An Ethical Evaluation of the PACE Program

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I. Introduction

The World Medical Association's physician oath declares that "the health of my patient will be my first consideration," and that "the interests of the subject must always prevail over the interests of science and society."[1] We all would hope that our physicians uphold these ideals, but the rise of managed care organizations (MCO) has greatly undermined a physicians' capacity to do so. Since the inception of MCOs the physician has experienced conflicts-of-interest that have led to increased responsibility to the group at the expense of the individuals' care. You may ask: why should I care? Because your physician may have denied or failed to inform you of a beneficial treatment because it is not covered by your insurance company. This paper will focus on the ethical stature of a new type of managed care system called the Program for All-Inclusive Care for the Elderly (PACE).

PACE is a progressive MCO in Chattanooga with a revolutionary delivery system. Their major goal is to provide good healthcare to the highest-risk patients – urban citizens who are poor, frail, and elderly. This means they cater to inner-city elders of the lowest socio-economic bracket. A literature search yields extensive discussion of PACE's financial structure yet no discussion about its ethical practices. My goal is to explicate the potential conflicts of interest and determine whether PACE has adequate mechanisms

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[1] WMA website. Accessed 4/15/04. http://www.wma.net/e/policy/c8.htm

for resolving such conflicts. To do this I will adapt the arguments for and against distributive justice in Managed Care Organizations (MCO) to the PACE program. To aide my literature based research I carried out interviews with physicians, nurses, social workers and chaplains at PACE, Chattanooga to gather some firsthand accounts of PACE's ethical practices.

The goal of my thesis is to determine if the PACE structure contains adequate measures to alleviate the conflict between obligations to participants and obligations to protect the financial well being of the program. I have isolated three important mechanisms built into the PACE structure for combating conflicts between the physicians' obligation to the patient's best interest and to the financial stability of the program. Despite the many arguments for and against distributive justice in the managed care setting, I will argue that PACE is adequately equipped to alleviate the tension. PACE's unique structure allows the physician to manage the fundamentally opposed goals of maintaining a healthy trusting patient-physician relationship while simultaneously protecting the financial viability of the program. To understand the arguments for and against PACE's ethical decision-making process, it is necessary to have a basic understanding of it's structure.

II. Overview of Healthcare System

Over the last thirty years the U.S. healthcare delivery system has experienced many changes. The literature, however, has remained relatively constant in its perception of a physician's ethical responsibility. Through the seventies and early eighties the U.S. healthcare system was dominated by a fee-for-service system where the patient pays the physician for each procedure. In this type of system the physician experienced few

conflicts of interest that compromised optimal care for the patient – there were no groups to worry about or third party payers restricting treatments. The physician's conflict of interest was between providing optimal care for the patient and excessive care that increased revenue.[2] The fee-for-service system became problematic when some physicians began exploiting their patients for financial gain by ordering too many unnecessary tests, which drove healthcare prices to inaccessible levels.

The desire to suppress these problems and lower treatment costs ushered in our current healthcare system directed by MCOs that both standardize prices and function as a watchdog to protect from excessive treatment.[3] Enrollment in PACE programs is increased by twenty five times between 1991 and 2001.[4] MCOs were a marketable scheme because the individual payed one premium every month and was guaranteed healthcare, no matter what the cost. What advertisements don't emphasize is that MCOs are often for-profit and consequently have an obvious monetary conflict of interest that often prevents patients from receiving optimal care and sometimes compromises adequate care. The major conflict of interest in all of these organizations is between quality of patient care and physician or corporate financial gain. PACE faces similar conflicts to other MCOs, but it has some fundamental differences that appear to fortify it against unethical behavior. First, the conflict of interest is program viability not physician financial gain. Intuitively, this appears to me morally choice-worthy because the physician's greediness is removed from the equation. Taking greed's place, the major conflicting consideration becomes the continued care of the other participants in the

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[2] Sulmasy D. et al,. "Physicians, cost control and ethics." Annals of Internal Medicine 116, no. 11 : 924.
[3] Rodwin M, "Sounding Board: Conflicts in Managed Care." NEJM 332, no. 9 (1995):604
[4] PACE National website

program. This means that the physicians may be faced with situations where denying a patient a procedure is in the best interest of the other 267 participants in the program. If the physician fails to deny an expensive procedure, he may set a precedent that leads to an unsustainable practice. To understand the increased pressure of this conflict – it is important to be familiar with the program.

III. Origin of PACE

The current PACE program is modeled after a demonstration project in San Francisco's Chinatown-North Beach area called On Lok (Cantonese for "peaceful happy abode"). The original idea was that the elderly population could avert institutionalization and continue living at home if they were provided with daily health and social services. The program's success attracted the support of several foundations that elevated the prototype to the national level.[5] In 1997 the Alexian Brothers Health System (ABHS) passed a resolution to develop a PACE program in Chattanooga, Tennessee. ABHS is a Christian organization that operates hospitals, nursing homes, assisted living centers, affordable housing, continued care retirement communities and now a PACE program. It is important to note that ABHS provided the necessary capital, absorbed deficits accrued during the programs infancy and consequently lay claim to any profits.

IV. PACE Participant Profile

PACE serves the highest-risk population in our nation—those who are old, frail, and poor. To be accepted to the program the applicant must be: 1) 55+ years of age, 2) living

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[5] Lee W et al, "A model for integrated care of frail older patients," Geriatrics 53, no. 6 (1998) : 62.

in Hamilton County Tennessee, 3) deemed appropriate for PACE by a two tier assessment procedure, and 4) Tenncare certified for nursing home care. The average PACE participant is 86 years of age, has 8.4 medical conditions, and needs assistance with 2.9 of the 5 activities of daily living (ADLs).[6] About half of the participants also have moderate to severe dementia.[7] Despite the many and varying ailments over 90 percent of PACE participants continue living in the community.[8] The latter statistic seems hard to believe considering the frailty of the population. Rollins points out the source of PACE's success:

> Success with such a vulnerable population requires very strong primary care. The idea is to aggressively manage enrollees, continually adjusting their care plans and reacting to even the slightest change in their condition to keep them as healthy as possibly and out of high-end care for as long as possible.[9]

This leads us to ask what about PACE's healthcare delivery system allows it to have superior results? The answer involves their emphasis on primary care and the streamlined manner in which care is delivered.

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[6] The five basic "Activities of Daily Living" are bathing, dressing, toileting, transferring, and eating.
[7] Case Study of Alexian Brothers Community Services Chattanooga, TN
[8] PACE National Website, <www.natlpaceassn.org/content/research/who_served.asp> accessed 1/06/04
[9] Rollins G. "Newly recognized PACE programs benefit patients, providers, payers. Hefty investment, new care model slows growth." Executive solutions for healthcare management. 2 no. 6 (1999): 13-6

V. What services does PACE provide?

Once a participant has been accepted to the program they have access to an incredible amount of services. PACE provides transportation for its participants to and from the center several times a week, depending on the patients needs. At the center itself participants have access to physician services, nursing, basic laboratory testing, social work, physical therapy, occupational therapy, speech therapy, recreational therapy, social activities, nutritional counseling, personal care (bathing and grooming), spiritual care, and meals. While in the community PACE participants have access to a 24-hour on-call physician, home health care services, homemaker/chore services, home-delivered meals, and adaptation of the home for disability. The program also offers referrals to specialists including: audiologists (hearing-aids), dentists, optometrists, podiatrists, and mental counselors. PACE benefits also include all prescriptions, preventative health services (influenza immunization), non-emergency transportation to specialists, lab tests and procedures, medical equipment and supplies, radiology, outpatient surgery, ER visits, and ambulance transportation. If necessary, PACE will also pay for hospitalization and institutionalization.[10]

The most fundamental guiding principle that sets PACE apart from standard MCOs is the "shift in care philosophy that emphasizes preventing declines rather than restoring functional impairments."[11] Most providers cover a wide range of preventative care, but PACE is more proactive and comprehensive than any other program. The general attitude of PACE administrators, physicians and employees in Chattanooga is that their

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[10] www.alexianbrotherssoutheast.com/pace.html accessed 1/05/04
[11] Rollins, 14

patients are receiving exceptional care. This belief is supported by a study done in 2000 that reviewed the quality of care at PACE sites around the nation. It revealed that: "in more than 90% of cases overall care was rated as good as or better than an acceptable standard, and PACE enrollees with a better than expected quality of life outnumbered those with a worse than expected quality of life by more than 2 to 1."[12] Many attribute this statistic to PACE's ability to keep the participants living in their community.

VI. PACE Financial Overview.

As with any MCO, the conflicts of interest PACE physicians are susceptible is rooted in their financial structure. PACE operates on a utilitarian financial structure, specifically catering to financially disadvantaged elderly who are eligible for both Medicare and Medicaid.[13] The government pays the program a flat capitated rate of $_____ which is equal to 95% of standard Medicaid covered care, plus the standard Medicare rate with a risk adjustment factor of 2.39.[14] Since the Chattanooga PACE program has a population of 268 participants the yearly budget is $_____. In order to maintain financial viability PACE expenditures must not exceed the capitation revenue.[15]

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[12] Pacala JT, "Using Structured Implicit Review to Assess Quality of Care in PACE." J Amer Geriatrics Soc 48 no 8 (2000):903-10

[13] Medicare coverage is earned by contributing to Social Security and provides for inpatient hospital care, critical access hospitals, and skilled nursing facilities (not custodial or long-term care), hospice care, and some home health care. A supplemental program called Medicare B has a minimal fee of $58.70 in 2003 and helps cover doctors' services, outpatient hospital care, and physical and occupational therapy. Medicaid is a joint Federal and State program that helps pay medical costs for elderly citizens with limited incomes and resources. It provides coverage for things like nursing home care, home care, and outpatient prescription drugs that aren't covered by standard Medicare.

[14] Case Study of ABCS PACE

[15] Case Study of ABCS PACE

Since "all payments are pooled by the PACE site and used without regard to traditional restrictions, providers have greater flexibility to render needed services."[16] Administration, physicians, and social workers all agree that the most valuable aspect of PACE is the flexibility it has to provide care both medically and socially. The following is an exemplary case where PACE was able to improve a patient's health with non-medical assistance – an impossible feat under standard medicare. He is a double-amputee diabetic with no teeth. In addition to his disabilities he developed sores on his hands and arms that prevented mobility. After being accepted to PACE, the nursing staff tended his wounds and taught him to check his own insulin. The dietician taught him the importance of good nutrition for his condition while the social workers purchased new crutches, dentures, and a microwave so he could fix hot meals for himself at home. After several months the man's health and quality of life had improved dramatically. "Try getting Medicare to buy a microwave for a patient…PACE allows you to manage the frailest individual without losing money and allows you to get creative and truly manage care." [17]

Lee and et Al. argue that "what distinguishes PACE from traditional fee-for-service or most managed care systems is that all services are provided in an integrated fashion at one center by an interdisciplinary team. PACE takes responsibility for providing social and all healthcare services to the frail older patient."[18] It is important to reemphasize the commitment PACE makes to its participants—PACE guarantees and delivers complete

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[16] Hansen JC, "Practical Lessons for Delivering Integrated Services in a Changing Environment: The PACE Model," *Generations* 23 no 2 (1999):22-8
[17] PACE website
[18] Lee W, Eng C, Fox N, Etienne M,. "A model for integrated care of frail older patients." Geriatrics 53 no 6 (1998):62+.

care for its patients. It seems counter-intuitive that PACE can provide more services for less money. How is this possible?

VII. **Financial Conflicts of Interest-**

PACE promotes several goals that can conflict: cost-containment, increasing efficiency, eliminating needless treatments, emphasis on preventative care, attempting to keep the majority of treatments "in-house," and PACE's ultimate goal of improving participant quality of life. Often these diverse goals mutually reinforce each other. Emphasizing preventative care keeps the patient healthy for the patient's sake and is also cost-efficient by precluding hospitalization or institutionalization. Existence of an inter-disciplinary team allows for better communication and consequently better care, while simultaneously eliminating redundancies in treatment.

Despite these positive associations there are also inherent tensions between the various goals. Cost-containment can eliminate beneficial treatments leading to less than optimal care. Increasing efficiency can lead to a conveyer belt method of treatment that decreases personal attention. The desire to streamline treatment by keeping many procedures "in house" can isolate physicians from the field of medicine and prevent them from practicing according to accepted standards. Promoting one objective frequently requires trade-offs with another. These are the predicaments that cause the conflicts of interest for PACE physicians. During an interview at PACE I asked Dr. Sheldon about his thought process when deciding to limit treatments for his patients. He replied:

> Unfortunately for me it's very practically related back to economics. Although I try to take that out—I'm an MCO. I would never deny care that would prevent my patients from recovering, but at the same time I have an absolute finite resource.

> When that resource is gone, I have to close my practice and 267 other people or more lose their services.[19]

Though most physicians become squeamish when talking about money and treatment plans, Dr. Sheldon's candor exuded a refreshing realism that sets him apart from the majority of the literature.

VIII. PACE Risk Management

In a financial structure with limited funds PACE has accepted an extraordinary risk by choosing the most disadvantaged cliental. PACE manages its daily financial risk by keeping the participant and his/her home environment as healthy as possible. In addition to the preventative care programs, PACE focuses on fighting learned helplessness. People are happier and healthier when they are assisted to do things for themselves. Since the majority of daily care is provided by family volunteers, the social workers at PACE arrange temporary respite care to relieve caregiver stress. When patients are admitted to institutions, a PACE hospitalist/social worker ensures proper care and works to discharge the patient at a prudent time. Probably the most effective cost-containment tool PACE uses is the advanced directive:

> One of the keys to managing risk in a PACE program is getting as many participants as possible to have a signed Advance Directive. We make sure we go through a process where we talk to participants and their families about what they want. Once people are educated about the trade offs, many participants at the end of their life will choose a less aggressive approach…The PACE program will respect the participant's wishes and provide non-futile aggressive care, as long as the participant desires it.[20]

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[19] Dr. Scott Sheldon, interview by Austin Cox, 4 March 2004.
[20] Case Study of ABCS PACE, 15

Advanced directive, in this situation, have a two-fold benefit. Firstly, they respect patient autonomy by objectively informing the patient of possible treatments and allowing them to make a decision in advance. Secondly, once patients are aware of the brutality involved in CPR, ventilation, and other life-extending measures they refuse them which results in decreased expenditures for the program.

IX. The Argument Section

An exhaustive literature search of PACE yields articles focusing on finances, quality control, start-up problems, or general laudatory articles noting it's progressive nature – but nothing on its ethical status. I believe this gap in the literature needs to be filled, especially considering that nationally the program is twenty-five times larger than it was in the early nineties.[21] The goal of my thesis is to determine if PACE is adequately equipped to deal with the ethical problems that plague the managed care system. A full explanation of the current healthcare system's problems is beyond the scope of this paper. It will be sufficient to note that physicians, patients, the government and society at large are attempting to reconcile the conflicting obligations medicine has to it's patient and to society. The literature is divided with one camp pledging allegiance to the best interest of the patient and the other to the best interest of the group. I believe there is a third unique pragmatic perspective that recognizes the necessity of both professional fidelity and cost-containment. To begin my evaluation of PACE I will outline the arguments for these three camps: patient-centered ethic, population-based ethic and what I have termed the

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[21] National PACE website.

tragic realist perspective. I will then present three financial predicaments in order to determine if PACE has adequate mechanisms emplace to deal with these conflicts.

X. MODEL 1. Patient-centered ethics.

A dominating perspective in the literature is a group of physicians advancing a patient-centered ethic.[22,23,24,25,26,27,28] Subscribing to a patient-centered ethic means that a physician considers the patient's best interest as paramount to all other considerations. The prevailing argument in the literature for this position appeals to the negative consequences of not accepting patient-advocacy as superior to social obligations. The AMA argues that trust in the patient-physician relationship is undermined when the patient feels the physician has ulterior motives. The ramifications of their position is that physicians must divorce themselves from all conflicts of interest (society, third-party payers, or personal financial gain) and make treatment decisions based only on the best interest of the patient.

In the 1995 article "Ethical Issues in Managed Care", The American Medical Association "concluded that patient welfare must remain the first consideration of physicians working in health maintenance organizations (HMOs)."[29] It is their belief that trust is the foundation of the patient-physician relationship and consequently must be

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[22] AMA, Council on Ethical and Judicial Affairs, (1995) *JAMA* 273(4):330-35
[23] Abrams FR, "Patient Advocate or Secret Agent." JAMA 256 no 13 (1986): 1784-85
[24] Emanuel EJ, Dubler NN, "Preserving the Physician-Patient Relationship in the Era of Managed Care." JAMA 273 no. 4 (1995) 323-39
[25] Sulmasy,
[26] Friedenberg RM, "Managed Care and Social Justice," Radiology 217 (2000): 11-13.
[27] Kassirer JP, "Managing Care – Should We Adopt A New Ethic." NEJM 339 (1998):397-8
[28] Pellegrino ED. "Interests, Obligations, and Justice: some notes toward an ethic of managed care." Journal of Clinical Ethics 6 (1995): 312-17
[29] AMA, 330

preserved. Trust enables patients to communicate private information. Patient trust allows patients to place their health and lives in the hands of their physicians. The authors emphasize that without trust, the success of the healing process would be seriously diminished. Physicians are the only party with the knowledge and authority to be true patient advocates. If a physician shirks his commitment to patient interests, there is no assurance that the patient's health and well-being will be protected. Since the only mechanism for ensuring a patient's health is to require physicians to respect the primacy of patient advocacy, then it seems obligatory that we do so. In summary patient awareness of cost-containing measures degrades the trust felt by the patient for his/her treating physician because they realize that the physician will not provide optimal care, but merely acceptable care. [30]

Richard Friedenberg recognizes and disregards the physicians' social responsibility in his statement, "although we as physicians must be responsible for community and social health, we must not let this occur at the expense of the individual patient; he or she is our first responsibility."[31] I interpret this to mean that regardless of the social and financial constraints, the only ethical action is to provide each individual all materially beneficial treatments. In addition Friedenberg summarizes the problem as a "basic conflict between medical ethics and medical economics."[32] Combined with his belief that the physician is capable of being loyal to only one entity in the system, the only ethical choice is to become the patient advocate.

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[30] AMA, 331
[31] Friedenberg, 12
[32] Friedenberg 11

XI. Model 2. Population-based ethics.

The opposing perspective in the literature holds that physicians have a primary obligation to practice medicine within society's financial constraints.[333435] Subscribing to a population-based ethic forces physicians to hold the good of the group as more important than the care of each individual. Under this model, it will not only be necessary but obligatory to deny care in some circumstances – either because the treatment benefits do not justify the cost or simply because the funds could be better used. This is a serious moral predicament for many physicians. David Eddy, a proponent of population-based ethics "recognizes that the discomfort is caused by a noble instinct, which is to try to help any individual we see in trouble. Trying to maximize the care we give to our personal patients is not a successful method for achieving the requirement that we keep costs within a limited budget."[36] Whether we call them financial conservatives or realists, their goal is to achieve a sustainable medicine.[37]

Because David Eddy's article, "Principles for Making Difficult Decisions in Difficult Times," explicitly captures this position I will provide the argument in its unaltered form:

1. The financial resources available to provide health care to a population are limited.

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[33] Berenson & Hall, "Ethical Practice in Managed Care: A Dose of Realism," Annals of Internal Medicine 128 no. 5 (1998) 395-402
[34] Eddy D, "Principles for Making Difficult Decisions in Difficult Times." Jama 271 no 22 (1994):1792-8
[35] Pearson SD, "Caring and Cost: The Challenge for Physician Advocacy." Annals of Internal Medicine 133 no. 2, (2000):148-53
[36] Eddy DM, 1794

2. Because financial resources are limited, when deciding about the appropriateness of treatments it is both valid and important to consider the financial costs of the treatments.

3. Because financial resources are limited, it is necessary to set priorities.

4. A consequence of priority setting is that it will not be possible to cover, from shared resources, every treatment that might have some benefit.

5. The objective of healthcare is to maximize the health of the population served, subject to the available resources.[38]

Since PACE is a capitated program it has no choice but to accept the reality of premise one. Premises two, three and four follow directly from one with little controversy. Premise four requires qualification – it operates on the implicit premise that providing every treatment that might have some benefit to every patient is an endeavor that requires infinite resources. Not accepting this premise is to expect the infinite from the finite. Premise five is what distinguishes proponents of population-based ethics from all others. In essence they have asserted that the overarching goal of medicine is to maximize population health. Advocates of this position respond to the tension between care by urging physicians to ration expensive treatments that yield minimal benefits. Physicians are advised to practice responsible medicine because the system functions on limited resources. This means that they should consciously participate in rationing by saying "no" to patients' requests for some marginally beneficial services.[39]

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[38] Eddy DM, 1793
[39] Pearson SD, 148

XII. Model 3. The Tragic realist perspective.

David Bloche takes the middle ground that places him in a third group that is at odds with both of the previous models. He criticizes the first two models on the grounds that conflicts of interest are extremely complex and not reconcilable by "a simple elegant algorithm."[40] I characterize his approach as pragmatic because it preserves elements of both the obligation to care for the individual while simultaneously striving to uphold medicine's societal responsibility. In opposition to the first two, model three recognizes that the conflict cannot be ultimately solved by mandating physicians uphold a single principle. As Bloche describes it, "the approach should be sensitive to both the moral import of medicine's social purposes and the ethical significance of fidelity to patients." The intent is to develop a method for mediating the necessity of cost-containment with the moral obligation physicians have to their patients.[41]

Tackling this inherent conflict in the healthcare system is not as simple as pledging allegiance either to clinical fidelity or to rationing of individuals' treatments for the good of society.[42] On the contrary, physicians should assess the harms and benefits to the individual patient, and consider the amount of strain the treatment places on society. Bloche, however stipulates that it is imperative that physicians be faithful to their patients and should not simply "adhere to disembodied principles. Assessment of social costs and benefits of breaches of fidelity should be done from a perspective sympathetic to the

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[40] Bloche DM, "Clinical Loyalties and Medicine's Social Purposes." JAMA 281 no 3 (1999):268-73

[41] Bloche, 269

[42] Beauchamp, T.L., Childress, J.F. Principles of Biomedical Ethics, 5th ed. New York: Oxford Press, 2001.

experiences of trust and betrayal."[43] Though the dual considerations complicate the decision-making process, Bloche believes that to omit either from medical decisions would be a travesty.

Beauchamp and Childress support Bloche's pragmatic perspective, but phrase their position in more mild terms. The following quote illustrates their method for managing ethically troublesome cases:

> Divided loyalty also occurs when fidelity to patients, subjects, or clients conflicts with allegiance to colleagues, institutions, funding agencies, corporations, or the state. In these cases, two or more roles and associated loyalties and their obligations become incompatible and irreconcilable, forcing a moral choice between them. This choice may alter the landscape of one's commitments. A divided loyalty can be reconciled only, by giving up or seriously modifying one or more of the conflicting loyalties. In extreme cases of divided loyalty, the professional faces conflicting moral obligations.[44]

In their attempts to reconcile conflicts of interest, Beauchamp and Childress recognize the tragic moral decision with which physicians are faced. Instead of establishing an absolute principle like models one and two to solve the conflicts of interest, they mete out the duty to the physician to determine the proper action in a casuistic manner. Their intention is too develop a thought process that allows the physician to incorporate considerations of both the individual, and the group for which the physician is responsible.

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[43] Bloche, 273
[44] Beachamp and Childress, 314

XIII. PACE's legal and ethical solutions to conflicts of interest.

Before determining which model PACE subscribes to the reader should be aare of the mechanisms available for alleviating the tension between interests of the individual and of the group. To test PACE's moral standing I will develop three scenarios, each increasing in financial detriment. To reiterate, we are concerned with cases where the physician must decide between providing treatment that will benefit the patient or denying treatment in order to conserve the groups funds. First, since participants join voluntarily, PACE can rely on **informed consent** as a tool for rationing treatments. Simply put – by informing the participant that does not offer treatment X then they are absolved of any obligation to offer it at a later date. If, however, the physician feels that the treatment would be materially beneficial then the second solution is to order the treatment, knowing that ABHS, the stable-underwriter, will absorb the deficit. The third ethical loophole is simply to discharge the patient back into the fee-for-service world. Again, this solution depends on the voluntary entry of participants to the program. With three escapes from the conflict of interest, it appears that PACE is well equipped to manage the conflicts of interest inherent in their system.

My goal with the three scenarios is to determine whether PACE physicians are ever in a position that prevents them from respecting both their obligation to the patient and to the group. The goal of the following section will be to illuminate three mechanisms for alleviating the conflict of interest introduced by cases that are potentially detrimental to the program's viability.

XIV. Dynamics of conflicts and how they arise in the PACE model:

In comparison to fee-for-service, is PACE making ethical decisions on a daily basis? PACE's drive to reduce the number of days participants are hospitalized is a serious conflict of interest that infiltrates every decision made. The concern is that patients might not be receiving timely or necessary hospitalization because the physicians are preoccupied with saving the program money. To determine if this was the case, I asked Dr. Sheldon if there were instances where the patient's best interest was compromised for the sake of the group? He responded:

> "Ultimately no, but we have pushed the envelope…delaying a hospitalization by one day hoping to turn them around on an outpatient basis. In the fee-for-service world it is just easier to send them to the emergency room. Here we may try to delay hospitalization if we honestly think we can turn them around. And I would say that we recognize that. The other members of staff and I are moving back more in line with the outpatient fee-for-service world."

This quote is a perfect juxtaposition for viewing the fundamental difference between the population-based ethics of PACE and the patient-centered ethic prevalent in fee-for-service medicine. In cases where it was unclear whether the patient needed to be hospitalized, Dr. Sheldon admits to have taken a position favoring the group. It is clear from his statement that he is uncomfortable with his lack of devotion to the role of patient advocate. The AMA expresses the same concern that in such cases "pressures of cost-containment may encourage some physicians to try to manage cases longer than they

should…inappropriate treatment and improper or missed diagnoses are potential outcomes of such decisions to delay or deny referral."[45] The implication of this view is that considerations of cost-containment will lead to incompetent physicians and consequently inferior care.

Should PACE be concerned with alleviating the conflict between individual and group? From the AMA's perspective PACE should align with patient-centered ethics and hospitalize every uncertain case. But then the population-based ethicists would criticize them for being irresponsible with the limited amount of resources. The third model would urge them to weigh and balance the benefits and harms to both sides and decide accordingly. Referring to the three mechanisms discussed in the previous section, it appears that PACE has multiple solutions for averting the tragic moral decision.

First, if PACE had an extant clause established by informed consent then the physician could discuss the ailment, possible treatments, and treatments declined in the informed consent agreement. Though this open and honest discussion appears callous, it does not denigrate the trust necessary to the patient-physician relationship. If the expensive treatment cannot be denied through informed consent, the physician has the option of relying on ABHS to absorb the deficit incurred when the treatment expenditures exceed the participant's contribution. The third option is to discharge the patient from PACE back into the standard Medicare fee-for-service system. Discharge is a possibility because the patient joined the program voluntarily. The following two cases will provide a concrete medium for grappling with the moral justifiability of the three mechanisms proposed.

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[45] AMA, 332

i. CASE 1.

The first case I will address is one in which a participant would likely benefit from a bone marrow transplant that would consume the yearly financial contribution of ten participants. As discussed earlier PACE is a capitated program that experiences an immense compulsion to make responsible treatment decisions in relation to the group. How then should the treating physician reconcile this with their moral obligation to the patient? Having outlined PACE's predicament, I will describe how PACE is able to avoid these decisions in a way that maintains their ethical stature.

For the sake of argument, consider a relatively younger participant who is still mentally coherent and mobile. The patient is diagnosed with a certain kind of advanced cancer that requires a bone marrow transplant. The stakes for PACE and the patient are high—a prolonged life if successful—but the costs are great and the likelihood of success uncertain.[46] Accepting model one obligates PACE to authorize the expensive treatment for the sake of the patient-physician relationship. But model two compels the physician to deny the treatment based on obligations to the group. Recalling the quote from Dr. Sheldon in the description of model 3, it is clear that the goals of medicine at PACE considers appeals to both the patient and society.

Another possible line of defense used "to legitimize medical activities that benefit third parties at the subjects' expense,"[47] is informed consent. The idea is that if the participant voluntarily joins the program after being made aware of PACE's stipulation that they will not cover bone marrow transplants, then PACE cannot be held morally or

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[46] AMA, 331
[47] Bloche, 271

legally blameworthy for denying the potentially beneficial treatment. Though it is logical to deny a treatment the participant agreed to forgo upfront the physician still has an obligation to inform the patient of the potentially beneficial treatment. To what extent does informed consent absolve PACE from the ethical quandary?

One response to this position calls into question "whether the act of joining an HMO constitutes informed, autonomous consent?"[48] Kassirer believes that "disclosure is not sufficient to allay ethical concerns. Those who receive the information may not know how to use it or many have no other choices."[49] The basic assumption underlying this response is that for autonomy to be respected, the patient must understand the policy they are purchasing. However, this is a difficult criterion to suffice considering the participant's limited understanding of medicine and the lack of knowledge considering his future health status. Suppose that when a participant joins PACE he agrees to the informed consent clause stating that if he is ever diagnosed with bone marrow cancer, PACE is not accountable for administering or financing treatment. Suppose that two weeks later the patient is diagnosed with a rare form of bone marrow cancer. Can we reasonably believe that the patient who had absolutely no suspicion of having cancer is in a position to make an autonomous choice two weeks prior to the diagnosis? Using such a method is a violation of autonomy because the patient was not in a suitable mindset to grasp the severity of his future condition.

Along similar lines, Marc Rodwin argues that informed consent is a legalistic tool with little ethical importance and posits that, "disclosing organizational policies is not a

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[48] Bloche, 271
[49] Kassirer, 397

panacea for the limitation of services in managed care, but it may reduce the risk of legal liability."[50] Rodwin's distinction of legal from ethical in this context is important because it asks the question, does legal constitute ethical? Though legality often overlaps ethics, physicians must maintain higher standards of ethical practice. Keeping physicians out of trouble with the law is much easier than doing what is right by the patient. Rodwin reasons that informed consent, though it will absolve the physician from legal obligations, is problematic from an ethical point of view. He concludes that informed consent is useful only in limited circumstances.[51]

Acknowledging the need to respect patient autonomy, it appears that PACE is only justified in denying treatment based on informed consent if the patient's decision is truly autonomous. Suppose that a patient previously diagnosed with bone marrow cancer desires to be admitted to the program. PACE can authorize the patient's admittance on the mutual understanding that the patient will not receive the bone marrow transplant. In this case autonomy is respected because the act of joining PACE is an autonomous declination of the treatment. Informed consent thus has potential for alleviating conflict in some specific types of cases, but it does not afford blanket protection against more difficult cases. Since the patient in our case was not aware at the time he joined, denying treatment based on informed consent is a violation of his autonomy. Consequently, we must look to one of the other two mechanisms to alleviate the conflict.

The second mode PACE has to alleviate conflicts of interest circumnavigates the need to make the tragic decision by relying on the financial support from ABHS. Beyond

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[50] Rodwin M, "Conflicts in Managed Care." NEJM 332 no. 9 (1995): 604-7
[51] Rodwin, 606

providing the capital to establish the program, ABHS provides support as necessary. In 2001, Tenncare[52] guaranteed PACE funding for 268 participants. After PACE enrolled to capacity, Tenncare reneged on its obligation and only authorized payment for 211 participants—leaving PACE in a multi-million dollar financial predicament. ABHS graciously absorbed the deficit, which allowed the program to maintain viability. Without a stable underwriter the program would have failed and the participants would have been without care. Since PACE has a capable and willing underwriter, it appears that they have an ethical obligation to cover the bone-marrow transplant as long as it does not damage the relationship with ABHS. This mechanism suffices model one by providing the needed treatment to the patient while not endangering the well being of the group. In conclusion, PACE has an obligation to practice medicine in the best interest of the patient as long as ABHS is willing to support the deficit.

ii. Case 2:

Is PACE setting a dangerous precedent? Relying on financial support to uphold the principles of the patient-centered ethic could cause problems if ABHS decides that they will no longer cover the expensive bone marrow transplant. Suppose that the following year ten patients would benefit from the bone marrow treatment. Furthermore, what if this phenomenon occurred ten years in a row? A stressor of this magnitude would eventually lead to the demise of ABHS as a financial supporter. This scenario functions to pigeonhole PACE in a situation where they no longer have ABHS to support their practices.

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[52] Tennessee equivalent to Medicare and Medicaid.

For the sake of argument, lets posit that rationing of the bone-marrow transplant cannot be denied using informed consent because all of the participants were diagnosed after they joined. In this financially disastrous situation, it is clear that PACE would be a financial abyss for ABHS, which would be forced to abandon the program to maintain its own viability. Considering the loss of informed consent and financial support from ABHS, PACE must resort to the third option - discharge. By discharging the patient from the program to a healthcare system that will provide the bone marrow transplant, PACE is able to again skirt the tragic moral decision. Despite PACE's denial of treatment, the physician upholds fidelity to the patient by being honest about the diagnosis and recommending a potentially beneficial treatment. Discharge also protects the other PACE participants by not over-extending PACE's budget.

Though this method seems like an evasion it is important to discuss the role of PACE in relation to Tenncare. PACE is an alternative to traditional healthcare; participants can join and quit the program voluntarily. Attributable to the voluntary admission policy, PACE's role in the healthcare system is analogous to the role of private school in relation to the public school system. In the same way that private schools have more flexibility to set social, religious, and curricular standards according to their own philosophies, PACE also retains the latitude to set its own standards. Forcing PACE to function like the remainder of healthcare providers would be identical to forcing private schools to emulate public schools in every respect. Accordingly, in the same way a dissatisfied parent removes their child from private school and puts them back into the public setting, a PACE participant can opt to be discharged back into the traditional Tenncare system.

Discharging the patient, however, is a successful solution because it mediates the competing obligations to individual and group. Physician honesty with the patient about the diagnosis and the forthright divulgence of treatment options upheld the physician's obligation to the patient-centered ethic. The act of discharging the patient allowed for the physician to fulfill his/her obligation to protect the group from financial detriment. The only other feasible solution is to provide the treatment on the understanding that ABHS would absorb the deficit. In this situation, the physician is able to fulfill his obligation both to the patient, by providing the treatment, and to the group, by not leading them into financial detriment.

XV. Conclusion:

The healthcare system in our nation has encountered some serious conflicts of interest since the introduction of MCO organizations. We have not yet been able to "reconcile our public and our deeply personal expectations of medicine." The two most prevalent positions in this debate diverge into fundamentally pledge their allegiance to medicine's obligation to the primacy of either the best interest of the patient or the best interest of the group. A third model that is less emphatically represented takes a pragmatic approach and recognizes the need for medicine to address both its duties to individual patients and to society. All three models believe that these two obligations are fundamentally opposed and attempt to solve the problem. Proponents of model one argue that clinical decisions should be made without regard to society, while advocates of model two argue that responsible medicine requires physicians to consider the strain placed on society by the given treatment.

Considering the lack of PACE-specific research, the goal of my thesis is to determine which of the three models PACE subscribes. It became clear that PACE's structure is unique from other MCOs, which prompted me to investigate what mechanisms Chattanooga's PACE program has available for alleviating conflicts of interest between the group and the individual. Informed consent, reliance on ABHS for supplementary funding, and discharging participants are the three methods PACE uses to resolve conflicts inherent in the managed care setting.

To test PACE's ethical structure I developed two hypothetical situations in an attempt to force PACE to abandon the patient-centered ethic. The first case undermined the value of informed consent as a justifiable method for rationing treatment. PACE, however, redeemed its ethical standing by relying on ABHS to provide financial support for the expensive yet beneficial bone marrow transplant. Case two creates a situation where providing the treatment sets a financially unsustainable precedent that leads to the demise of the relationship with ABHS. Since losing the support of ABHS would be detrimental to the well being of the program, PACE has an obligation to the group not to practice in such a way that forces ABHS to abandon them. It became clear in the late stages of the paper that there is no hypothetical conflict-of-interest that PACE is incapable of managing. By discharging patients, PACE is able to act in the best interest of the patient while conserving finite funds for the sake of the group.

My intent was to reveal a flaw in PACE's structure that prevented it from managing its obligation both to the individual and to the group – thus forcing it to make a tragic moral decision. Informed consent, however, was found to be useful only in limited circumstances where the autonomy of the patient could be preserved. Reliance on ABHS allowed PACE to manage the conflicting interests only to the extent that PACE did not become a financial abyss for ABHS. Discharging patients, however, proved in every case to be an effective mechanism for respecting both the patient's and the group's best interest. An important caveat to discharging patients is that the program must preserve the voluntary admission policy. If PACE ever became a patient's only choice, then it would be necessary to re-evaluate their mechanisms of conflict resolution.

Contrary to this conclusion, some critics could argue that the extraordinary care provided by PACE is a coercive factor that hinders patient autonomy. If a participant is denied the request for a bone marrow transplant, they have two choices. First, they can accept the decision and continue receiving the extraordinary treatment PACE has to offer, or second, they can agree to the discharge. By agreeing to the discharge in order to receive the bone marrow transplant, the participant must accept the lower quality of care offered in the traditional Tenncare setting. The participant is thus forced to make a tragic decision between the bone marrow transplant and the benefits of the program. In essence, discharging a patient places them in a catch-22 situation. It is obvious that their desire to stay in PACE will have a serious influence on their decision that constitutes a breach in autonomy.

Such an argument is problematic because it attacks the program for allowing its patients to make their own decisions. If the critics want to tout autonomy, what is their solution? Taking their perspective, they seem to imply that PACE should make the decision for the participant whether to be discharged or not. It is an incoherent position because they simultaneously want PACE to respect their autonomy and relieve them from the decision-making process. There are only two possible ways PACE could alleviate the patients conflict: paternalist action by PACE or provide the treatment. The latter has proven to be contrary to a financially sustainable practice and the former solution is thoroughly criticized in the literature. Consequently, the only solution PACE has under today's policies and guidelines is to bequeath the decision onto the participant. Any tension created by a conflict of interest can be reconciled by components of the PACE structure. Discharging the participant is the most effective method for alleviating tension

and respecting autonomy, because ultimately, it is capable of transferring the decision-making process out of their hands and into the participants.

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