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Special Article

The Ethics of Cost Containment from the Anesthesiologist's Perspective

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Cost containment, as an essential part of current efforts to manage health care, has been examined thoroughly from the perspectives of finance and patient care. In this article, the ethics of cost containment are discussed from the vantage point of the health care provider. Cost-cutting initiatives, however necessary and sound, nevertheless may place anesthesiologists in situations of ethical conflict and ultimately interfere with their rights as workers and professionals. The anesthesiology community is encouraged to investigate the effect of cost-cutting measures on patients and physicians alike.

Keywords: Anesthesiology practice; cost containment; managed care; medical ethics.

Introduction

Cost containment is an essential part of the current effort to manage health care. Since the late 1970s, the rules of the free marketplace have dominated the economic and political functioning of health care,[1] placing cost containment and financial streamlining in the forefront. As a result, for-profit managed care, with its philosophy of delivering health care as a business commodity,[2] has grown tremendously. This has occurred primarily because of rising health care costs; health care expenditures in the United States comprise approximately 14% of the gross domestic product (GDP). This percentage is reflected in the cost of health care benefits that most employers extend to their employees, an expense that has become insupportable. In other highly developed countries no more than 8% to 10% of the GDP is spent on health, and, among their populations, life expectancy and the level of health care are not significantly different from what is found in the United States. Surely, in those countries, there sometimes is a longer waiting time for elective hospital admission and more government control of health insurance. Although physicians tend to cite outside forces (e.g., increasingly expensive diagnostic and therapeutic modalities, managed care company profit, and government agencies) as the cause of spiraling health care costs, physicians and patients must assume much of the responsibility for the situation as it now exists in the United States. Many years of provider-insurance agreements led to a situation in which physicians and hospitals

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provided care without consideration to cost, and by doing so, in a sense, created their own market. In the United States, governmental health insurance began in limited form in 1965, with the institution of the Medicare program. Traditional indemnity insurance has persisted, however, preferred by the population at large. This type of insurance led to prolonged hospitalizations, an increase in the number of tests and investigations, and the use of expensive medical equipment. Clearly, both patients and physicians, encouraged by the medical technology and pharmaceutical industries, share the responsibility for this uncontrolled inflation of health care expense. Thus, the health care industry is now faced with the necessity for outside regulation and aggressive cost containment initiatives.[1]

The issue of cost containment, its effect on quality of care, and the ethical implications involved have generated considerable discussion both in the medical and nonmedical literature. Much has been written about conflicts (physician self-interest *versus* the patient's best interest), the threat to the patient-physician relationship, and the detrimental effects on patient care that some strategies for cutting costs may create.[3] Most discussions have focused on the ultimate effect these pressures to contain costs have had on the final product—patient care—or how they impact on certain principles (e.g., autonomy, beneficence) from the *patient's* perspective.[4] We pose that an ethics analysis of cost-containment strategies that focuses purely on the effects on patient care from the patient's perspective is incomplete, and that the effects of cost containment pressures on the physician *from the perspective of the physician* as a stakeholder in the health care covenant deserve careful consideration. We argue that cost containment efforts, if carried to extremes, may place physicians in positions of conflict between their patients and their institutions (employers?) and, consequently, interfere with their rights as workers.

The Situation

Under pressure to succeed financially, medical institutions are seeking to cut costs wherever possible. "Economic credentialing"[5] has become a gauge of physician performance and a predictor of remuneration (e.g., it determines whether or not a physician is eligible for a "year-end bonus" from a managed care company).[6] In addition to economic credentialing, other financial incentives to contain costs include capitated reimbursement, other fee withholds, and even unilateral termination of managed care contracts by the managed care company.[6] Under these conditions, anesthesiology, with its costly intraoperative procedures, medications, and monitoring, attracts greater scrutiny; anesthesiologists now face the problems posed by cost containment.

The pressure to cut costs in anesthesiology is high.[7] It has been estimated that anesthesia accounts for approximately 5% to 6% of total hospitalization costs.[8,9] Only half of these costs are directly influenced by the anesthesiologist's clinical decision making,[8] particularly choice of pharmaceuticals, with neuromuscular blocking drugs and inhalational agents accounting for perhaps more than 50% of medication costs.[9] Choice of medications, therefore, has become an easy target for cost-containment measures, sometimes with considerable savings. Johnstone and Jozefczk[10] demonstrated a 23% savings in medication budget as a result of the substitution of less expensive for more expensive medications.

A 1-year study by Becker and Carrithers[11] found a 13% reduction in anesthesia drug costs with cost-containment measures in one hospital. This amounted to a total savings of $127,472 in a hospital with a yearly operating expense of approximately $350 million.[11] This figure may appear to be a mere "drop in the bucket" with respect to total operating expenses, but in this age of managed care and decreasing profit margins, even such small amounts represent a disproportionately important percentage of the hospital's budget balance. Not surprisingly then, a survey of 147 anesthesia departments found that 83% of respondents identified hospital administrators as the main source of pressure to reduce costs.[12] The same survey found that in 53% of the institutions policies or guidelines existed to reduce medication costs, and that in 48%, there were policies concerning anesthesia items other than drugs.[12]

Expensive medications are an easy mark, but other aspects of anesthesia care also have been targeted for cost containment.[7,13] These include, but are not limited to, decreasing the number of preoperative tests, using outpatient ambulatory surgery centers instead of inpatient surgery, administering general anesthesia, which can be more rapidly and therefore more economically induced than regional anesthesia, limiting the use of blood products, using low-flow anesthesia, re-using disposable breathing circuits, reducing the use of warming blankets and monitoring devices, eliminating premedication with anxiolytics, and avoiding wastage of materials and medications.[11]

As mentioned above, cost-saving measures in the operating room (OR) are not limited to those costs directly controlled by the anesthesiologist.[8] According to Valenzuela and Johnstone,[12] "Costs of anesthesiology services generally derive from three sources: the professional providers of care, the technology used, and the overhead expenses of the facility where anesthesia is administered." Personnel costs contribute greatly to the overall expense for OR time,[14] accounting for perhaps more than 60% of the average anesthesia department's budget.[7] In a survey by Valenzuela and Johnstone[12] of 147 anesthesia departments, 90% of respondents reported efforts to improve operating room utilization. A different study in 1992 showed similar results with "the main cost containment activity being the cost-efficient management of anesthesia personnel."[12] Examples of such efforts include "cross-training of personnel, replacement of scrub nurses by operating room technicians, and a more flexible work schedule arrangement to match supply and demand for personnel."[13] Emphasis has also been placed on decreasing OR turnover time between cases.[9] Many departments are experimenting with part-time staffing and downsizing.[9]

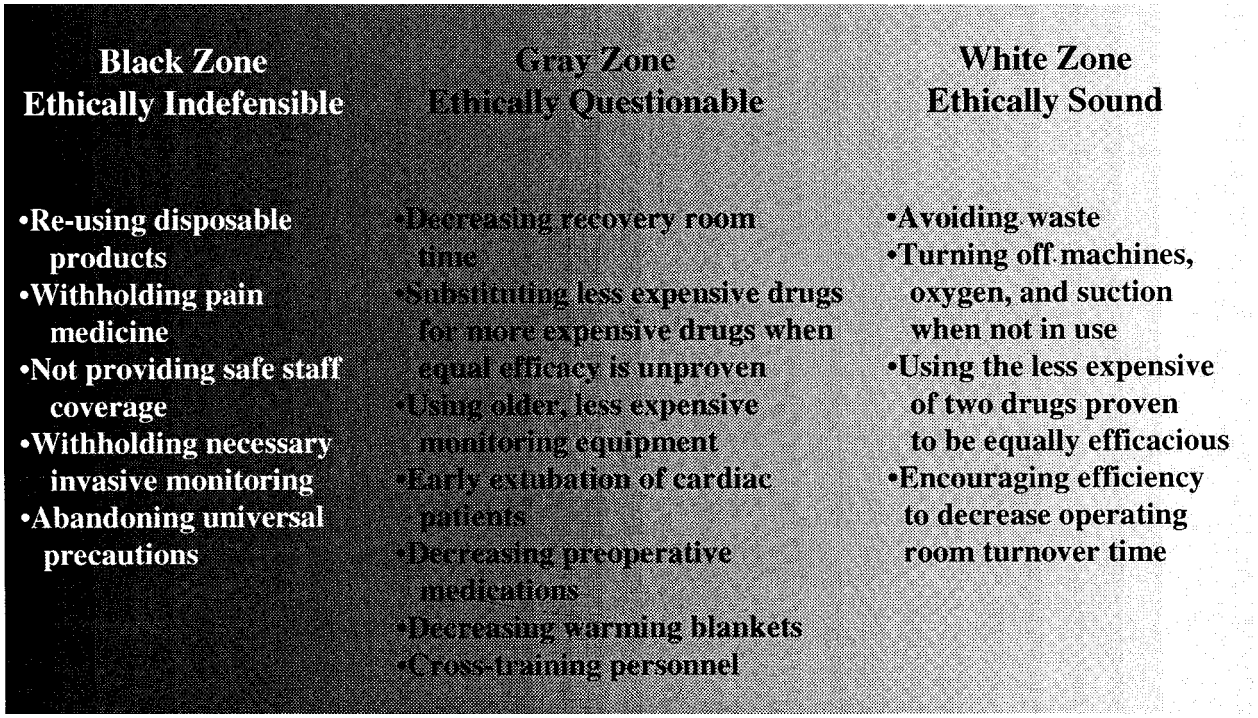

Figure 1. Cost containment strategies in anesthesia on an ethical continuum.

The Ethical Continuum

Although hospitals must contain costs, it is clear that many different approaches to cost cutting exist. One can envision cost-containing strategies as a continuum from ethically sound to ethically insupportable measures (*Figure 1*). For strategies falling at either end of the continuum, the issues are clear. For example, reducing the waste of materials by shutting off the anesthesia machine and suction when not in use, or choosing the less expensive of two equally effective medications, is ethically sound. On the other hand, such measures as cutting staff so that safe coverage of cases is impaired, or withholding necessary invasive monitoring, is clearly unethical.

Most cost-containment measures lie somewhere in the intermediate "gray zone," subjecting the anesthesiologist to uncertainty as to whether his or her obligation of providing optimal patient care is compromised. Clearly, if the anesthesiologist could be reasonably certain that the best interests of the patient were not undermined, then these waters could be navigated easily. Unfortunately, for the majority of these measures in the "gray zone," such information does not exist. Current research aims to establish the effects of cost containment on quality of care and patient outcome.[15,16] Nevertheless, much remains unclear or unknown.[17] Moreover, some of what constitutes the art of medicine may remain unquantifiable, and its value may not become apparent under the scrutiny of traditional research methods.

As physicians, anesthesiologists are trained to be caring patient advocates and to have the paramount obligation (ethically and professionally) to do what is best for their patients.[13] As individuals and medical staff, they also have obligations to their families to earn a livelihood, and to the institution where they practice. These pressures could, on occasion, lead the anesthesiologist to place his obligation to the institution and its ability to attract future patients above the needs of the individual he is currently treating. This could ultimately undermine the anesthesiologist's confidence in the level of care he can provide and lead him to believe that this may be inimical to his professional obligations. Ironically, as some anesthesiologists are pressured to forego certain invasive monitoring techniques, they are still expected (and feel obligated) to provide optimal care to a patient population that is aging and growing more seriously ill. Anesthesiologists are trained to be perfectionists, but they may feel compelled to practice what they perceive to be mediocre medicine. The unseen and as yet unrecognized emotional stress that this internal conflict may have on the practitioner cannot be ignored.

Such stress and conflict is experienced on a daily basis by many health care workers, not only anesthesiologists.[2] Cost containment requires critical assessments of cost-to-benefit ratios. In some instances, however, the focus is on cost, independent of benefit and quality of care.

Physician Rights and Business Obligations

In this consideration of the ethics of cost containment, the interests and welfare of the patient are clearly paramount. Nevertheless, one should not lose sight of the needs and rights of the health care providers who strive for optimal patient care. If one accepts the idea that the workers have

certain inalienable rights (i.e., the right to receive fair wages, to have safe working conditions, and work satisfaction), then one must also accept that the employer is ethically obligated to respect those rights, and that the employer-employee relationship is a social contract as well as an economic one.[18]

As health care gradually shifts from a cottage industry model to an industrialized business, and the position of physicians moves from self-employment to being employed, new workplace pressures are being placed on them. Instead of being free to decide courses of treatment based solely on perceived patient needs, doctors must consider a third party in the traditional doctor-patient relationship—the insurer. Pressures to protect profits through cost-cutting strategies create a new set of ethical problems for physicians. The emphasis on cutting costs, from the physician's perspective, may create a work environment that prevents the anesthesiologist from being certain that he has provided the excellent care he is obligated to deliver and for which he is trained. This has the potential to undermine the physician's right to be able to do meaningful and satisfying work. As professionals whose work encompasses alleviation of suffering and the compassionate attempt to heal the sick and injured, it is likely that the ethical standards of physicians are, on the average, higher than those of workers in other fields. Therefore, one might expect that pressures to deviate from the highest standards of care in the expectation of ensuring greater profits would create painful dilemmas for physicians. Additionally, the pressure to cut costs promotes staff downsizing and cross-training, situations that may contribute to low morale. This can cause a potentially hostile or harried work environment. These pressures, if they interfere with workers' rights, become ethically suspect.

This potential conflict between the rights of workers and the interests of the employer is ubiquitous in business. For example, in 1967, the B.F. Goodrich Company won a lucrative new contract to build brakes and wheel assemblies for a new Air Force jet.[19] The junior engineer assigned to the project discovered a serious design flaw. Bringing it to the attention of the senior engineering staff, he was coerced into falsifying prototype test data so that production could continue. The test flights were plagued by brake problems resulting in several near crashes, almost killing the test pilot.

Within the continuum of cost containment measures discussed earlier (*Figure 1*), the B.F. Goodrich case clearly falls in the black zone. Although this is an extreme case of infringement on the right to satisfactory working conditions, one should consider whether the environment created by the current cost-containing strategies in health care similarly diminishes, though to a lesser extent, the sense of professionalism and job satisfaction.

Historically, the employer-employee relationship in United States business has been ruled by the "employment-at-will" (EAW) doctrine, an implied legal agreement in effect since the 1884 court case *Payne v. Western A.R.R. Co.*[18] Essentially, it states the belief that employers have the right to terminate employment without giving a reason, and an employee can quit whenever he desires. However, since the 1930s, state and federal legislation has altered the EAW doctrine and defined the employer-employee relationship as a social contract of rights and obligations beyond the narrow scope of EAW.[18] Employees have certain rights, which imply a legal and moral duty on the part of the employer: "Employers are obliged to pay employees fair wages, to provide safe working conditions, and to provide meaningful work."[18] The obligation to provide meaningful work refers to the *environment* in which the work is done as well as the nature of the work: "Employers are obliged to offer employees working conditions that provide meaningful work and job satisfaction."[18] Employees also have certain moral rights (moral entitlement) by virtue of being human beings.[20] Moral entitlements are nonnegotiable (e.g., the right of due process) and represent "a general and presumptive moral entitlement of any employee to receive certain goods to be protected from certain harms in the workplace."[18]

Most ethicists concede that with respect to business, "without ethics the only restraint is the law."[21] In medicine, as in business, it is far better (and probably necessary) to promote ethical standards in order to protect all parties. Zoloth-Dorfman and Rubin state the following:

> . . . the growth of the managed-care marketplace can in many ways be compared to the rapid growth and economic vigor of the unfettered marketplace of the 19th century, which was based on an understanding and ingenious grasp of new technologies and new financial instruments. However, then, as now, what is needed is careful social review and discussion about the limits and excesses of such a system, and the staunch ethical and legal protection of those who are most vulnerable and who are therefore most likely to be harmed: workers and consumers.[2]

Different schools of thought exist among ethicists on the extent of social responsibility that business holds. Generally speaking, they range from a productivist model, which poses that the sole responsibility of business is to make a profit, directly satisfying stockholder expectations, to a stakeholder model of ethical idealism, which contends that business should help workers realize their human potential and that profits should be used to bring about a more humane society.[18] Stakeholders include the "customers, suppliers, the community, [and] employees."[22] Obviously, there is a spectrum of views within the extremes.

Although practically speaking, business is not expected to adopt a stance of radical ethical idealism, it can be argued that the business of managing the health care of human beings and their right to high-quality care lends itself to a progressive model of social responsibility. Elizabeth Vallance, business ethicist and chairman of St. George's Healthcare Trust, states:

> The ethical corporation is not defined as one which abides by legislation; ethics is not merely compliance. Rather, the ethical corporation will normally obey the law as the basic minimum response in any problematic situation in which it finds itself. But it will do more than this: it will be aware of its obligations to those

inside and outside the company who are affected by its actions and whose interests will be reflected in its values.[23]

This includes, of course, a recognition of the basic rights of those workers involved in producing the business' end-product.

The environment for health care professionals today is little different from that in industry mentioned above; it is just a matter of degree. Health care reform and the managed care market have made some physicians direct employees of managed care organizations and/or hospitals. Managed care companies now control such a large share of the market ("covered lives") that many physicians have no choice but to contract with these agencies, lest they have so few patients that they cannot earn a living. When seen as employees, physicians, as well as other health care providers, have the same inalienable rights as employees in the general workforce. Consequently, the *environment and working conditions* in which physicians find themselves, i.e., those created by the pressures of cost reduction, must protect the rights of the physician-workers. Although the strategies employed for cost containment are not inherently morally or ethically unacceptable, if these strategies and pressures infringe upon the rights of the employees, they approach being of questionable ethics. In the case of anesthesiologists, if their working environment is affected by cost-cutting measures to the point where they cannot practice according to accepted professional standards (thus far we do not believe this is the case), their rights as workers will be infringed upon.

Ironically, at a time when research is most needed to clarify the effects on patient care of cost-containing strategies in the "gray zone," economic pressures are forcing many departments to reduce or eliminate the amount of research performed.[14] It is highly desirable that anesthesiology departments continue to investigate the effects of cost containment on patients and physicians alike. It is equally desirable that anesthesiologists (and other health care professionals) take an active role in protecting the ethics of their practice from extraneous considerations. The goal should be to ensure that the anesthesiologists' professionalism and, ultimately, patient care are not threatened.

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