptor* should not now reign even under the market metaphor. But when must enrollees in MCOs be informed and how?

Disclosure and Consent at the Time of Enrollment. Even though I have concentrated on physicians' obligations of disclosure in the context of managed care, nothing I have argued denies the importance of general or global disclosure at the time people enroll in particular plans. Such a disclosure should include the MCO's rationing scheme as well as its financial incentives for physicians to restrict access to medical services and procedures. In addition, it should include information about ways to appeal a physician's decision and the like.

One fundamental question concerns the moral significance of consent at the time of enrollment, based on adequate disclosure. However necessary it may be—and I certainly view it as necessary—is it also sufficient to obviate the need for physicians' specific disclosures later? First of all, although morally required, "global disclosure of rationing incentives, rules, and mechanisms . . . at the outset of enrollment . . . presently is not done, and the details of what should be disclosed still have to be worked out."³² Second, if such disclosure occurred at the time of enrollment, would it justify some subsequent rationing decisions without additional specific disclosure about the rationing incentives, rules, and mechanisms?

Mark Hall has proposed a "theory of economic informed consent" that in either of its two forms could justify, "silent rationing," i.e., rationing that is undisclosed at the time it occurs. General or global disclosure at the time of enrollment (or re-enrollment) in a managed care plan could be viewed as (1) "prior consent to the bundle of non-treatment decisions implicit in a more conservative (i.e., cost-sensitive) treatment style," or as (2) a valid waiver of the right to subsequent specific disclosures and consent at the time of actual rationing decisions. Prior consent, which Hall also calls "bundled consent," might appear to be an attractive way to combine respect for personal autonomy, represented by prior consent, with the successful management of health care costs. And there are relevant moral and legal analogies, for instance, when patients consent to treatment according to a certain standard of care by their choice of a particular type of physician or other health care professional. However, Hall suggests, it might in fact be easier to construe an informed enrollment decision as

“a waiver of the right to be informed when a chosen rationing mechanism denies costly treatment of marginal benefit.”³³

In either prior, bundled consent or prior waiver, some conditions need to be met. Obvious ones include adequate information and, in addition, voluntariness of choice. Hall identifies specific disclosures not only that the MCO rations health care but that physicians will not always disclose this at the time of specific decisions, that patients may ask questions at any time and that their questions will be answered thoroughly, and that some nontreatment decisions will always be disclosed at the time they are made because they are “so dramatic and high-stake”—such as not providing a potentially life-saving operation for a terminally ill patient.³⁴ Furthermore, Hall argues only that it is legitimate not to disclose, at the time of the rationing decision, treatment variations that fall within the standard of care.

Voluntariness of choice is also crucially important. For prior consent or waiver to be more than a fanciful exercise, enrollees must have more than one option. However, as I will note later, most employers provide only one plan, and this, Hall concedes, is “an important and potentially disabling objection” to his theory of economic informed consent.³⁵ In fact, it undermines his theory in the real world. At most, disclosure at the time of enrollment is morally necessary so that people will know what they’re getting into, but difficulties in understanding and in voluntariness of choices militate against making it sufficient, either morally or legally. Physicians cannot ignore their responsibilities of specific disclosure as fiduciaries for patients by appealing to their patients’ prior consent or waiver. Furthermore, specific disclosure at the time of rationing allows patients to take further actions, including appeals.

As morally necessary, though not sufficient, enrollment disclosure needs to include what is most important for enrollee/patient trust, since, in David Mechanic’s formulation, they are “basically purchasing trust.” Under such conditions, Mechanic argues, “information about specific clinical judgments is less important than understanding how organizational arrangements and contractual relationships between physicians and plans bear on trust.”³⁶ In this way, they can understand how the MCO’s operating incentives may make a differ-

ence in physicians' judgments about appropriate care "at the margins, or in situations of uncertainty."

Public Policies, Professional Character, and Social Ethics

Organizational Structures and Professional Character. Financial gain is generally a motive for professional life, but it becomes sinister as a motive for particular clinical choices. "It is hard to be a good doctor," Woolhandler and Himmelstein stress, "[t]he ways we are paid often distort our clinical and moral judgment and seldom improve it."³⁷

Clearly there are important interactions, not only between professionals and MCOs, but also between both and the larger society. Aristotle emphasized the close connection between social structures and the character of the individuals involved in them. Social structures and organizations are not made up of individuals, but rather of patterns of individual acts.

We have to be concerned about the kind of professional character, attitude, and outlook MCOs may over time tend to engender, and particularly what will happen to traits of loyalty and fidelity, of care and compassion, of (some) effacement of personal interest. MCOs reward motivations of self-interested behavior. And, as Marc Rodwin reminds us, such rewards have symbolic effects, legitimating effects, especially when socially supported or tolerated.³⁸ When MCOs use financial incentives to get physicians to curtail or limit services, they do not use neutral means to gain an end. These means will have (predictably negative) effects on professional character and, in the process, on public and patient trust, already at serious risk.

We cannot simply expect professionals to be immune to the effects of these incentives—if these incentives work, as they appear to do, then they will reshape professional character. Any realistic view of human nature will recognize that they will probably work in many, perhaps most, cases over time, especially because there is an abundant supply of physicians. Consider Elena Gates' case again and note how the obstetrics group had to consider the possible loss of 25% of its patient population. We cannot expect individuals, even in small groups, to resolve the ethical problems of managed care by themselves, and we should not expect too much sacrifice on their part.

However, some physicians and others will resist. We may praise the character of physicians and others for their conscientious objection or refusal—those who refuse to follow some HMO directives perhaps by breaching “gag rules” or by gaming the system by using deception to benefit their patients. Yet there are moral costs here too, particularly in cultivating professional traits of deceit and practices of deception. That this is not an insignificant concern is evident from a study that indicates that physicians would put “rule out cancer,” rather than “screening mammography,” when the latter was the reason for the mammogram, so that an insurance company would cover the costs of the procedure for the patient. According to the insurance company’s policies, “rule out cancer” indicates that there is a breast mass or objective clinical evidence of the possibility of cancer. Neither is present in this particular; the physician simply believes that annual mammograms are important for women in their fifties. Hence, putting “rule out cancer” is a way to deceive the insurance company to help the patient. However, in response to this scenario, almost seventy percent of the physicians surveyed indicated that they would put “rule out cancer,” and eighty-five percent of this group insisted that their act would not involve “deception.”³⁹ Perhaps they could deny that their act would involve deception because they thought that the insurance company did not have a right to the truth. Whatever their rationale, they did not discern even a *prima facie* moral problem with putting “rule out cancer.”

Others may resist by silently withdrawing from the MCO, without giving their reasons, while still others may blow the whistle. Dr. Himmelstein and a colleague wrote an exposé of MCO practices in the *New England Journal of Medicine*: “Until [needed] reforms are carried out, many physicians scrambling to preserve their careers will be tempted or forced into the corporate embrace. But if we shun the sick or withhold information to benefit ourselves, we conspire in the demise of our profession. Let us not end up like tobacco-company executives, who, repenting their sins, find that their contracts forbid confessing them.”⁴⁰ (Dr. Himmelstein was fired by his MCO after this exposé appeared, but the company said Himmelstein was not dismissed because of his efforts for government-financed health care. He was subsequently rehired.)

A range of non-compliant acts may express and protect an individual professional's conscience—conscientious objection or refusal, withdrawal, whistleblowing, etc. But the personal and professional costs may be quite significant, and some forms of non-compliance are themselves morally problematic. Furthermore, the decisions can be quite difficult—consider, for instance, an obstetrician in the case presented earlier trying to determine the responsible course of action if the group accepted the contract and decided not to disclose the financial incentives to patients.

Public Policies. Public policies are important not only to shape professional character but also to ensure certain minimum standards of conduct because it is not possible to rely on professional virtue in the context of managed care. Public policies need to prohibit, regulate, and mandate certain forms of organizational structure and professional action. In view of the ethical arguments I have presented about disclosure, policies should require adequate disclosure at the time of enrollment and during care, and it should prohibit “gag clauses,” as some states have done. Not only are there ethical grounds to remove the veil of secrecy, but, as Haavi Morreim reminds us, that veil has been pierced so much in recent years that it is hardly effective.

Beyond such information requirements, which are arguably necessary for informed consumers, public policies should also regulate MCOs in various ways by limiting what they may do. In the obstetrics case, the group would have to try to bring the length of stay for uncomplicated births down from 1.8 days to 1.3 days, and they would have a strong financial incentive to do so. Several states have set a standard for length of stays in hospital following uncomplicated deliveries, and this legislative action is symbolically as well as actually important.

Many find it easy to ridicule business ethics as inferior to medical ethics. But, as Marc Rodwin observes, “[s]urprisingly, physicians are not even held to standards that exist for many business professionals.”⁴¹ Physicians are not even held to the standards of accountability of some business professionals in conflicts of interest. To this point, both medical ethics and law have viewed physicians as fiduciaries for their patients—“seeing physicians as fiduciaries is a central metaphor

in health law and ethics today.”⁴² Managed care now severely threatens this metaphor. However, as Rodwin argues, the law holds physicians accountable as fiduciaries only in very circumscribed situations—mainly by prohibiting non-abandonment, and by requiring confidentiality and informed consent. The classic fiduciary relationship clearly involves considerable trust, and usually involves a disavowal, often legally enforced, of conflicts of interest. As yet, however, physicians are not subject to the conflict-of-interest prohibitions that obtain for most classic fiduciaries. “As patients,” Rodwin notes, “we would like doctors to work loyally for our individual interest. That is the crux of the fiduciary metaphor. Yet the law today goes only a small way in holding doctors to fiduciary standards. There are also significant social and financial demands for doctors to serve interests other than patients,” especially in the context of managed care.⁴³ At the very least the law should bring its requirements for physicians as fiduciaries in line with its requirements for other fiduciaries in avoiding conflicts of interest.

Constraining Choice and Limiting Access While Controlling Costs⁴⁴

The Illusion of Choice. The market metaphor’s emphasis on free choice is seriously misleading in the managed care revolution. The illusion of choice—rather than real choice—prevails. One constraint is that most individuals cannot even choose the health plan they pay for. While Americans typically choose their own home, automobile, and life insurance plan, their choices about access to health care providers and services are largely determined by their place of employment. Over seven out of ten Americans purchase health insurance at the workplace, and increasing numbers of those are enrolled in managed care plans that limit the choice of doctors.⁴⁵ Ideally, in an open market, they would be able to choose from various options, but, in reality, they face limited choices. Eighty-four percent of employers who offer health insurance to their employees offer only one plan,⁴⁶ and some of these plans offer a limited choice of providers. Such restrictions are allegedly justified by the need to reduce administrative and other costs. But the result is that employees have little say in their

health care, even though it is purchased through their copayments, deductibles, out-of-pocket cost sharing, and foregone wages.⁴⁷

The employer's need to control costs often conflicts with the employee's desire for certain services and providers. Employers change plans over time, and small businesses, in particular, often switch to less expensive health care coverage for their employees, further compromising continuity of care and constraining choice. In addition, the average worker changes jobs eight times over a lifetime, moving from one plan to another. Despite all the disadvantages of an employer-based health insurance system, it remains in place because of the tax-free status of the company-provided fringe benefit, Americans' largest tax break, worth approximately \$90 billion in federal, state, and local taxes.⁴⁸ Under the illusion of choice, it actually undermines individual choice in two ways: By disadvantaging those who wish to purchase health insurance outside the employment arena (where there is no tax relief and nongroup rates are markedly more expensive) and by substituting corporate decisions for consumer choices.

Finally, over 41 million people who are uninsured in this country, one-quarter of whom are children, have little choice in the type of health care they receive or how they receive it, if they can gain access to it at all. Traditionally, uncompensated indigent care has been provided—however incompletely and inadequately—by private and public hospitals that shift the costs onto their paying clients (patients and insurers). However, managed care programs severely limit such shifts, and states have not been able to provide sufficient coverage. In one study, 34 percent of the uninsured reported that over the previous year they had needed medical care but did not get it, and 71 percent stated that they had postponed medical care because they could not afford it.⁴⁹ Working Americans and their families without company-provided benefits often must go without care or purchase bare-bones policies with only catastrophic coverage. Either way, their choice about and their access to health services are severely limited. By all accounts managed care arrangements will further reduce the availability of health care to those with inadequate or no insurance, and further limit their choice.

In short, our new world of corporate managed care threatens choice in several interconnected ways—employers limit health plans, health plans limit physicians and hospitals, employees are limited in their ability to protect their interests or find other employment, and they usually lack other means of access to health care not provided by their health plans. These reductions of choice will continue without serious public accountability, unless major changes occur in societal discourse and policies.

Our society's failure to recognize and attempt to correct the limitations of managed care in part reflects its ambivalence regarding the role of the government. It also reflects our temptation, especially in times of economic exigency, to view the less fortunate as the victims of their own failures rather than as victims of a "natural lottery" or "social lottery."

Equitable Access to Health Care. Efficiency and cost control, values central to the market, will be destructive in health care unless balanced by a societal commitment to provide equitable access to quality care. In order to be ethically sound, managed care must include—or at least the broader society must include—equitable access to health care as a goal. Equitable access could occur (1) through increasing the social responsibility of MCOs beyond cost containment, or (2) through providing societal funds, to ensure equitable access within a general political-legal right to health care. In principle, the cost savings from managed care could be used to provide wider access to health care, but this will almost certainly not occur in practice without a fundamental societal commitment expressed in new policies to ensure equitable access to health care. For instance, in many MCOs, there is a temptation to shift risks or to neglect the needs of chronically ill populations in order to limit costs.⁵⁰ And, when we turn to the other option, our society has not yet displayed the political will to provide anything close to fair access to health care.

Perhaps managed care will contain the costs of health care. But there is no reason to believe that such cost containment will be accompanied by increased access to health care—so far there is little evidence of a societal commitment to use any cost savings to bring others into health care. Our de facto policy of managed care may thus address one problem of contemporary health care—its rapidly esca-

lating costs—while failing to attend adequately to access as well as to availability and quality. Without a societal perception of and commitment to resolve the problem of access, a less costly system will still remain an unjust system. The fact that it is less costly in no way diminishes its injustice. Managed care arrangements to control costs have their own costs, including threats to the integrity of physician-patient relationship, to public and patient trust in health care and health care professionals, and, ironically, to individual choice itself, particularly (but not only) because the society has failed to address serious, persistent limits on access to health care.

Endnotes

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- 11 See G. Annas, "Reframing the Debate on Health Care Reform by Replacing Our Metaphors," *New England Journal of Medicine* 332 (1995): 744-747, which has greatly influenced these paragraphs on the market metaphor.
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Managed Care: Some Basic Ethical Issues

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“Managed Care: Why, How and for Whom?”

John A. Sbarbaro, M.D., M.P.H.

“Health Care Professionalism in a New Age”

Steven Miles, M.D.

“Legal Accountability of Physicians and Health Plans:

Compassionate, Proportionate, or Extortionate?”

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“Ethics and Managed Care”

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