Managed Healthcare: Ethical implications on the doctor-patient relationship

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1

Abstract

Managed health system remains a topical issue worldwide. The main concern is whether it is an ideal method for the provision of health care in an effective and efficient manner whilst at the same time curbing spiralling healthcare costs. South Africa is not spared this debate on managed health care. The main aim being to guarantee that cost-effective quality healthcare is provided to patients who are members of a medical aid scheme within the managed healthcare context (Mahlo & Muller, 2000, Pg. 37; Booyens, 2000)

In implementing managed healthcare, there are resultant unforeseen ethical implications which may have an effect on the doctor patient relationship. In view of these ethical implications, I set forth to look at to what extent these have on the doctor patient relationship. The focus of this research report is to argue that one of untoward ethical consequences that managed health care has brought about is the impact it has on this relationship. Thus, the question being posed is, is it ethically justifiable for managed healthcare to interfere in the doctor- patient relationship?

This report was purely normative, involving online library sources, academic search engines and desktop-based research to obtain the literature. Ethical arguments and counterarguments are presented in the research report regarding the ethical issues managed healthcare has on the doctor patient relationship. Ethical principles and theories were used to bolster the focus of the argument that the relationship is negatively impacted. I explored principles of autonomy(both of the doctor and the patient) , beneficence and maleficence in support of the relationship , with counter-argument in justice and redistribution of scarce resources. Therefore I concluded by arguing, that managed healthcare has adverse ethical consequences on doctor –patient relationship

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TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

1.1 Background

Much of the bioethics community was awakened to the fact that delivery of healthcare has been profoundly altered by the growth of managed healthcare (Biblo, Christopher, Johnson & Potter , 2004). As a result of this alteration and growth, a new landscape emerged in the delivery of healthcare.

Managed healthcare(MHC), in the South African context, is a system of healthcare delivery that seeks to guarantee that cost-effective quality healthcare is provided to patients who are members of a medical aid scheme within the managed healthcare context (Mahlo & Muller, 2000; Booyens, 2000). It is pertinent to describe ethical implications in the application of managed healthcare and to define the ethical responsibilities of each stakeholder in order to protect the beneficiaries.

With the introduction of managed healthcare, ethical implications that were previously not thought of presented themselves(Biblo et al, 2004). The doctor is forced into a position of being a gatekeeper, being responsible for both cost containment and service offering; this creates a problem in the traditional doctor-patient relationship (Feldman, Novack & Gracely , 1998). The concept of the doctor-patient relationship as described by Emanuel and Dubler's model, states that aspects of this relationship include communication, compassion, competence and trust (Emanuel & Dubler, 1995) and to some extent these may be influenced in one way or the other by managed healthcare.

In the traditional fee-for-service system, ethics of delivery centred around respect for autonomy and it was the responsibility of the hospitals and doctors(Feldman et al, 1998) to ensure that this is the case. The traditional fee-for-service system was patient-focused and protected the autonomy of the treating physician(Feldman et al, 1998) and respected patient choice(Forrest et al, 2002). It also offered treatment that had potential benefits and purported to prolong life . Because of ethical issues involved in the fee-for-service system, mainly of over-servicing, overutilisation and rationing on the basis of financial means, managed healthcare was seen as an alternative to circumvent these concerns(Mehlman, 2015).

It was envisaged that in the managed healthcare scenario, the co-existence of the patient and the managed healthcare company would be mutually beneficial(Feldman et al, 1998). The intended benefit of the managed care model is such that doctors would help keep costs down for the benefit of not only the individual patient, but also for the general membership of the scheme (Booyens, 2000). By doing so, the membership premium would be kept low and there will also be more services to the rest of the membership offered as a result of cost-saving measures. (As we will see later, this is not always the case with how managed care is being implemented in the South African context, (Hugo & Loubser, 2005)).

As the social justice model of John Rawls asserts, the principles of social justice provide a way of assigning rights and duties in the basic institutions of society(Rawls,1999) . In his book, A Theory of Justice, John Rawls describes justice as fairness, and the role that justice needs to play within the social contract model. He describes the role that social justice needs to play in guiding the society on equitable distribution of resources. That is, in implementing managed care, the benefit should be to all parties concerned i.e. to the managed healthcare company and the community it is meant to serve.

We should be able to overcome the social problems of co-ordination, efficiency and stability so that in implementing agreements and activities, there should be compatibility with one another. These activities can be carried through without anyone's legitimate expectations not being fulfilled (Rawls, 1999).

Managed Healthcare should contain contribution inflation on the one hand, and on the other hand improve accessibility of healthcare to more consumers without compromising quality of care in the most cost-effective way (Hugo et al, 2005; Hattingh, 2015). Ideally, the needs of all the role players should be met(Mahlo et al, 2000).

However, when these needs were compared and evaluated, the patient's , the healthcare provider's, the schemes' and administrator's needs, it appears that the intended purpose is not necessarily the case as evidenced by higher costs and negative influence on accessibility, quality and efficiency of healthcare (Hugo et al, 2005). As the role players' needs are all different, it is difficult to keep costs down(Hugo et al, 2005 Pg. 76). It also limits access to healthcare services and ultimately results in reduced quality of care due to inefficiencies in the delivery of the service. Assessing the patient's legitimate needs, which are resolution of emotional and physical illness, patients require these resolved at whatever cost. (Hugo et al, 2005).

In the South African context, application of managed healthcare is leveraged on a good working relationship between the doctor and the patient(Booyens, 2000). The co-operation and harmonious interaction between the doctor and the patient is of utmost importance if managed healthcare is to succeed (Kinghorn, 1996). Therefore, the doctor patient relationship is paramount in keeping healthcare costs down (Booyens, 2000). In essence, the success or

failure of managed healthcare is dependent on a good working relationship between the provider and the receiver of the service or the paying consumer/employee (Booyens, 2000; Kinghorn, 1996).

Managed healthcare has at its tenet of cost-saving as the major outcome, and the patient has resolution of their ailments at the best services at whatever cost, as theirs(Hugo et al,2005). In managed healthcare, the treatment option and the "preferred" way that a patient would like to access the healthcare service is not necessarily in the way the patient perceives it as in their best interest (Hugo et al, 2005). In his article Hugo asserts that fulfilling patient's needs can adversely affect cost, accessibility, quality and efficiency of healthcare provision(Hugo et al, Pg. 76).

Also doctor preference of the patient are not a priority as the treatment protocols dictate that the patient will be attended to by a doctor "approved" and designated by a medical scheme(Emanuel et al, 1995).

Funders or medical schemes have increased influence over the provision of healthcare (Kinghorn, 1996). This influence is exerted through scheme incentives to the provider and awarding providers with designated provider status with the aim of paying them a percentage fee higher than the non-designated provider so as to adhere to the schemes' protocols and formularies to help keep costs down(Klinck, 2018). As we will see later, tools that are used to implement managed healthcare include among others, drug formularies, recommended clinical protocols by healthcare funders, treatment algorithms and the contract of option plans that patients belong to (Hugo et al,2005). Thus, both the patient's and doctor's autonomy are affected by decisions of administrative protocols of managed care.

Autonomy is based on the principle of respect for others. The idea of autonomy is that people should be able to make their own independent decisions (Rachels & Rachels, 2015). The autonomous choices and preferences that the patient is entitled to are superseded by managed care, giving rise to ethical dilemmas that were not anticipated by the role players within the healthcare industry(Biblo et al, 2004).

Doctors have to motivate why certain treatment options are necessary if they deviate from what the managed care protocols and algorithms recommend(Mahlo et al, 2000). These algorithms mean doctors have to follow particular recommended treatment protocols failing which they fall out of favour with the managed care companies and may be excluded from preferred provider status(Hamdulay, 2013).

In the fee for service model, doctors were their own autonomous agents making own decisions of what treatment is best in a particular situation(Biblo et al, 2004). Managed care systems now assume responsibility for decision making for the practitioner, provision and financing of healthcare, thereby presenting new problems for doctors (Feldman et al., 1998) and interfering with their autonomy.

Some of the managed healthcare control approaches include the following

- monitoring wasteful practices by both practitioners and patients,
- educating the patient by pro-actively sending out health information on how to live healthy and to adopt healthy lifestyles(Kinghorn 1996, Booyens, 2000).
- To discourage unnecessary utilisation of healthcare services. (Kinghorn,1996)

Monitoring wasteful practices entails constantly checking on the treatment plan instituted and whether it is working as it was intended, failing which it may need to be altered to appropriate measures(Klinck, 2018).

Managed healthcare techniques can be applied through a variety of models. These include independent provider associations (IPA) , health maintenance organisations(HMO) and preferred provider organisations(DSP). These various models of managed healthcare have one way or another, an impact on the doctor patient relationship.

Doctors declare their allegiance to the Hippocratic oath. The Hippocratic Oath is the cornerstone of healthcare that all doctors subscribe to. It has, over the years, sustained ethical behaviour among healthcare practitioners and has been a guiding light to the profession.

In the Oath it is mentioned that the doctor ,"*.... will use treatment to help the sick according to my ability and judgemen*t… ." (Hippocratic Oath) . In dealing with managed healthcare protocols , the doctor is obliged to consider cost when treating patients by adhering to protocols and algorithms recommended by the managed healthcare company and thus dual loyalty to company and patient.

One of the potential ethical issues raised by the managed care models is the use of designated service providers (DSPs) and capitation system or global fee arrangement. Under the capitation system, the doctor receives a lump sum per subscribed member(Moosa, Luiz & Carmichael, 2012). The system is intended to cover a fixed “basket” of provided services. With the capitation system, irrespective of how often and how much the “client” utilises the service, the agreed fee will still cover only the original service provided without unforeseen

circumstances(Moosa et al, 2012) which could have the unintended consequence of underservicing by the healthcare practitioner to cut costs(Moosa et al, 2012).

For instance, in the case of a service provided for a particular procedure, if the procedure has unforeseen circumstances and complications arise, the agreed fee is what will be reimbursed leaving both the doctor and the patient in a financial quagmire. (Agyei-Baffour, Oppong & Boateng, 2013). This might have an impact on the health outcome of the patient as the fee may not be adequate to cover the treatment cost.

The quality of the doctor-patient relationship has an impact on patient health outcomes (Stewart,1995). Research has shown that a patient who trusts their doctor has a better outcome than one who does not (Stewart, 1995; Kaplan, Greenfield & Ware, 1989). As a result, attending to issues that negatively affect this relationship is important.

In view of this effect of managed healthcare issues in our context, I will normatively assess the impact that managed healthcare has on the doctor-patient relationship in the South African context.

I will assess whether implementing managed healthcare, with the supposed benefit to cost(Booyens, 2000), is ethically justifiable to interfere with the doctor-patient relationship as set out in the Hippocratic Oath and the World Medical Association Medical Ethics Manual. Managed healthcare has a negative impact on the doctor-patient relationship, with negative health outcomes (Stewart,1995) and thereby negating the very supposed cost-benefit that is intended. This also interferes with the patient's autonomy of choice and self-determination

and erodes the patient's trust in their physician and ultimately in the profession as a whole(Pellegrino, 1987).

1.2 Literature critique

The doctor-patient relationship has been the cornerstone of delivery of healthcare since the time of Hippocrates. In the Hippocratic Oath and in the World Medical Association (WMA) Medical Ethics Manual the doctor is urged to always put their patient first and to act in the best interest of the patient at all times(WMA, 2015).

With implementation of managed healthcare, the doctor-patient relationship may be negatively impaired, as the doctor may be put in a morally compromising situation of putting profit before patient(Feldman, 1998). This negative impairment on the doctor-patient relationship might result in the patient not having faith and trust in the doctor (Feldman et al., 1998). This in effect might have a negative health outcome for the patient (Stewart, 1995) and an impact on the continuity of care and the trust factor in the doctor-patient relationship. For the doctor-patient relationship to survive, the autonomy of both the doctor and the patient needs to be respected and preserved.

The sentiments expressed by some authors regarding managed healthcare is that there is a disconnect in the original doctor-patient relationship. In a study conducted by Feldman et al., some doctors felt that both the doctor and the patient had a contract with the healthcare organisation but not with each other (Feldman et al., 1998). Ethical obligations to the patients are impeded by costs and, as much as the doctor would have liked to do the right thing, there was financial disincentive to do so(Feldman et al, 1998). There was also the issue of patient

confidentiality, as the practitioner had to interact with the managed care company, further having a negative impact on what WMA considers as the pillars of a good doctor-patient-relationship (World Medical Association Guidelines, 2015).

1.2.1 Cost containment

Granted, the rise and need for managed healthcare came about as a result of ethical problems in the fee-for-service model(Booyens, 2000). The ethical problems encountered included overutilisation(Moosa et al, 2012), those that had financial means benefitting more from the system than those that did not(Aggarwal et al,2010), and poor communities i.e. those in lower medical scheme option plans, being given limited access and resources(Aggarwal et al, 2010)

Some have highlighted certain ways in which costs can be contained, which may not always be beneficial to the patients. In the practice of risk skimming, managed healthcare implementation has been shown to keep costs down by denying health to poor-risk , high cost populations with a major disease burden and chronic illness (Kinghorn,1996; Aggarwal, Rowe & Sernvark, 2010).

1.2.2 Putting the Patient First

According to the World Medical Association Medical Ethics Manual, the doctor-patient relationship is the cornerstone of medical practice, and therefore medical ethics (WMA, 2015). According to the Declaration of Geneva, "*the health of my patient will be my first consideration.*" Although doctors are encouraged not to let race or financial ability interfere with how doctors provide healthcare under the Declaration of Geneva, with managed care

this has not been shown to be the case(Aggarwal et al, 2010). The International Code of Medical Ethics emphasises this doctor-patient relationship by stating that "a physician shall owe their patients' complete loyalty and all the scientific resources available to them" (WMA, 2015).

In managed healthcare, the doctor is cast in the role of being both a gatekeeper and a healthcare practitioner, thereby altering the traditional doctor-patient relationship (Reagan, 1987). Managed healthcare has put the doctor in a morally difficult position as to where their loyalty lies. Some have suggested that doctors should guard against putting their patient's interest second to the managed care company's interest and should guard against dual loyalty (Klinck, 2003).

Among other ethical problems identified as a threat to the doctor-patient relationship is the ability of the doctor to communicate freely with the patient, thereby creating trust issues in the profession(Breen , Wan , Zhang , Marathe , Seblega & Paek , 2009). As demonstrated, when communication from the managed company and the doctor is poor, patients remain uninformed of the benefits they have (Agyei-Baffour et al., 2013).

1.2.3 Communication, confidentiality and trust

According to the tenets of managed healthcare in WMA, communication is key to the doctor-patient relationship(WMA, 2015). In managed healthcare, the doctor is unable to treat the patient with equal and beneficial treatment devoid of corporate interference(Kinghorn, 1996). Also, the doctor's obligation to maintain confidentiality at all times is also affected by managed healthcare (WMA, 2015). When patients feel that there is no compassion from the

treating doctor and that they are not respected, they will have a tendency of distrust towards the profession and this distrust will contribute negatively to the healing process (Stewart, 1995).

In the international setting of managed care, the doctor-patient relationship has been shown to be affected by the doctor not spending enough time with the patient as emphasis is on productivity(Feldman et al, 1998) rather than quality of care, which negatively impacts patient outcome (Stewart, 1995).

A global fee, as described earlier, is a managed healthcare system where a funder goes into a contract with a healthcare facility for a set fee for a basket of services(FPD, 2003). In the South African context, this type of system does not afford the patient a choice in the treating facility and options available to them(Moosa et al, 2012). The patient may not have an input in the choice of the doctor, the choice of facility and how long their hospital stay will be. The managed care plan or option the patient is on determines this without taking the patient's circumstances into consideration(Klinck, 2018). In the event that patients choose their own practitioner, they will have to make out of pocket payments to access the treatment (Klinck,2003).

Consequently, the doctor is seen as the one imposing this on the patient. Patients perceive the doctor as an adversary to them, as their gatekeeping roles further erode this trust relationship (Feldman et al., 1998). Autonomy of the patient is the cornerstone of the doctor-patient relationship. With the erosion of autonomy comes lack of choice in treatment options and the ability to make decisions in the patients' own disease treatment and to what extent the physician should go.

According to the Constitution of the World Health Organization, “health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion or political belief ” (WHO, 1946). Managed care has the potential to take away this right; patients perceive this as the doctor not listening to them and not communicating with them honestly. This leads to a breakdown in trust and then has an impact on the doctor-patient relationship, which adversely affects outcomes(Biblo et al, 2004).

The doctor-patient relationship can also be affected in several areas. There is reduced communication from caregivers with their patients, as management is more concerned with productivity and client numbers than with aloofness of the doctor and proper interpersonal integration(Biblo et al, 2004) . Some healthcare providers feel that the managed care companies do not care for their members(Feldman et al, 1998). Practitioners have to take up the role of educating the members(Agyei-Baffour et al, 2013) about what they are entitled to and what the managed care company is willing to pay for, which is a source of great frustration for the doctors (Mahlo et al, 2000) and a further thorn in the flesh of the doctor-patient relationship. As a result, patients end up not trusting their doctors anymore and feel that the doctors are colluding with the managed care company. Patients have a sense that the doctor represents the company more than them.

According to the Health Professions of Council of South Africa guidelines, good practice includes respecting the patient and the patient’s autonomy and self-determination(HPCSA Booklet 3, 2016). The practitioner should always act in the best interest of the patient. This is

also emphasised by the recommendations made by the World Medical Association on what duties doctors have to their patients(WMA, 2015).

1.3 Research question

The research question in this study was, “Is it ethically justifiable for managed care to interfere in the doctor-patient relationship?”

1.4 Rationale for the study

In this research, I set out to answer this question of the impact of managed healthcare on the doctor-patient relationship, be it negative or positive, and to show that there is an unnecessary negative impact on this sacrosanct relationship.

Studies have looked exclusively at the impact of managed healthcare on either the doctor or the patient individually. This study will look at the impact of managed healthcare on the doctor-patient relationship itself, from an ethical and legal perspective. The impact that managed healthcare has on doctors’ decision-making and the autonomy of the patient in choosing their treatment options from an ethical and legal perspective will be investigated. There is paucity of literature on this from South Africa.

1.5 Thesis statement

It is not ethically justifiable for managed healthcare to interfere in the doctor-patient relationship.

1.6 Research aim

To assess the impact of managed healthcare and how it relates to the doctor-patient relationship from an ethical and legal perspective.

1.7 Research objectives

1.7.1 To give a description of what constitutes managed healthcare

1.7.2 To describe the characteristics of what makes an ideal doctor patient relationship

1.7.3 To show ways in which the ideal doctor patient relationship is compromised by different practices of managed healthcare

1.7.4 To show why this harm to the doctor patient relationship is ethically unjustified

1.7.5 To defend my position that managed healthcare has a negative impact on the doctor-patient relationship and thus poor health outcomes.

1.7.6 To make recommendations, if any, on ways to implement managed healthcare without interfering in the doctor-patient relationship.

1.8 Research Design

The research design of this dissertation is a bioethical study using normative analysis. Normative ethics is the study that is concerned with criteria used to determine what is morally right or wrong. Normative ethics answers the question of what ought to be done and what ought not be done. In this study we asked the question, *Is it ethically justifiable for managed healthcare to interfere in the doctor patient relationship?* We set out to answer this question using the following methods.

1.9 Research Method

This is a normative study looking at the impact of managed healthcare on the doctor patient relationship. This study and the research was conducted by literature search, analysis and review. No human subjects were involved. Manual literature search was

done online from April 2019 to August 2020 and extended to October 2021 and again to January 2022. The literature search was used using the following tools: Google Scholar, Pubmed, MeSH, Clinical Key , looking through all the literature but concentrating mostly on literature pertaining to ethics and philosophy.

The key words used were “managed healthcare”, “doctor patient relationship”, “managed healthcare ethical implications”, “managed healthcare legal implications”, “managed healthcare in South Africa”, “managed healthcare fiduciary duties”. All the relevant articles were identified and stored in a database. The literature search was done first then review and reading of the articles done. First a draft was written up and reviewed before the final write up was done.

1.10 Argumentative Strategy

The argumentative strategy is divided into six chapters.

- The first chapter is the introductory chapter with literature review and critique. This chapter also introduces concepts and provides definitions of relevance to the study.
- Chapter two is a descriptive account of what managed healthcare entails and the ways in which it is implemented in South Africa. This is contrasted with tools used in other countries in the continent and outside of the continent, but with special emphasis on South Africa
- Chapter three explores what the ideal doctor-patient relationship looks like and what the nature and characteristics of this relationship are.
- Chapter four looks at ways in which managed healthcare affects this ideal doctor-patient relationship and what my objections are to this impact

- Chapter five will look at the counterargument of why it may be acceptable for managed healthcare to have an effect on the doctor patient relationship. Under what circumstances it will be acceptable for managed healthcare to interfere in the doctor-patient relationship.
- Chapter six I will look at conclusions and briefly make recommendations, if any, on how to implement managed healthcare without unwanted influence on the doctor-patient relationship

1.11 Ethics

As this is a normative study with no involvement of human subjects, ethics waiver will be requested

CHAPTER 2:

A DESCRIPTIVE ACCOUNT OF WHAT CONSTITUTES MANAGED HEALTHCARE

2.1.Introduction

The interaction between a doctor and a patient takes place in both public and private sector and it exists in multiple forms. The interaction may be out of choice or out of necessity as in an emergency. In the public sector, which is mostly government funded, there is no private funding or authorisation to be approved for the interaction to take place(Booyens, 2000). In the private sector, which is funded "privately" by a medical insurance or scheme, permission is required by the patient to access health services (Booyens, 2000). This is where managed care comes into the picture.

In this chapter I will define what constitutes managed care as described in the legislation (Medical Schemes Act, 1998) and describe ways in which managed healthcare is implemented(Kinghorn, 1996; Booyens, 2000; Hugo et al, 2005) and what methods employed constitute managed healthcare in the private sector(Klinck, 2003).

Also in this chapter I will briefly introduce the ways in which managed care is employed that will hinder the doctor-patient relationship.

Managed healthcare was introduced into the healthcare arena in an effort to curb the ever rising cost of healthcare, especially in the private sector(Booyens,2000; Kinghorn, 1996). In South Africa , the annual expenditure on health was estimated to be about 5 fold in the private sector compared to the public sector(Hugo et al, 2005) at R5112.80 per

beneficiary(R35.6 Bn for 6962914 beneficiaries) as against R1100,00 per beneficiary(R39,7 Bn for 36 million beneficiaries) respectively(Council of Medical Schemes, 2003). As a result of this expenditure, it was evident that the introduction of managed healthcare was inevitable.

Managed healthcare is defined in Regulation 15 of the Medical Schemes Act as:

> *"Clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes."*

Managed healthcare in South Africa was introduced to curb spiralling costs of the traditional fee-for-service model(Hugo et al, 2005; Kinghorn, 1996). The fee-for-service model concentrated on the individual patient, protected doctor autonomy and promoted treatment that was beneficial to the patient; the fee-for-service model also assumed unlimited resources. In the managed care setting, this is not always possible (Appelbaum, 1993).

Due to constraints of population growth and allocation of limited resources, there was a need to introduce managed healthcare system. Managed healthcare is therefore a delivery of healthcare that is indirectly controlled by the management company taking over the day-to-day administration of health service delivery(Booyens, 2000; Kinghorn, 1996) and by so doing curbing the spiralling cost of healthcare in the private sector in South Africa (Kinghorn,1996).

In the South African setting, the administration or medical aid scheme assumes the responsibility of authorising and rationing healthcare according to the rules of the medical

scheme (Hugo et al, 2005; Klinck, 2018). Managed healthcare can be looked at as a management process involving contractual agreements between healthcare funders and providers, viz. healthcare professionals(Kinghorn, 1996)

In clinical and financial risk assessment, the managed care companies have a set protocol to follow in terms of what conditions will be covered and which conditions will not be covered, depending on cost-effectiveness and necessity(Booyens, 2000). Appropriateness and cost-effectiveness of relevant health services pose a dilemma. The doctor has to choose between what is cost effective as against what is appropriate as recommended by the managed care treatment protocol, which creates an ethical dilemma.

There are a number of ways that medical aid schemes can introduce methods of curbing these costs. Contracting designated service providers and patients, giving incentives to reduce unnecessary healthcare utilization(Jones, 2003), usage of drug formularies(Klinck, 2003) to promote cost-effective management of particular medical conditions and controlled access to expensive services by means of authorization (Kinghorn, 1996).

Managed care companies have case managers that make decisions on the appropriateness of care(Booyens, 2000; Klinck,2018). The case managers also act proactively by monitoring the care of the patient continuously(Booyens, 2000). If the patient's condition does not meet the set criteria for treatment, the decision will be to decline the care(Klinck,2018). As much as declining of care is meant to be a financial decision, provision of care is much more than just looking at costs (Kinck, 2018).

Although managed care programs often maintain that their efforts will improve quality of care, it is clear that their bottom line is more concerned with cost-cutting and profitability, namely reducing healthcare costs (Appelbaum, 1993; Feldman et al, 1998). However, this is problematic in that it does not take into consideration the severity of the clinical condition. As Klinck(2018) puts it, managed care company should

a) Provide health that is appropriate for the patient
b) Cater for cases where not all patients are equally well on the same medicine

"Rules-based and clinical management-based programs" refer to a set of formal techniques designed to monitor the use of and evaluate the clinical necessity, appropriateness, efficacy and efficiency of healthcare services, procedures or settings, on the basis of which appropriate managed healthcare interventions are made(Klinck, 2018). As mentioned in the Medical Schemes Act, managed care organisations should have protocols in place to evaluate the appropriateness of the treatment and the cost-effectiveness of the recommended treatment without prejudice to the patient.(Medical Schemes Act, 1998)

Patients who belong to a medical aid scheme pay a monthly premium to the scheme according to the chosen option with standard, less or more benefits(van den Heever, 2001). The scheme in turn has an administrator of these funds, who together with case managers, assist in monitoring costs according to the rules of the scheme(Klinck, 2018, Booyens, 2000).

The different models employed by medical schemes in managing these funds, as mentioned earlier, include Health Maintenance organizations(HMO), preferred provider organizations and independent provider associations. With HMOs, care is delivered by a pre-set group of

providers for a fixed annual fee(Feldman, 1998). Designated gatekeepers who are primary care doctors serve the pre-screening role. These have pre-set, uniform protocols that restrict provider discretion. Because the organisation has a fixed fee, the compensation of individual doctors is determined by their abilities to control costs(Feldman et al,1998)

According to the capitation model, which is in use in other countries, doctors are paid a lump sum for a basket of services(Agyei-Baffour et al, 2013). These fees are usually based on future expenditures determined through an assessment of predictable risks or events, including demographic variables and variables such as previous diagnoses, self-reported health status and previous utilisation(Agyei-Baffour et al.2013)

Although the implementation of managed healthcare is done with good intentions, and it is geared towards cost-saving measures and prevention of wasteful expenditure, it should not be myopic in looking at only the cost without a holistic approach to other issues. Issues including patient autonomy, doctor independence and societal needs should also be considered. There are multiple role players in this space, including doctors and other healthcare workers, as well as service providers as in hospitals, patients and the "funders", namely medical aid schemes and managed care organisations(Mahlo et al, 2000).

In my opinion, all the role players in this space have a fiduciary duty to the patients. At least in so far as the doctor is concerned, there is a well-established common law and ethical foundation that the doctor-patient relationship is a fiduciary one(Hall, 2019) .

In the South African context, managed healthcare programs were introduced in a variety of forms and systems tools, viz. risk sharing arrangements, clinical guidelines protocols, disease

management protocols, drug formularies, hospital networks and independent service provider networks(Klinck, 2003; Foundation for Professional Development(FPD), 2003). As mentioned previously, the main reason for healthcare management programs was for cost containment, especially in the private sector, which year on year its growth was beyond inflation.(Booyens, 2000)

The two key elements of managed care are restricting access of patients to their providers and management of utilization of healthcare services by way of authorization of medical care required(Klinck, 2018). Sponsors of managed care in South Africa are the traditional medical aid schemes.

The following are the tools that have been used by managed care companies in South Africa to control costs in the private sector.

2.1 Utilization Management

Funders of healthcare introduced a limitation on the volume of use of clinical services in order to curtail costs(Jones,2003). Utilisation management is the ongoing evaluation of the necessity of medical treatment recommended, its appropriateness and efficiency under the provision of a particular medical scheme benefit plan(Medical Schemes Act, 1998). The evaluation includes both the use of the facility and the procedure /healthcare service accessed.

This is implemented by way of pre-authorization of required services(Booyens, 2000). The case manager will either decline or authorize the service request by first requesting a

treatment plan. If the service is authorized, the case manager will find alternative and cost effective treatment options that will minimize the length of stay in the healthcare facility(Jones,2003).

The managed care company will analyse medical treatment of members admitted to a healthcare facility in order to evaluate and control the prudent use of resources. Utilization management reduces costs by use of facilities and treatment methods that are less expensive without affecting the quality of care(Klinck, 2018). Examples would include use of day-care facilities for outpatient and/or day-care surgery, encouraging the use of generic medicines and home healthcare management. There is ongoing case management involvement by assessing the appropriateness of care delivered.

2.2 Provider Networks,

The other tool utilized is that of designated health provider (Klinck, 2003; Jones, 2003). Provider networks is a system where healthcare providers and practitioners enter into a contract with the managed care company to look after the members of a particular scheme at a discounted fee, in return the scheme guarantees traffic to these facilities and practices(Hamdulay,2013; Moosa et al,2012). It also guarantees payment to the contracted health service providers. Health provider networks have been touted as creating access to affordable and quality healthcare for more medical aid members (Hamdulay, 2013). The system involves contracting with general practitioners, with specialists and lastly with healthcare facilities and hospitals.

With general practitioners, independent practitioners associations(IPA) enter into a contract with the scheme on behalf of their doctors and negotiate a fee to be re-imbursed(Jones, 2003; Hamdulay, 2013). In contracting, the doctors also agree to a peer-review process to ensure that quality of care is not compromised and treatment protocols are adhered to(Hamdulay,2013) .

In the fee for service model, patients would present to their healthcare provider and the doctor would provide individualised treatment plan. With IPAs contracting, the doctor has to adhere to protocols and formularies recommended by the managed care company and the medical scheme(Klinck,2018). If the doctor deviates from the said protocol, punitive measures can be taken by either refusing to pay or asking the patient to pay out of pocket. Patients are therefore discouraged from using doctors that are not on the designated service provider list(Kinghorn, 1996). If patients do consult a non-DSP doctor, they are required to pay out of pocket for services rendered or the medical scheme can impose a co-payment (Council for Medical Schemes, 2003).

2.3 Risk sharing arrangements,

Fee for service system of reimbursing healthcare practitioners creates incentives for overutilization of healthcare services(Feldman et al, 1998). The more patients are seen by the provider and the more procedures the provider does, the more the income(Feldman et al,1998). One of the ways of reducing cost to healthcare is the introduction of risk sharing arrangements (Compcom, 2018). One of the risk transfer methods is that of capitation.

Risk sharing method is allowed by the Medical Schemes Act and the method mentioned is that of capitation(Medical Schemes Act, 2003). The Act defines capitation agreement as "an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme"(Medical Schemes Act, 2003).

Managed care organisations and healthcare practitioners share this risk interchangeably. In capitation scheme, a doctor receives a fee for each patient that they enrol in their books(Moosa et al, 2012). If treatment costs exceed the capitation fee, then the doctor runs at a loss. The only way that managed care can reduce costs, which is its main objective, is if the doctor adheres to treatment protocols and make efficient and sound treatment decisions(Feldman et al, 1998).

2.4 Drug Formularies

As managed care moves away from "expensive" drugs in order to save costs, healthcare insurers use drug formularies as one of the tools to keep costs down(Booyens, 2000).

These are formularies that medical aids and managed care organizations have compiled to counter the more expensive drugs available on the market by encouraging doctors to use cheaper alternatives and to use generic drugs(Landon et al, 2007). In one observation over a ten year period, it was noted that the costs of medicine to the medical aid industry had more than doubled and 35% of a medical aid plan's costs was for medicines alone(Booyens, 2000). Drug formularies were introduced for this reason, to cut this astronomical cost.

In the drug formularies, medical aids and managed care companies would advise that they will pay for certain medicines and not for others(Klinck,2018). In this scenario, the ideal drug to be included should be one that is cost-effective, easily accessible, proven drug safety profile and effective with a low side effect profile(Perumal-Pillay et al, 2020; Matlala et al, 2020). It is also recommended that the medical aid scheme should choose their drugs based on evidence based medicine(Klinck, 2018). The drug should also be appropriate for a particular patient(Klinck, 2018).

Exclusion of drugs on a formulary should not be based purely on cost alone, but should also be based on sound clinical principles, considering above(Perumal-Pillay et al, 2020). Some managed care companies, however, were noted to have excluded a drug purely on pricing. Cost was an important factor in the decision to include a medicine at a specific benefit option (Perumal-Pillay et al, 2020).

Despite the high costs of some of the drugs excluded from the formulary, some medical schemes are willing to deviate from the drug formulary based on motivation from a healthcare provider(Perumal-Pillay et al, 2020). The motivation would be considered based on clinical effectiveness of the drug and with a good safety record. This was also noted to be the case in public hospitals where formularies needed to be improved by Therapeutics Committees(Matlala et al, 2020)

2.5 Clinical guidelines protocols

As part of this cost containment strategy, some medical aids design recommended clinical guidelines on how to manage certain conditions, especially pertaining to chronic illnesses such as diabetes, HIV/AIDS and chronic respiratory diseases(Booyens, 2000, Klinck, 2018).

Clinical practice guidelines are a set of recommendations that advises on the clinical management of individuals, in a particular setting for a particular disease condition(Medical Schemes Act Regulations, 2004). The guidelines can include, but not limited to screening, prevention of certain conditions by way of educating patients e.g. adopting healthy lifestyles and encouraging patients to be physically active, diagnosis, treatment, rehabilitation and palliation(Wilkinson et al, 2018).

Some have described these as step by step "recipes" for doctors on how to manage certain conditions(Klinck, 2018; Mahlo et al, 2000)). If the doctor deviates from the recommended treatment protocol, then punitive measures are to decline authorization and payment for the condition. Fortunately, there is legislation in place to assist "in the best interest of the patient". Regulation 15H(1)(c) of the Medical Schemes Act compels the medical aid scheme to provide alternative treatment and deviate from the recommended treatment protocol where there is "treatment failure" or where there is an adverse reaction to the recommended drug(Medical Schemes Act Regulations, 1998).

When the patient is on a recommended treatment protocol and they are not getting better Regulation 15H(1)(c) recommends the medical scheme must pay for the deviation from the protocol.

For managed healthcare to work, there need to be synergy and understanding between the role players(Booyens, 2000); relationships have to be nurtured and co-operation is paramount as the success and failure of managed care depends solely on the success of the doctor -patient relationship(Booyens, 2000) There are a number of relationships to be considered, namely doctor-patient, doctor-medical aid, patient-medical aid, medical aid-facility. The most important of them all is the doctor-patient relationship(Booyens, 2000) . Without it, there is no transaction to speak of.

In the next section, I will define what the characteristics of a doctor-patient relationship are and explore the legal and ethical implications of this relationship.

CHAPTER 3

AN ACCOUNT OF THE NATURE AND CHARACTERISTICS OF AN IDEAL DOCTOR-PATIENT RELATIONSHIP

3.1 Introduction

In this chapter I will define what a relationship is, specifically the interaction between a doctor and his patient. I will elaborate on the elements that make this relationship unique and why it is important to safeguard its existence. I will introduce what the law says about this doctor-patient relationship. How the patient ought to be treated and managed , without which there will be dereliction of duties by the doctor.

In the doctor-patient relationship, the doctor is meant to put the patient first i.e. the interaction has to be patient centric(Breen et al, 2009; Forrest et al, 2002)) and the doctor assumes the role of a fiduciary agent(Hall, 2019) as there is information asymmetry(Cruess et al, 2014). The patient centred treatment approach requires the clinical treatment provided by the doctor to address the patient's preferences, desires and values and simultaneously focusing on respecting the patient's needs. The respect being synonymous with patient autonomy(Breen et al, 2009).

Autonomy is best described as the ability of oneself to self-govern and to self-rule (MacQoid-Mason and Dhai, 2011). In the application of autonomy in health matters, this is the ability and the freedom that the patient exercises to make responsible decisions that affect their own health(Pascual-Ramos et al, 2020).

Therefore, the elements that make up a doctor -patient relationship will include trust, autonomy, respect, confidentiality and putting the patient first(Biblo et al, 2004; Breen,2020).

3.2 Characteristics that make an ideal doctor-patient relationship

3.2.1 Trust

When is a relationship between a doctor and a patient established? As mentioned in the case of *Hurley vs Eddingfield,* the state concluded that a doctor is not obligated to treat a patient if s/he chooses not to.

In another case in Utah, in *Ricks vs Budge,* the state ruled in favour of the patient. The patient had been to see Dr Budge and came for a follow-up consultation a couple of days later. Dr Budge refused to see the patient as he had unpaid medical bills and Dr Budge told the patient to go to the local hospital. The doctor at the local hospital operated on the patient's hand, which unfortunately ended up being amputated. Dr Budge was held liable as he had already seen the patient and was therefore deemed to have established a relationship. As these cases demonstrate, the doctor-patient relationship is difficult to define (Ricks vs Budge,1937).

To patients, a healthy relationship is the ability to interact freely with their doctor, feeling that the doctor is providing quality care and that the doctor, in practising the latter, does so with integrity, respect, compassion and understanding (Biblo et al., 2004). This is the background of **trust.**

The interpersonal trust relationship has been said to have moral content in it. The moral content of this trust relationship is that faithfulness and loyalty to trust are morally praiseworthy and, on the other hand, to betray that trust is morally blameworthy.

A doctor-patient relationship is characterised by empathy, proper communication, mutual trust and a doctor's whole-person knowledge of the patient (Forrest et al., 2002). The trust between the doctor and the patient is what constitutes the vitality and existence of this relationship. In consulting with the doctor, patients are vulnerable and helpless and surrender themselves completely to a complete stranger(Pellegrino, 1987;Pascual-Ramos et al, 2020). By the time a patient consults a doctor, they are in great distress and emotionally unstable, and therefore at the mercy of the doctor (Goold, 2001). The trust relationship is therefore of utmost importance in the doctor-patient interaction(Feldman et al, 1998).

The ideal doctor-patient relationship (DPR) should have the following six fundamental elements, namely (i) **choice** – the ability of patients to choose the practice type and setting and the individual doctor; (ii) **competence** – the doctor should have the technical skills and know-how; (iii) **communication**; (iv) **compassion**; (v) **continuity** – the relationship must endure over time in order for empathy to develop; and (v) **(no) conflict of interest.** (Emmanuel et al, 1995, Pg. 323) .

If the doctor has obligations that are in conflict with one another, the doctor should always act in the best interest of the patient and the patient should take precedence, especially over financial interests (Emmanuel et al, 1995, Forrest, 2002). By so doing, there will be continuity in the relationship, understanding and no apprehension.

Continuity of care is a very important part of the doctor-patient relationship. In a study conducted in New England, 90% of surveyed patients were willing to go extra lengths to maintain this continuity (Alexander et al, 2006). In Francis Peabody's famous paper

published in 1927, he asserts that “the care of the patient lies in caring for the patient”. With the introduction of managed healthcare, caring for the patient is not necessarily the priority (Peabody, 1927).

One has seen a deviation from the classical doctor-patient relationship to more of a patient-healthcare industry relationship, where there is no continuity of care.
As mentioned, a happy patient in a happy doctor-patient relationship will be more likely to be compliant with the treatment plan recommended by the doctor and will have a good health outcome (Stewart, 1995; Riedl & Schüßler, 2017).

Patients also feel that their doctors have to be honest in communicating with them and in providing care in a confidential manner(Riedl et al,2017). They also value reasonable access to care through reasonable availability of appointments and ease of access to provider locations.

Even in the Islamic context, there are certain principles to follow in establishing a good doctor-patient relationship from a moral standpoint. There should be justice to the patient; the doctor must have good communication skills, be empathic and facilitate broad interaction between the doctor and the patient’s next of kin (Chamsi-Pasha & Albar, 2016).

3.2.2 Doctor autonomy and patient trust

Autonomy is described as a person's ability to decide for themselves how to live their own life, according to their desires and values (Rachels et al, 2015, Pg. 3-4). Relationship is defined as the fact or state of being related or a connection or association (Concise Oxford Dictionary,).
Like all relationships, the doctor-patient relationship is based on trust(Feldman et al, 1998).

An autonomous relationship then would be a relationship where both participants choose freely to do what is mutually beneficial to that interaction within a framework of trust. Trust and autonomy go hand in hand(Gray, 1997); you cannot have one without the other. If we use one person to benefit another, then we are violating that person's autonomy(Rachels et al, 2015). We are using them as a means to an end, which could be perceived as such by the interference of managed healthcare in the doctor-patient relationship.

The World Medical Association defines the doctor-patient relationship as "a unique relationship which facilitates an exchange of scientific knowledge and care within a framework of ethics and trust" (World Medical Association, 2015; Jotkowitz, 2006). What is clear is that in the event that there are trust issues, there will be a breakdown in that relationship and vice versa. Where there is mistrust, health outcomes will be affected (Stewart, 1995). By the same token, where there is mistrust, there is an increase in litigation, malpractice and negligence lawsuits (Ancane et al , 2015). Trust is a vital component and the basis for a good relationship, especially between a doctor and the patient (Goold, 2001).

Outcome in health is closely related to trust in the interaction between the doctor and the patient (Stewart, 1995; Kaplan et al., 1989; Riedl, 2017). The importance of the trust factor is

demonstrated by what impact it has on patient behaviour, compliance to treatment plans and openness about the patients' medical conditions(Stewart, 1995; Zucker et al, 2019) . As shown by a number of studies conducted on the effect that managed healthcare has on the doctor-patient relationship, the common theme that stands out the most is that of trust. Doctors find themselves pressed to be accountable rather than to be communicative, to conform to regulations rather than to enter into relationships of trust(O'Neill et al,2002)

When patients do not have faith and trust in their doctors, there is poor health outcomes as a result of poor follow-up and poor adherence to prescribed medication (Stewart, 1995; Chamsi-Pasha et al, 2016, Zucher et al, 2019, Ford et al, 2004).

The importance of trust in the doctor-patient relationship is highlighted in the following five dimensions. Patients trust that:

- their treating physician is appropriately skilled to do their job
- the doctor will always act in the patient's best interest
- doctors have control over the environment which will allow for optimal patient care
- patients' confidentiality will be upheld at all costs; and
- the treating doctor will disclose all the necessary information to allow the patient to make a fully informed decision.

Patient trust is highly dependent on the perceived independence of the doctor from funders and managed care companies(Gray, 1997). The doctor-patient relationship requires some ethical code because of the vulnerability of the patient and the belief that the doctor is skilled and knowledgeable in their subject i.e. information asymmetry (Hall et al, 2019). The patient

trusting the doctor is an essential part in the outcomes in healthcare(Stewart 1995; Zucher et al, 2019; Ford et al, 1997).

In the event that patients trust their doctor, there is a high probability that they will wholly submit themselves to the doctor(Zucher et al, 2019), submit to treatment and examination (Ford et al, 2004), follow the doctor's recommendations(Ford,2004; Zucher et al, 2019) and comply with treatment offered by the doctor(Zucher et al, 2019).

Most important is the likelihood that they will comply with the doctor's orders. As this dissertation is on the ethical implications of managed healthcare on the doctor-patient relationship, the primary objective of medical ethics then is to maintain the conditions necessary to preserve trust, prevent the abuse of that trust by both the doctor and the managed care organisation and promote trustworthiness in the doctor-patient relationship.

3.2.3 Respect for autonomy and patient choice

The idea of respect for persons encompasses the basic principles of "doing ethics". The practice of ethics has to do with moving the "moral is" when dealing with persons (what the current situation is) to a "moral ought" (the ideal that we want it to be or to be achieved).

The accepted basic principles of ethics are autonomy, beneficence, non-maleficence and justice(Rachels et al,2015) .

Autonomy of the patient in managed healthcare applies to the managed care organisation having a duty to respect the right of their members to make decisions about the course of their lives(Feldman et al 1998). This respect for persons allows both the doctor and the

patient to be able to make decisions that are favourable to their relationship, without feeling pressured into accepting what they are uncomfortable with(Hattingh, 2015). Rachels et al have the following to say about choice: "an **autonomous** patient should have the right to choose how they want to live, and not dictated to by corporate." Socrates is quoted as having said that morality is about "how we ought to live" (Rachels et al, 2015, Pg. 1).

The patient and the doctor, in nurturing a relationship (the DPR), ought to do so by choosing freely to associate and interact. The patient has the right to choose a doctor that they feel is competent(Emanuel et al, 1995) that they are comfortable with and who speaks a language that they understand(Emanuel et al, 1995); in other words, who communicates with them freely. As mentioned in the previous section, where the autonomy of the doctor is curtailed, the patient will lose trust in their doctor(Feldman et al, 1998). When a patient does not trust their doctor, adverse health outcomes follow as compliance with instruction from the doctor stems from faith in the doctor (Stewart, 1995; Ford, 2004; Zucher et al 2019).

Given the choice that patients have in an autonomous relationship, patients would be able to change doctors if they could(Agyei-Baffour et al 2013). Unfortunately, with managed care, patients do not have this option if they are dissatisfied with their practitioner, leading to unhappiness and breakdown in trust, which translates into poor health outcomes (Forrest et al., 2002; Stewart, 1995).

Implementation of managed care has its inherent problems. Managed care plan options determine when medical care is necessary(Klinck, 2018; Booyens, 2000), and patients will therefore be covered. Managed care plan options vary from low-end with limited benefits to high-end with unlimited benefits(Hugo et al, 2005). The lower the plan option, the fewer the

services available to patients. This is an ethical dilemma in that the doctor should be the one to determine whether treatment is necessary and what type of treatment to administer (Mahlo et al, 2000). This impacts negatively on the doctor autonomy and freedom to decide what is best for their patient. This has the unintended consequence of depersonalising medical care; patients being treated as commodities.

If one were to consider autonomy as the sole determinant of what access to healthcare patients have, they would opt to choose the fee-for-service model. This model, however, needs to be balanced by fairness and equity in the distribution of resources. If the resource allocation is prudent, this will ultimately result in the good of the whole membership.

In the same token of respect for autonomy, as a case in point demonstrated in the Ghanaian model(Agyei-Baffour et al, 2013), the capitation method implemented in the region maintained some sort of autonomy, which may be comforting to patients. The capitation system allows patients to choose their doctor, which in a way gives them some control over their healthcare. This is important to the doctor-patient relationship. The contract is such that patients are allowed to establish a rapport with the doctor of their choice, and if they are not happy, they are given an option of changing the doctor after a period of six months (Ageyi-Baffour et al., 2013).

3.2.4 Respect for beneficence

In the implementation of managed care, the providers have to be cognizant of the fact that each has to be prudent users of healthcare resources to the benefit of their members. However, in the same token, the doctor should at all times act in the best interest of their patients(Forrest et al, 2002).

The duty of beneficence is the ability of persons to care about one another. Beneficence is natural for human beings as we are by nature social beings (Rachels et al, 2015). Beneficence becomes strained when the best interest of the patient gets influenced by economic incentives. This is more so when doctors are rewarded financially for limiting necessary care in individual cases. This seems to be the case with DSP. DSPs are doctors chosen by a medical aid scheme to treat the schemes' members with a promise of above average payment agreement(Klinck, 2018; Booyens, 2000). This creates a perverse incentive in that doctors can overservice to be paid more. On the other hand in the case of capitation, doctors will undertreat patients to save on allocated funds , especially in risk sharing (Compcom, 2018; FPD, 2003). Some managed care (medical aid) companies promise to pay doctors more if they curtail use of certain important services (Biblo et al., 2004; Mahlo et al, 2000).

Non-maleficence and justice have equal weighting in decision-making and none has prima facie value over another (Rachels et al , 2015)

3.2.5 Justice and fairness

Social justice revolves around the concept of human rights and equality. Social justice seeks to address the inequalities that are based on a number of factors, viz. race, gender, religion and socioeconomic class. Application of social justice in managed healthcare, therefore, involves the equity that needs to be applied in rationing healthcare in unequal societies(Emanuel, 2000).

Factors such as education, socioeconomic status and employment can contribute to injustices. Managed care managers need to take this into consideration when drawing up protocols in

managed care. They need to ensure that individuals who have been marginalised and are currently vulnerable to inequality should be considered and be taken care of and should be fairly treated.

There are two dimensions of justice in healthcare, viz. access and allocation.(Emanuel, 2000). Access to healthcare has to do with human rights and ability of people who are entitled to services actually receiving them(Emanuel, 2000; Constitution of South Africa, 1996).

According to the Constitution of the Republic of South Africa, Chapter 2 on the Bill of Rights states that each person is entitled to have access to healthcare(Constitution of South Africa, 1996, Pg. 11). This is also emphasised by the patients rights' charter. According to the Declaration of Lisbon of 1981, during a meeting of the Assembly of World Medical association, it declared that the patient has the right to choose his physician freely, the patient has the right to be cared for by a physician who is free to make clinical and ethical judgements without any outside interference and that the patient has the right to expect his physician will respect the confidential nature of his medical and personal details, amongst others(WMA, 1981).

South Africa declared their patients' rights charter in 1999 after it was enacted in 1996. Among these rights are included the right to access to healthcare, the right to choose health services and the right to knowledge of one's health insurance.

Allocation , on the other hand refers to the type of resources that should be devoted to healthcare i.e. having access to poorly resourced health services is not justice nor is it fair(Emanuel, 2000)

3.2.6 Confidentiality in the doctor patient relationship

Confidentiality has been an issue when patients need to consult with their healthcare professionals(Ford et al, 2020). Confidentiality has always been recommended when healthcare practitioners interact with their patients. Their interaction with the patient should be in a safe, secure and confidential environment(WMA, 1981;WMA, 2015; HPCSA booklet 3).

In the event that patients feel there is breach in confidentiality, it is highly unlikely that they will return for follow-up visits(Pritt,2020). In the same vein, research has shown that where patients feel that there is confidentiality, there is bound to be adherence to treatment, increases satisfaction and there is a high incidence of return visits(Ford, et al, 2020). Conversely, where patients feel that there is a likelihood that someone will know about their conditions and there is breach of confidentiality, the opposite will be the case i.e. poor adherence, poor satisfaction, poor health outcomes and low compliance(Pritt, 2020; Stewart, 1995).

Evidence has shown that providing confidential care is critical to providing appropriate health care especially when patients feel comfortable with their doctor (Ford, 2004). Other studies have shown that patients will not seek medical care if they feel that their confidentiality may be breached and they may not disclose all information during

consultation(Zucker et al, 2019). Discussing confidentiality with patients markedly enhances creating rapport and taut between the doctor and the patient, and thus strengthening the doctor patient relationship(Zucker et al, 2019). As we will see later, converse is true and has a negative impact on health outcomes.(Stewart, 1995)

3.3 Legal perspective

In this section, I will define and expand on legislation pertaining to the governing of medical schemes, doctors and medical facilities in relation to the doctor-patient relationship.

I will discuss regulations relating to managed healthcare as prescribed by the Council on Medical Schemes (CMS) and describe the patient charter and the patient's rights.

3.3.1 The Doctor as a fiduciary agent

The legality of the doctor-patient relationship rests on the notion that the doctor has a fiduciary duty and loyalty to their patients(Hall et al, 1999). In fact, the premise in legal perspective of healthcare provision rests in the bold declaration that all healthcare stakeholders, namely the state, doctor, medical aid schemes, hospital and all relevant entities create finance and distribute healthcare in the context of their fiduciary relationships with patients (Matthew, 2011).

In law, a person is said to have fiduciary duty if that person has power or property entrusted to them for the benefit of another i.e. one party, a fiduciary, performs some service for another party, an entrustor (Frankel, 1993,Pg. 177). In medicine, there is an archetypical

fiduciary relationship between a doctor and the patient and has certain attributes of agency, dependency, trust, and information asymmetry (Hall et al, 2019)

In other words, with the knowledge and the power that the doctor has, much is expected from them in terms of benefitting the patient. Thus, the doctor is legally and morally bound to protect the patient at all costs, even against the managed care company (Mehlman, 2015).

This concept of fiduciary duty espoused is not without precedent, having been supported by two cases in 1760 and 1819, in which Chief Justice John Marshall affirmed this (Marshall cited in Matthew, 2011). Fiduciary law focuses on the quality and integrity of the expert's effort, dedication and decision-making on behalf of the patient(Hall et al, 2019). When a patient is sick, they open themselves up to scrutiny by the doctor, pouring out the most essential aspects of bodily intimacy (Hall et al, 2019).

These attributes of agency, dependency, **trust** and information asymmetry constitute an archetypal fiduciary relationship (Hall et al, 2019). In *Lockett vs Goodill* (1967), the judge clearly stated "that the relationship of patient and doctor is a fiduciary one of the highest degree. It involves every element of trust, confidence and good faith". To be a good fiduciary agent, one needs to refrain from practising in a manner that is inconsistent with the good faith the patient expects from the doctor(Hall et al,2019).

In emphasising this fiduciary duty and loyalty in the doctor-patient relationship, the breach in loyalty can be seen in *Moore vs Regents* of University of California, which upheld a patient's cause of action. This was a case of a breach in fiduciary duty of a doctor who took spleen cells from a patient during surgery without the patient's knowledge. The doctor developed a

range of biological products with an enormous commercial value. In protecting the sacrosanct relationship between the doctor and the patient, and in affirming the duties and responsibility of the doctor towards his patient, the courts found in favour of the patient in that the doctor was not consistent with what was expected of him as a fiduciary agent (Hall et al, 2019).

3.3.2 Confidentiality and consent

A doctor patient relationship is established "when a doctor affirmatively acts in a patient's case by examining, diagnosing, treating or agreeing to do so" (Blake, 2012). A relationship is paramount in the interaction between the doctor and their patient. In *Hurley vs Eddingfiled*, the Supreme Court of Indiana in 1901 held that a patient who walks through the doctor's door is not necessarily a patient of that doctor. This was the case of Charlotte Burk, who had complications during childbirth. Upon being called, Dr Eddingfiled refused to treat Ms Burk. The mother and child subsequently died. Dr Eddingfield was not obligated to provide care to Ms Burk unless he chose the terms of practice. So, a rapport needs to be established between the doctor and the patient and patient should have absolute confidence in their doctor that they will do the right thing.

Doctors also have a duty to their patients when it comes to **confidentiality issues**. In a case of *Jansen van Vuuren and Another NNO vs Kruger*, the judge in the appeals division ruled in favour of the patient, Mr McGeary, and against the doctor, Dr Kruger. Although the Supreme Court ruled in favour of the doctor in the original case, upon appeal the Appellate Division found that the doctor had breached the patient's confidentiality in disclosing the patient's HIV status to two colleagues on the golf course without the patient's informed consent. In the finding against the doctor, the appellate division had determined that Dr Kruger had not

obtained the **patient's consent** to disclose the information. He had, in fact, promised the patient that he would not disclose the information (Dancaster & Dancaster, 1995).

The doctor also has a duty to inform the patients if he is in the employ of managed care companies. The doctor has a fiduciary duty to his patients and cannot abandon that responsibility due to their association with a managed care organisation(WMA, 1981). The doctor has a fiduciary duty of loyalty and duty of care(Hall, 2019).

Although there are case law reports that reject the notion of a fiduciary duty in the doctor-patient relationship, there are more reports in favour of than against this duty. In short, informed consent, confidentiality and conflict of interest are the primary areas of fiduciary doctrines for medical personnel. As we have seen, managed care has an effect on this fiduciary duty of the doctor in a number of ways. Firstly, the doctor is coerced into not putting the patient's health first but rather the interest of the company. Secondly, the doctor is conflicted in that there is incomplete disclosure of financial interest on the part of the doctor. Thirdly, at times, the doctor is forced by the managed care organisation to disclose confidential information about the patient(Feldman et al, 1998).

In the South African context, the fiduciary duty is detailed by the recommendations from Council of Medical Schemes. CMS is established in terms of the Medical Schemes Act (MSA).

3.3.3 Medical Schemes Act

The Medical Schemes Act (131 of 1998) consolidates the laws relating to registered medical schemes and provides for the establishment of the Council of Medical Schemes under Chapter 3.

The Act provides for the:

1. Appointment of Registrar of the Council Medical Scheme;
2. Registration and control of certain activities of medical schemes;
3. Protection of interests of members of medical schemes in so far as the managed health organisations are concerned; and
4. Supervision of private health financing through medical schemes.

In a nutshell, the purpose of the Act is to ensure financial viability of the registered schemes so as to not jeopardise coverage of the insured beneficiaries of the scheme.
It gives guidelines to medical schemes and administrators and also accredits managed care organisations. CMS enhances the doctor-patient relationship by legally protecting the vulnerable patient.

The identified levels include hospital benefit management via preauthorisation, case management and specialist care; disease management programmes targeting specific diseases and pharmaceutical benefit management by the use of generic and brand medicines(MSA, 1998). The models utilised include capitation system, health management organisations (HMO) and preferred provider (PP) systems.

The council acknowledges the need for managed healthcare funding in South Africa and the document is intended to develop an approach to the development of appropriate regulations. The departure point of this document is that medical schemes and the managed care companies need to integrate sound financial models in order to ensure that clinical interventions are appropriate and in turn cost-effective(MSA, 1998)

This section is relevant in that the arguments in favour of managed healthcare are for more funds being made available to more members than a few by rationing services(Emanuel, 2000). This is a utilitarian approach. This section prevents abuse of the funds by the members.

As we can see, the Medical Schemes Act (MSA) will have a direct impact on the doctor-patient relationship in that it upholds the patient's autonomy and the rights of the doctor. The doctor is protected from abuse by the funders.

3.3.4 The Constitution of the Republic of South Africa (1996)

The Constitution of South Africa is the supreme law of the country. It provides the legal foundation for the existence of the Republic, sets out the rights and duties of its citizens and defines the structure of the Government. It is the highest law in the land. Chapter 2, sections 7–29 of the Constitution, is called the Bill of Rights (BOR). I am of the opinion that this is the most contested part of the Constitution as the values enshrined in it have a direct bearing on health issues. The BOR is the cornerstone of democracy in South Africa and has the most bearing on health issues.

Sections of the BOR which can be interpreted to support the doctor-patient relationship are evident in the equality section. Section 9(1) states: “Everyone is equal before the law and has the right to equal protection and benefit of the law.” Section 9(4) states: “No person may unfairly discriminate directly or indirectly against anyone in terms of subsection (3).” The fact that a doctor is presumed to possess skills and knowledge on clinical matters which a patient does not have, does not mean that the patient is inferior. Equality therefore must form the basis of a doctor-patient relationship.

The human dignity section (10) states: “Everyone has inherent dignity and the right to have their dignity respected and protected.” This means that a hallmark of a good doctor-patient relationship is guided by this section, which upholds human dignity. The privacy section (14) stipulates: “Everyone has the right to privacy, which includes the right not to have … (d) the privacy of their communication infringed.”

3.3.5 The National Health Act (61 of 2003)

The National Health Act “gets its authority and essential elements from the Constitution” and also forms a foundation of close corporation between the “public and private hospitals to regulate the minimum standard of care to which all people living in South Africa are entitled”.

Sections and subsections that are in line with the Constitution and thus enhance fiduciary duties are sections 6, 7 & 8. Section 6 details the obligations of the doctor to their patients. Doctors must communicate to their patients what they are entitled to and explain in a manner and language that the patient clearly understands. This section clearly confirms the fiduciary

duty of the doctor to their patient. Section 7 deals with informed consent and section 8 with involvement of the patient in decision-making with regard to their health.

Section 26 of the Act, states that once a scheme is registered, “it will assume liability for and guarantee the benefits offered to its members and their dependants in terms of the scheme rules.” This ensures that the patient is protected against unfair treatment from the medical scheme and that they are not short-changed. Section 28 of the Act ensures that patients, in turn, do not defraud the scheme by having access to more benefits than they are entitled.

In this chapter we have seen what an ideal doctor patient relationship should look like and what its attribute are. Also from a legal point of view, there are certain protections that are guaranteed in this relationship and how it should be conducted failing which there may be recourse.

In the next chapter I will outline ways in which different practices and tools of managed healthcare may threaten this ideal doctor patient relationship.

CHAPTER 4:

WAYS IN WHICH MANAGED HEALTHCARE MAY THREATEN THE IDEAL DOCTOR-PATIENT RELATIONSHIP

4.1 Introduction

South Africa is a country with a lot of contrasts between those that have and those that do not(Booyens, 2000) . It is a land where some have the best quality of healthcare that money can buy, provided for by the private health sector, and those that are indigent with the most burden of disease that are cared for by the public sector(Moosa et al, 2012) .

The private health industry covers 16% of the population and the public health sector the remainder 84%(Hugo et al, 2005). In this chapter, I will discuss the ways in which managed healthcare will have an effect on the doctor-patient relationship and the ethical and legal implications thereof. How the method of implementing managed healthcare will have an impact on the doctor morale which in turn will affect quality of care with unhappy patients and possible litigation.

4.2 Underservicing in risk sharing

This disparity in healthcare is what necessitated the government to introduce legislation to rollout national health insurance (NHI)(Moosa et al, 2012) . NHI is a form of managed healthcare that will be managed and funded by the government on a capitation basis, moving away from a fee for service model (Moosa et al, 2012). The proposed NHI will be the

government buying healthcare services to improve access to healthcare(Moosa, et al 2012; van den Heever, 2001).

Although managed by the government, there are going to be shortcomings when it comes to the doctor-patient relationship. There is a risk with the introduction of National Health Insurance that the overservicing that was seen in fee for service may be replaced by underservicing (Moosa et al, 2012).

The basis for reimbursement for NHI will be on a capitation basis, which is risk sharing tool, which puts the risk in the practitioners' court. i.e. to control utilisation by patients(Moosa et al, 2012). There is the risk that per head capitation fee may not be enough if patients use the NHI more frequently because it is free .This will put the relationship between the doctor and the patient at risk as doctors will prefer not to refer patients for costly investigations in a quest to maximise profit (Agyei-Baffour, 2013; Moosa et al, 2012). This will have two unintended consequences, viz. poor quality service from the doctors in order to maximize profit and patients will be short changed in that the service they receive will be perceived as substandard.

4.3 Health as a right

Health should be seen and treated as a right(Aggarwal et al, 2010), and not as a commodity as envisaged by managed healthcare. In utilization management, health is treated as a commodity. Managed healthcare is perceived as concerned more with profits and cost containment than quality of health delivery as some payment methods may discourage the provision of additional services(Gray , 1997) .

As a right, health is grounded in principles of justice and social good(Emanuel, 2000). As a right, healthcare is a need and not a choice and as such should not have profit motives as this would undermine the fiduciary relationship between the doctor and the patient(Aggarwal et al, 2010). Accessibility to health should be a right as defined in the Constitution of the Republic of South Africa(Constitution, 1996) and in the National Patients' Rights Charter(1999). The patient has the right to be cared for by a doctor who is free from outside interference. The doctor should be able to make clinical and ethical judgements without being influenced by such forces(WMA,1981). As a commodity, health is seen in the light of profitability(Aggarwal et al, 2010).

If allowed to shape healthcare delivery and given the right to determine policy, managed healthcare will result in inequalities and poor quality of health delivery to those who do not have the means .Those seen as high risk high cost and the elderly will be excluded from proper coverage(Aggarwal et al, 2010) . The impact that managed healthcare has on determining delivery should be curtailed and be put in the hands of the other role players, namely doctors and the members of the schemes(Gray,1997; Aggarwal et al, 2010). Market forces should not determine health policy and should not be allowed to determine healthcare delivery(Hugo et al, 2005).

4.4 Doctor morale and interaction with managed care companies/Trust and confidentiality

In the health sector, role players are the professional service providers (doctors and hospitals), funders (managed care companies) and members (patients) (Mahlo et al, 2000).

The doctor and patient are at the mercy of the managed care companies, who hold the purse strings and control what doctors can or cannot do through the implementation of provider networks (Klinck 2018, Booyens, 2000). This has an impact on patient's trust on the doctor and affects the doctor patient relationship.

Doctors' autonomy is affected by accountability to the medical aid companies (Light, 2006; Gray,1997) and this is perceived by patients as the doctor not being on their side. When trust is affected, health outcomes are affected negatively(Stewart, 1995).

In a survey conducted among role players in the healthcare industry, the authors found that the major concern of doctors was their perceived loss of power when managed healthcare was in place (Mahlo et al 2000). Patients also feel that because doctors have to abide by protocols from managed care companies; doctors are not on their side and see them as colluding with the managed care companies, thereby negatively affecting the doctor-patient relationship(Agyei-Baffour; Moosa et al 201; Gray 1997; Aggarwal, 2010) .

Managed healthcare delivery systems differ depending on the plan chosen by an employer for their employees(Booyens, 2000, van den Heever, 2001). Available medical aid options in South Africa are either closed or restricted medical schemes or open medical schemes. In a closed medical scheme the employer has an in-house medical care facility, and the scheme is community rated (van den Heever, 2001).

A scheme is regarded as community rated if contributions are in no way differentiated on the basis of health status(van den Heever, 2001). In the case where the scheme is restricted,

patients do not have the liberty to see a doctor of their choice, and thus affecting the patients' autonomy and choice(Moosa, 2012; Aggarwal, 2010)

The other option is the open medical scheme, where each patient is allowed to belong to a medical scheme of their choice and have free choice to visit whichever doctor they choose(van den Heever, 2001). With the open scheme, the original fee-for-service may be replaced with a capitation system that further erodes patient autonomy(Gray, 1997; Klinck, 2018). Patients will have limited services and doctors will be obligated not to recommend further necessary investigations to manage costs, which patients may see as inferior quality of service(Gray, 1997) .

Another option is that of designated service providers (DSP) where the patient is assigned a doctor to consult by their medical aid plan(van den Heever, 2001; Klinck, 2018). All these options have the commonality of a scheme, a doctor, a managed care company and an administrator. These all have the doctor-patient relationship at their core; the fear is that, irrespective of whether it is fee-for-service or managed care, this relationship is at risk due to financial incentives(Gray, 1997; Aggarwal, 2010). In a fee-for-service structure, the risk stems from over-servicing (over treatment) and in managed care from under treatment to save the managed care company money(Moosa et al, 2012; Compcom, 2018; FPD, 2003). Both systems are flawed, and both have an impact on the relationship (Biblo et al., 2004).

In the current situation, there is a shortage of doctors per population in South Africa. The recommended doctor-patient ratio from WHO is 1 doctor per 1000 population(WHO, 2018). South Africa is in the same economic category as China (1.8 per 1000), Brazil (2.1 per 1000), Russia (4 per 1000) and India (0.8 per 1000) and clearly these countries fare better when

compared to South Africa in terms of this ratio(WHO, 2018). South Africa has a ratio of 0.9 per 1000. The health of a nation can be determined by various factors, including socio-economic, environmental factors, burden of disease and the ratio of doctors to patients.

It is against this background that rationing of shared resources is inevitable (Hall et al, 1998; Hattingh, 2015).

As much as managed healthcare was introduced to curb spiralling costs, some do not see this deemed benefit of managed care (Gray, 1997). Instead, it is regarded as corporate exploitation of market failures which, in the process, exploits doctors and professional providers(Hugo et al, 2005). This in turn allows corporate providers to exploit patients for a profit(Aggarwal et al, 2010).

Doctors are bound by formularies that restrict their autonomy(Klinck, 2018) and freedom to practise to the best of their ability. If they do not adhere to formularies, they are taken off the medical aid's payment scheme and will not be allowed to charge what is deemed a fair price for services rendered. Patients are also disadvantaged in that they are given options that exclude conditions that they suffer from(Gray, 1997, van den Heever, 2001).

Although rationing of health resources is a necessity, literature shows us that the manner in which this is implemented is of utmost importance(Mahlo et al, 2000). It is between either doctor-centred implementation and central implementation, where managers who have no contact with patients (i.e. non-clinicians) make all the decisions. The ethics of managed healthcare emanate from what can be seen as the "what is" versus the "what ought". The ideal situation is implementing managed healthcare by constantly looking at the *moral ought.*

As much as doctors are placed in a gatekeeping role, the term needs to be clarified. The gatekeeping role should be seen not only as cost containment, but also as the doctor acting efficiently, using their knowledge to fast-track patient treatment and prevent over treatment and unnecessary, costly medical tests(Kinghorn, 1996). The gatekeeper should not be seen as an individual intent on denying access (Biblo et al., 2004). As described by Mahlo et al (2000), this seems to be the case when doctors were interviewed and asked for their opinion in their interactions with the medical aids (Mahlo et al, 2000).

One of the points they identified was the perception that cost saving is against or counter to quality of care. In other studies, the patients perceived doctors as denying them access to quality healthcare, creating an adversarial doctor-patient relationship (Feldman et al., 1998; Hall et al., 1996).

With managed healthcare, patients often do not necessarily have a say in how they will be treated(Agyei-Baffour et al 2013) or benefit from the arrangement that the scheme enters into with doctors and medical facilities(Kinghorn, 1996).

Unfortunately, application of managed care is based on affordability of the members of a scheme. As is the case in the international setting, those who have the means are the ones who benefit from “managed inequality”. In South Africa, to circumvent this trend, the government introduced a system where the most basic services are available to all, irrespective of affordability(Klinck, 2018). These are called this prescribed minimum benefit (PMB). PMB prevents coverage to only the affluent and those in the high end of the bracket receiving more on the basis of their higher plans (economic discrimination). Patients utilising

the services should be afforded the same cover irrespective of power, influence or financial status (Rylko-Bauer & Farmer, 2002).

In this roll-out of managed care and in order to safeguard the sanctity of the doctor-patient relationship, managed care companies need to educate and re-orientate both the public (members) and the doctors so that all stakeholders are on the same page(Mahlo et al,2000). This is one of the points identified as critical to the success of managed healthcare (Mahlo et al, 2000;Booyens, 2000).

Granted, there is a scarcity of resources due to aging and underserved populations, technological advances, member and patient expectations and changing patterns of diseases. Managed care companies are therefore cornered into rationing resources, but this needs to be done equitably without pitting patient against doctor.

4.5 Commercialisation of Health Services

In implementing managed care, there is a perception of commercialisation and corporatisation of healthcare(Booyens, 2000; Kinghorn, 1996). Some have equated managed healthcare as corporate takeover of health services(Booyens, 2000) and hence apprehension and rejection by doctors to managed healthcare(Moosa et al, 2012; van den Heever, 2001).

History has shown that marketisation and corporatisation of healthcare do not necessarily translate into lower healthcare costs as envisaged (Hugo et al, 2005). Cost containment based on competitive market principles does not decrease healthcare costs(Hugo et al, 2005; Booyens, 2000). Rather, it has been shown to actually increase rather than decrease health

costs(Hugo et al,2005). This, in turn, has led to greater numbers of patients being uninsured as well as widespread rationing of healthcare based on the patient's ability to pay, resulting in serious ethical dilemmas for medical practice (Rylko-Bauer et al, 2002).

Managed care companies are by nature focused on profit and have shareholders who expect dividends(Feldman, 1998). It is unethical to expect profit from healthcare delivery at the expense of quality of care to the patients. Managed care should be a means of providing quality care in an efficient manner at a cost-effective rate and must provide appropriate care to a large number of people without any disadvantage to the individual . In the process, the doctor-patient relationship should not be jeopardised. In reference to practice guidelines and protocols, managed care should not be implemented in a "cookbook approach" fashion (Biblo, et al, 2004) or step by step cooking "recipe"(Klinck,2018).

4.6 Practice guidelines and treatment formularies

Practice guidelines are an essential part of managed healthcare(Wilkinson,2018), but with this approach, which at times may be seen as rigid(Klinck,2018), it may have an adverse effect on the doctor-patient relationship(Feldman, 1998). It interferes with doctor autonomy, to do what the doctor deems fit for the patient and the type of treatment patients ought to receive. When the doctor is unable to practise medicine the way they were taught without considering what the quality of care will cost, autonomy is affected(Feldman,1998).

As we have seen, South Africa has a two tier healthcare system, one private(16% of the population) and the other public(84%)(Hugo et al, 2005). The private sector is mostly managed by medical aid schemes, which is probably the best example of managed healthcare

in South Africa(Hattingh, 2015) The way managed healthcare is implemented in the current form, managers and people (case managers) who are responsible for authorising treatment plans have a rigid approach without taking each case on its own merit(Klinck,2018). The treatment formularies used restrict the prescribing power of the doctor. The patient will feel as if the doctor is colluding with the managed care company in the event that authorisation is declined and if clear communication from the doctor to the patient is not forthcoming as to why the service is declined(Gray, 1997; Agyei-Baffour et al, 2013)

The roll-out of managed healthcare should not be seen as rewarding financial incentives(Feldman,1998) to hospitals and doctors for underservicing(Moosa, 2012; van den Heever, 2001; Medical Brief, 2017); this would be unethical. Both systems of fee-for-service and managed care can fall into the trap of financial benefit. Both will be seen as unethical as the former will result in over-servicing and the latter underservicing. Both systems are equally improper(Moosa et al, 2012).

Managed healthcare has serious ethical implications in the delivery of healthcare. Parameters have been identified by Feldman et al. (1998) where managed healthcare may have an effect on the doctor-patient relationship. The parameters are: 1) physicians' obligation to put the patient first; 2) the ability of the patient to choose their own treating doctor, that is, autonomous choice; 3) patient choice in medical decisions affecting them; 4) continuity of the doctor-patient relationship; 5) communication between the doctor and the patient; and 6) overall doctor-patient relationship.

A negative impact was shown across all parameters (Feldman et al., 1998). The parameter that was affected the most which doctors bemoaned was the impact on the time doctors have

for their patients. In order for the doctor to maintain a certain income, they have to work faster so as to see more patients and make more money(Feldman et al,1998). Emphasis is therefore on productivity rather than on patient care. This in turn has a negative impact on the quality of care that the doctors provide to their patients.

So overall, implementation of managed healthcare in whichever form may have a negative impact on the ethical obligations of the doctor to the patient and thus a negative impact on the doctor-patient relationship. Managed healthcare has been shown to have a negative impact on the doctor-patient relationship in up to 66% of the cases investigated (Feldman et al., 1998).

In the next chapter, I will discuss why the harm to the doctor -patient relationship is not ethically justified.

CHAPTER 5:
WHY THE HARM TO THE DOCTOR-PATIENT RELATIONSHIP IS ETHICALLY UNJUSTIFIED

5.1 Introduction

In this chapter I will introduce the bioethical principles of autonomy, nonmaleficence, beneficence and justice to highlight the importance of safeguarding them in the introduction of managed healthcare. I will show why the harm to these principles are unjustified and unethical. I will also discuss the impact that their effect has on the patient's access to healthcare.

5.2 Bioethical principles

In their implementation of managed care, there are certain criteria that the companies need to meet for their members. The five main criteria as mentioned by (Biblo et al, 2004) are the principles that are widely accepted in the field of bioethics. These criteria are the bedrock of "respecting persons". Managed care organisations need to guarantee their members that they will at all times act with integrity and allow their members the right to choose (autonomy), and give their choice the respect it deserves. With free choice comes trust and with trust comes good health outcomes (Stewart, 1995).

The relationship between the managed care organisation (medical aid scheme) should not be dictatorial(Gray, 1997). In the process, the managed care organisation should be obliged not to harm their members (non-maleficence)(Klinck, 2018). Not harming their members should

imply that, within a reasonable means, the organisation should not refuse treatment options that are recommended by the doctor within the confines of cost containment.

The decision to reject or approve an application of request for authorisation for a procedure should not be arbitrary, but informed(Klinck, 2018). That is, each member should be treated in a manner that respects their own goals and values(Rachels et al, 2015). This should not apply only to the individual member, but also to the collective of the bigger group. In its current form, the application of managed care and the incorporation of doctors' professionalism are centred around accountability of doctors to the medical aids instead of autonomous practice to the best of the patient's wellbeing(Kinghorn, 1996). The effect that is unjustified on the doctor patient relationship is that as a result, medicine has lost both autonomy and influence on the profession throughout the world (Cruess et al, 2000).

Some studies have shown that managed care organisations sometimes do not allocate and share resources equitably(Aggarwal, 2010). Those that have strong financial means tend to benefit more than those that do not have the same means. Those that have the highest burden of disease, who are seen as high risk by managed care have limited access to services (Aggarwal et al, 2010; van den Heever, 2001).

In the distribution of justice, managed care organisations are urged to allocate resources in a way that fairly distributes benefits and burdens among their members and at all times should act in the best interest of the patient (beneficence)(Gray, 1997). When the patient's interest is adversely influenced by economic incentives, the beneficence will be strained.

5.3 Effect of managed care on patients: the right of the patient in access to healthcare

Managed healthcare companies need to consider that healthcare is a basic human right (Aggarwal et al , 2010; Constitution of Republic of South Africa, 1996). Healthcare is a moral entitlement which should not be interfered with (Biblo et al, 2004). In this rolling out of healthcare, it should not be acceptable to deny care to a patient that is clearly indicated and beneficial(Klinck, 2018, Gray, 1997).

In the same token, no futile treatment should be given either. Every patient has a right to be treated with respect and their values and beliefs to be respected(Rachels et al, 2015). Patients desire to be treated in a manner in which they do not feel discriminated against on the basis of their race, religion, sex, age, disability or financial means(Emanuel, 2000). If such discrimination is present, patients will not trust their healthcare professionals and suffer subsequent poor health outcomes(Stewart, 1995) .

Patients should be given a choice of a panel of doctors to choose from; it should not be the prerogative of the managed care company(Agyei-Baffour et al, 2013). Among other problems identified by patients is the restriction of patients to one practitioner. The most cited reason why patients did not renew their managed healthcare plans was their inability to access healthcare everywhere as they were restricted to one preferred provider and they were not given the primary provider of their choice(Ageyi-Baffour, 2013).

Also, negative sentiments with regard to managed care is the perceived poor quality of healthcare provided by the company and that the service does not cover certain conditions

and medications. They cited limited services provided by their plans as a major reason for clients' being dissatisfied with the system(Agyei-Baffour et al, 2013).

Accessibility to healthcare and continuity is seen as a cornerstone of the doctor-patient relationship (Institute of Medicine, 1996). Implementing certain managed care plans entails uprooting patients from their usual physicians to those "designated" by the plan, not taking into consideration the doctor's knowledge base and skill or the financial cost to the patient(Feldman et al, 1998), whose newly designated doctor is quite a distance from the patient's residential area. This erodes the patient's autonomy and free will.

In the South African context, there has been talk of implementing a global fee payment structure. Global fee reimbursement models provide a single payment to a surgical team performing a particular operation. The fee will mostly cover all the tests, procedures, devices and rehabilitation needed for a patient's condition(Medical Brief, 2017) . This will harm patient and doctor autonomy as the patient will have no say as to whom their primary doctor will be (knowledge and skill) and the doctor will not be able to bill the scheme an appropriate fee for the complexity of the operation or procedure undertaken. This will be in violation of the code of practice by the HPCSA. Patients have the right to choose a doctor and a facility where they want to be treated and should have a say in the type of treatment to which they are subjected (Patient Charter, HPCSA 2016).

Global fees have an ethical problem in that they create an incentive for underservicing (Medical Brief, 2017). Other ethical concerns with a global fee arrangement that will have a negative impact on the doctor-patient relationship is autonomy issues to both the doctor and

the patient. The global fee model is also in breach of the HPCSA (HPCSA Booklet 2, 2016) ethical rules 7(3), which state that:

> *A practitioner shall not offer or accept any payment, benefit or material consideration (monetary or otherwise) which is calculated to induce him or her to act or not to act in a particular way not scientifically, professionally or medically indicated or to under-service, over-service or over-charge patients.*

As well as rules 8 and 18:

> *A practitioner shall accept a professional appointment or employment from employers approved by the council only in accordance with a written contract of appointment or employment which is drawn up on a basis which is in the interest of the public and the profession.*

These rules prohibit professional appointments by non-healthcare professional entities and prohibit fee sharing with persons not registered at the HPCSA or not registered in same category of the professional(HPCSA, 2016). All these are in breach of the ethical obligations of the doctor stipulated by the HPCSA. HPCSA cautions doctors against such practices as it interferes with doctor autonomy and patient safety (Medical Brief, 2017). Global fee arrangement is unethical in that the Patient Rights Charter clearly states that a patient has the right to choose a doctor and a facility where they want to be treated. With a global fee structure, to whom does the patient belong? This puts the patient at risk.

5.4 Effect of managed care on doctors: Physician autonomy and managed healthcare

For doctors, autonomy is the key to practising healthcare. When doctors are restricted, the doctor-patient relationship will be adversely affected. Among the issues identified to be eroding the doctor-patient relationship is the payment systems for service providers. Agyei-Baffour et al. (2013) identified capitation as a potential source of conflict.

In a capitation system, the doctor is paid per basket of services that they are going to provide(van den Heever, 2001). The problem with the capitation method of payment is that it will not be sufficient for those doctors who are extremely busy compared to the doctor who gets paid the same amount but are not busy(Agyei-Baffour, 2013). In effect, busy providers are underpaid and those that do not provide complex services are overpaid(Moosa et al, 2012).

Under managed healthcare, there is lower perceived clinical freedom and poor doctor satisfaction (Pillay, 2002). Doctors are under the impression that the introduction of managed care has led to poor quality healthcare(Kinghorn, 1996; Hugo et al, 2005), while reducing doctors' income and autonomy. Some researchers have given credence to this perception by asserting that the introduction of managed care contributes to the de-professionalisation of doctors. This is done by restricting the key to what defines their profession by threatening doctors' independence to make decisions unhindered and by compromising patient loyalty and trust in their doctors.

The introduction of managed care in its current form clearly has a negative impact on doctors' morale and moral consequences. As far back as the days of Hippocrates, emphasis has been on medical doctors' doing their duties diligently to treat their patients to the best of

their skills, personal integrity and privacy. “Salus aegroti suprema lex” (the wellbeing of the patient is the supreme law) and “primum nihil nocere” (first of all do not harm) are the principle professional rules (Ancane et al., 2015).

Although this was a paternalistic approach, this was a guiding principle in the absence of any other directive. In the same breath, the World Medical Association implores doctors to act in the best interest of their patients and not to let any financial, social or medical matter interfere with this duty(WMA, 2015). These duties have improved and enhanced trust in the medical profession and created a healthy relationship between the doctor and the patient. The ethical obligations stated above are at the core of the doctor-patient relationship.

Having seen what ethical impact tools utilized by managed healthcare have on the doctor patient relationship, in the next chapter I will discuss why it is sometimes justifiable to have this impact. This may be to the good and the benefit of the society at large.

CHAPTER 6:

DEFENDING THE ARGUMENT AGAINST OBJECTIONS

6.1 Introduction

In this section, I will present a counter-argument to my assertion that managed healthcare is inherently bad to the doctor-patient relationship. I will present evidence that under certain circumstances, for the benefit of the greater majority, it may be necessary to curtail individual rights and autonomy.

In order for the larger community to benefit, roll-out of healthcare has to be pooled into a single resource, be distributed equitably and rationed appropriately for the benefit of all(Moosa et al, 2012). In the previous section, I demonstrated the negative impact that managed healthcare has on the doctor-patient relationship. We discussed the bio-ethical principles of autonomy, beneficence and non-maleficence. Counter to my assertion, managed healthcare organisations and medical aids would use the principle of justice to guide the allocation of limited, pooled resources (Hattingh, 2015).

The managed care companies are also under strain to provide future distribution of healthcare and resources and must be prudent in distributing care. Therefore, they will be opposed to other bio-ethical principles. However, all bioethical principles have equal weighting in their application. No one principle is superior to or supersedes the other(Rachels et al, 2015) . Therefore, in choosing to apply one principle over the other, one will need to invoke morality in the decision-making.

Of relevance to the managed care organisations is that the healthcare to be distributed must be done from pooled resources. It is up to the organisation to devise solutions to this equitable and just distribution of scarce resources.

6.2 Justice in healthcare distribution

In the ever-rising cost of healthcare, be it in the public or private sector, healthcare delivery becomes unaffordable to most people in their own personal capacity(Hugo et al, 2005). This is a result of new innovations and modern technology; hence the need to pool resources and to ration healthcare service delivery(Booyens, 2000). In the patient's interactions with the healthcare system, there is a cost involved, either in the patient's personal capacity, the medical scheme that they belong to or to society at large. Some people will appeal to the ethics of utility as a guiding principle to making ethical decision in allocation of scarce resources(Rachels et al,2015) .

The managed care companies utilise distributive justice in order to justify rationing of resources. With distributive justice, there is a drive to distribute healthcare to as many people as possible under the constraints of limited resources(Hattingh, 2015). This approach creates a safety net to prevent the most vulnerable in society from facing gross violation of their basic right to healthcare(Beauchamp ,2003 ; Emanuel, 2000). As we have seen in the case of *Soobramoney vs Minister of Health(Kwazulu-Natal)* in the Constitutional Court, which ruled against Mr Soobramoney in rationing of scarce resources(Soobramoney v Minister of Health, 1998). He had appealed a ruling denying him renal dialysis as the appellant had other irreversible medical conditions and thus could not be dialyzed as a result of limited resources. What this case illustrates is that in the face of limited resources, some form of rationing of services is imperative, for services to be utilized for the greater good of the greater society.

In rationing care and distributing healthcare, one needs to guard against bedside rationing (Ubel et al, 1997). Bedside rationing is the withholding of a medically beneficial service by a doctor because of that service's cost to someone other than the patient(Gray 1997, Aggarwal 2010, Hugo et al, 2005) . When bedside rationing is applied, there is no equitable distribution in that the doctor can see that the patient requires the said treatment, but decides against it because it is going to cost the managed care company a lot of money(Moosa et al, 2012; Gray, 1997) .

Ubel et al suggest three conditions that defines what bedside rationing is.

1.) The doctor must withhold, withdraw or fail to recommend a service that, in the doctor's best clinical judgement, is in the patient's best medical interests.

2) The doctor must act primarily to promote the financial interests of someone other than the patient (including an organisation, society at large and the physician).

3) The doctor must have control over the use of the beneficial service (Ubel et al, 1997).

An example of bedside rationing would be a patient who presents to their doctor with what the doctor suspects to be a vestibular schwannoma, a rare tumour arising in the internal acoustic meatus. The doctor knows that a superior investigation to do would be an Magnetic Resonance Image (MRI) scan as it is a better modality to delineate even a 5 mm tumour, which can easily be missed by a CT scan. The doctor then elects to do the CT scan because, in comparison, it is cheaper than an MRI scan. The best investigation and in the best interest of the patient would have been an MRI scan. The point raised by bedside rationing is that in

all their interactions with patients, doctors should be advocates for the patient and not let economics cloud their judgement(Gray, 1997; Ubel et al 1997). Economic interests should not supersede patient interest.

The impact on the doctor-patient relationship is immeasurable. According to arguments, bedside rationing is wrong as it harms the doctor-patient relationship and at times creates possibilities for injustice(Ubel et al, 1997). Often, these economic-patient decisions which are moral in nature are placed in the hands of doctors and healthcare professionals who are often ill-equipped to deal with the situation(Biblo et al, 2004) .

6.3 Utilitarianism

Utilitarianism as a moral theory holds that moral decision-making should be based on a particular action and its consequences and not the action itself(Rachels et al, 2015) . The morality of that action depends solely on the consequences of that action; nothing else matters (Rachels et al, 2015).

The consequence of that action is that there should be happiness of individuals, meaning that nobody's wellbeing matters more than another. All are treated as equals. This theory will resonate with managed care companies as more people will benefit to the disadvantage of the few(Hattingh, 2015). To the utilitarian theorist, as long as the action is right, it is morally correct. The morality of that action is measured by how much good there is to the greater society(Hattingh, 2015).

Considering utilitarianism as a moral compass in the distribution of healthcare, there is interference with the guaranteed individual rights as enshrined in the Constitution of the Republic of South Africa. Section 27(1) states that "everyone has the right to have access to health care services"(Constitution of the Republic of South Africa, 1996). Utilitarianism conflicts with the ideal of justice (Rachels et al, 2015). As managed care organisations are more interested in monetary benefit and how much they can save, utilitarianism would appeal to them. Measuring overall happiness will be in terms of how much money the managed care company would have saved by utilising the system of authorising certain procedures and declining others(van den Heever, 2001; Klinck, 2018) . These decisions are based on how much such a procedure costs instead of looking at the whole picture and treating each case on its own merit(Klinck, 2018). However, in the managed healthcare companies, this would be ideal as more people will be covered by the savings made.

The other problem with utilitarianism is that limited information is available about what the future consequences of a particular action will be. What if there is an unintended consequence by applying this rationing of services? It is counterproductive to save a company money but then the company that they have saved money for gets into financial difficulties and ends up being unable to fulfil their financial obligations. None of the members of that company will be "happy" as a result of the saving. So, there will be injustice to those who did not benefit and later for those members whose intention of the managed care company was to make them happy. Justice requires us to treat people fairly and according to the merits of their situation (Rachels et al, 2015).

However, mostly and in all respects, utilitarianism does play a vital role in decision-making. A good example would be in a resource-constrained country like South Africa. With the

government having limited financial resources and a high HIV/AIDS burden, should the government pay for a procedure that costs R400,000 per patient before spending that money on a roll-out of antiretroviral medication to at least 400 people? The utilitarian theorist would argue that it is an obvious decision to make: the money should be spent on the 400 patients rather than on one patient. Those opposing would argue that doing the procedure would render the recipient financially productive and "may" go on to be financially secure to provide employment to the said 400 people and their families. As mentioned before, however, the consequence is not guaranteed.

The only problem is that utilitarian theorists base their decisions on insufficient information and incorrect assumptions about the future. This may ultimately lead to failure in achieving the greater good, despite the utilitarian theorist's best attempts (Rachels et al, 2015).
This decision will have a negative impact on the doctor-patient relationship as the individual who would have been a recipient of the rare innovative technology would feel that they are being discriminated against and their rights are trampled upon. The managed care company, on the other hand, would argue that it is benefitting many more individuals than only one.

Invariably, when rights get trampled upon, the rights of the most vulnerable in the society are affected the most(Aggarwal et al, 2010) . In healing the rift between the doctor-patient relationship and the managed healthcare organisations, we should use an approach advocated by the World Medical Association and that of Peabody(WMA, 2015 ; Peabody, 1929). The most vulnerable should come first.

In the utilitarian approach of benefitting the many, it should be the most vulnerable and indigent that should benefit. This is what John Rawls refers to as "justified unequal

distribution of health"(Rawls, 1999). In such a situation, it will be a win-win. Those who can afford will pay out of their pocket and not tap into the scarce resources. The indigent will benefit and therefore have a limited negative impact on the doctor-patient relationship. In our context, this is the intended principle of the NHI(Moosa et al, 2012; van den Heever, 2001). Those who can afford it can have a top-up medical insurance.

As the community is somehow involved, some have mentioned some form of utility in addressing this issue. Utilitarianism needs to be applied for the benefit of the majority.

6.4 Communitarianism

Communitarianism places a special emphasis on standards of justice as described by different communities. Human identities are largely shaped by different communities and social relations. This relation should help us make moral and political judgments and help us develop policies(Bell, 2020).

The theme that emanates from the literature in favour of managed care policies is mostly based on utilitarian and communitarian theories. The communitarian emphasis is that this is to the common good(Etzioni, 2014). It attempts to find a balance between individual rights and social responsibilities, which will appeal to the managed care company.

Their justification is that the managed healthcare aims to benefit the majority. Such policies may, however, be counterproductive affecting the doctor-patient relationship negatively. Health outcomes are negatively affected by this and have deleterious effects (Stewart, 1995).

Communitarianism is counter to Rawls's theory of justice(Bell,2020). It challenges the claim that western liberal culture is too individualist; in reality, people live in communities. In belonging to a medical scheme, one automatically joins a group of other members of that scheme and therefore becomes part of that community(van den Heever, 2001). In the communitarianism theory, emphasis is placed more on the community than on the individual, thus denying the patient the right to autonomy. On the other hand, communitarianism need not be authoritarian as it can work if applied correctly.

Some communitarians claim that we should not be concerned about only the individual good. We should also look at the common good(Etzioni,2014). The common good in the instance of managed healthcare is for the benefit of the larger community rather than for the individual patient. The argument put forth is that we should, at times, limit the individual's interest to that of the community.

According to the capitation model of healthcare funding in managed healthcare, the advantage of communitarian is that the pool of resources or funds available to the larger group is what makes this option viable(Agyei-Baffour et al, 2013). The composition of the enrolled group to the scheme plays an important role in determining the financial risk to the whole group.

Correct application of the capitation model will work in favour of the members and the doctor and will be a win-win for both (Agyei-Baffour et al., 2013). Obviously, not all funding models in the communitarianism realm are beneficial. Again Agyei-Baffour et al. (2013) mention a system of a "cash and carry" funding model where patients have to bear the costs themselves.

This introduces the issue of authoritarian communitarianism versus responsive communitarianism. The latter seeks a balance between the individual good and the common good. This is decision-making by consensus.

6.5 Social contract theory

The doctor-patient relationship is based on the principle of a social contract and social contract is closely linked to professionalism(Pellegrino, 1987). This social contract is as a result of an unwritten contract between society and the medical profession(Cruess et al, 2008, 2014). This contract dictates that the medical profession acquires the knowledge for the benefit of the society at large(Pellegrino, 1987) and the practice of medicine requires some element of altruism and selflessness(Pellegrino, 1987). Professionalism is related to the art of healing through a commitment in the relief of suffering. Therefore, in their nature, doctors are expected to act professionally all the time and are expected by society to have some semblance of selflessness(Pellegrino, 1987).

The society came to see the medical profession individually and collectively as a group that would behave in a certain way and their behaviour would somehow benefit the society as whole (Cruess et al, 2014). For as long as the society is satisfied with the behaviour of the medical profession, there was no need to question their integrity. A social contract is therefore a commitment made by the medical profession to the society as a whole, in return for their independence(Cruess et al, 2008, 2014). In the early stages of the "social contract " the benefit was to the individual patient(Cruess et al, 2014) In the implementation of managed healthcare, it interferes with this contract.

This contract has certain elements that need to be fulfilled by both parties. The profession should adhere to a certain professional code of ethics(HPCSA, 2016) and should always act with integrity and morality(WMA, 2015; HPCSA 2016). On the one hand, society agrees that the sole purpose of the medical profession is to benefit society(Pellegrino, 1987) and on the other hand society allows doctors to self-regulate and maintain a certain discipline in the practice of their profession(Cruess et al, 2014). Doctors, in return, promise to act and set ethical guidelines that they will follow(Hamdulay, 2013).

Over the years, the way the medical profession has functioned has dramatically changed (Cruess et al, 2014) . Due to effectiveness of the profession and what was perceived by third parties as a monopoly, there was interference by third parties, i.e. funders and governments(Cruess et al, 2014). The stature of the medical profession has diminished over the years because of increasing intrusion into the profession by both the government and the private sector(Cruess et al, 2014) .

Government dictates through legislation how doctors should practise medicine, and the private sector instructs doctors on what they can or cannot do and how much they can or cannot do for their patients(Klinck, 2018; Gray, 1997; Moosa et al, 2012) . This is done by restricting services provided and through limits to access to drugs and procedures(Booyens, 2000; Hugo et al, 2005; Klinck, 2018) . The social contract theory that can be used by managed healthcare to justify the implementation and curbing the autonomy of the medical profession is that by its very nature the contract is for the benefit of the society at large(Pellegrino, 2014).

Doctors must abide by the corporate rules for which services are paid at a fair price and saving the pooled resources to benefit the majority. The social contract is based on the doctor being more of a professional than a simple healer of the Hippocratic era. He is expected to be altruistic and moral in their day-to-day activities(Pellegrino, 1987) .

If the above conditions and expectations are not met by the profession, the profession risks losing respect and trust(O'Neill, 2002). As mentioned before, with loss of trust, society will be at a disadvantage as the health outcomes will be reduced (Stewart, 1995; O'Neill,2002). Society expects doctors to practise honestly and provide treatment at whatever costs for the benefit of society(Hugo et al, 2005). Managed healthcare is concerned with cost containment and, therefore, the type of treatment the patient receives may be construed as substandard(Gray, 1997;Moosa et al, 2012) . With the DSP option, the patient will not have the autonomy to choose the best clinician but the one chosen for them by the managed care organisation(Klinck, 2018) , irrespective of their skill and knowledge.

The medical profession is different to the other professions in that the purpose of its existence is to serve the interest of the patient above their own self-interest (Gray, 1997; Pellegrino, 1987). Professionalism aspires to altruism, accountability only to the patient and no other parties, excellence in carrying out their duties(Pellegrino,1987; Cruess et al, 2008), being of service and acting with integrity at all times. As Sulmasy puts it, society expects the physician to act with a special degree of trust in the delivery of healthcare. The trust issue is of utmost importance so that the profession does not lose face in society (Sulmasy, 1999).

As we can see, the argument by healthcare management company in justifying their implementation are of generally benefitting the population at large and not only the individual. Communitarianism dictates that a person lives within a community and is part of that community. Utilitarianism is happiness of the many at the expense of the individual(Rachels et al, 2015).

Social contract theory also dictates that the sole purpose of the medical profession is its use in benefitting the society(Pellegrino, 1987,Cruess et al, 2008) in return for the society giving the profession its autonomy to do with the knowledge and art as they please(Pellegrino, 1987). As Pellegrino(1987) puts it, medical knowledge is not individually owned and it ought not to be used primarily for personal gain, prestige or power(Pellegrino, 1987, Pg. 1939).

CHAPTER 7:

CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

The objective of this research was to evaluate and to normatively assess the impact that managed healthcare in its current form is having on the doctor patient relationship.

I defined what managed healthcare is and its different forms of implementation and what impact this has on the doctor patient relationship. The identified managed healthcare tools include, amongst others drug formularies, provider networks, risk sharing and utilization reviews. We showed that some of these tools had a negative impact on the relationship and as a result negative health outcomes(Stewart, 1995). It affected patient autonomy, affected doctors' autonomy and also presented a dilemma to the doctor in serving both the patient and the managed care organization.

We identified the moral issue of dual loyalty, which makes the doctor's position all the more difficult.

I presented evidence for and against this impact. The evidence presented for , shows the merits of managed healthcare and what its intended purpose and benefits are, i.e. curtail costs, improve access to the greater majority and create synergy amongst the healthcare participants.

However the evidence against show that the intended benefit is not always achieved, and at times to the contrary (Hugo et al, 2005). Where the benefits are not achieved, it affects the patient's trust in the doctor and as result it affects health outcomes adversely(Stewart, 1995).

In this chapter I will address possible remedies that can be applied to implement managed healthcare without negatively affecting the doctor patient relationship.

As we have seen, there are ethical and legal challenges in the implementation of managed healthcare on the overall relationship between the doctor and the patient. In order for the doctor-patient relationship not to suffer and the healthcare profession losing faith, there needs to be an environment of mutual agreement among stakeholders.

There should be honest, effective and open communication(Emanuel et al, 1995). In this open communication, policies and procedures should be in keeping with the plan to which the patient belongs. Everyone's rights and responsibilities should be clearly defined(Mahlo et al, 2000). There should be policies and procedures in place to provide guidance to members(Agyei-Baffour et al, 2013), providers and the plan. There should be a culture within all spheres of the managed care process where ethical considerations should be integrated into decision-making at all levels.

7.2 Improving trust in the doctor patient relationship

Autonomy is the key element in patient and doctor satisfaction in dealing with each other. Enhancing patient autonomy by taking them into confidence and ensuring that they feel part of the decision making will greatly assist this relationship. Patient-centred medicine has been

shown to enhance patient autonomy(Forrest et al, 2002). Its implementation has shown that it enhances patient satisfaction and in turn improves the doctor patient relationship(Forrest et al, 2002). Communication is key in clearing confusion and misconception(Emanuel, 1995). Loosening of certain requirements e.g. gatekeeping arrangements, improves trust in the doctor patient relationship and enhances adherence to treatment.

Improved communication from the managed care company to their members, informing them on what their benefits are and reasons behind declining and authorising certain management plan is key(Agyei-Baffour et al, 2013). If patients feel valued they are more likely to comply with their funders and adhere to treatment protocols(Forrest et al, 2002). In the same vein, if doctors feel that their concerns are given a high priority and not dismissed, they are more likely to promote the goals of managed healthcare.

7.3 Fostering relationship between the funders and the doctors

The relationship between medical practitioners and the managed care companies can be greatly improved. In improving this relationship, the relationship between the doctor and the patient can be improved. If medical practitioners have a good working interaction with the managed care company, it bodes well for the interaction with the patient.

Ways in which this interaction can be bolstered is consultation between the company and the doctor. When the company implements healthcare management tools, they should negotiate with the doctor representative groups for an equitable outcome(Klinck,2003).

7.4 Enhancing cost effective treatment plans and achieving managed healthcare goals

The main aim of implementing managed healthcare schemes is to curb spiralling healthcare costs. As noted, cost saving is not always achieved in implementing managed care. Sometimes the opposite happens(Hugo,2005). To improve compliance, managed care companies need to be open when dealing with medical practitioners. The success or failure of managed healthcare is dependent on a good working relationship between the provider and the receiver of the service (Kinghorn 1996; Booyens,2000)

To improve cost effectiveness, the managed care company should at all times look at the relationship, as its success will enhance the intended goal of managed healthcare(Booyens, 2000). In using managed care programmes, these should be evaluated periodically for their relevance in a changing environment and when the aged care companies implement the programmes it should be a transparent process with verifiable criteria(Klinck, 2003). Where the doctor is seen to be valued, the more they will support the process and ensure its success and the opposite will also be true.

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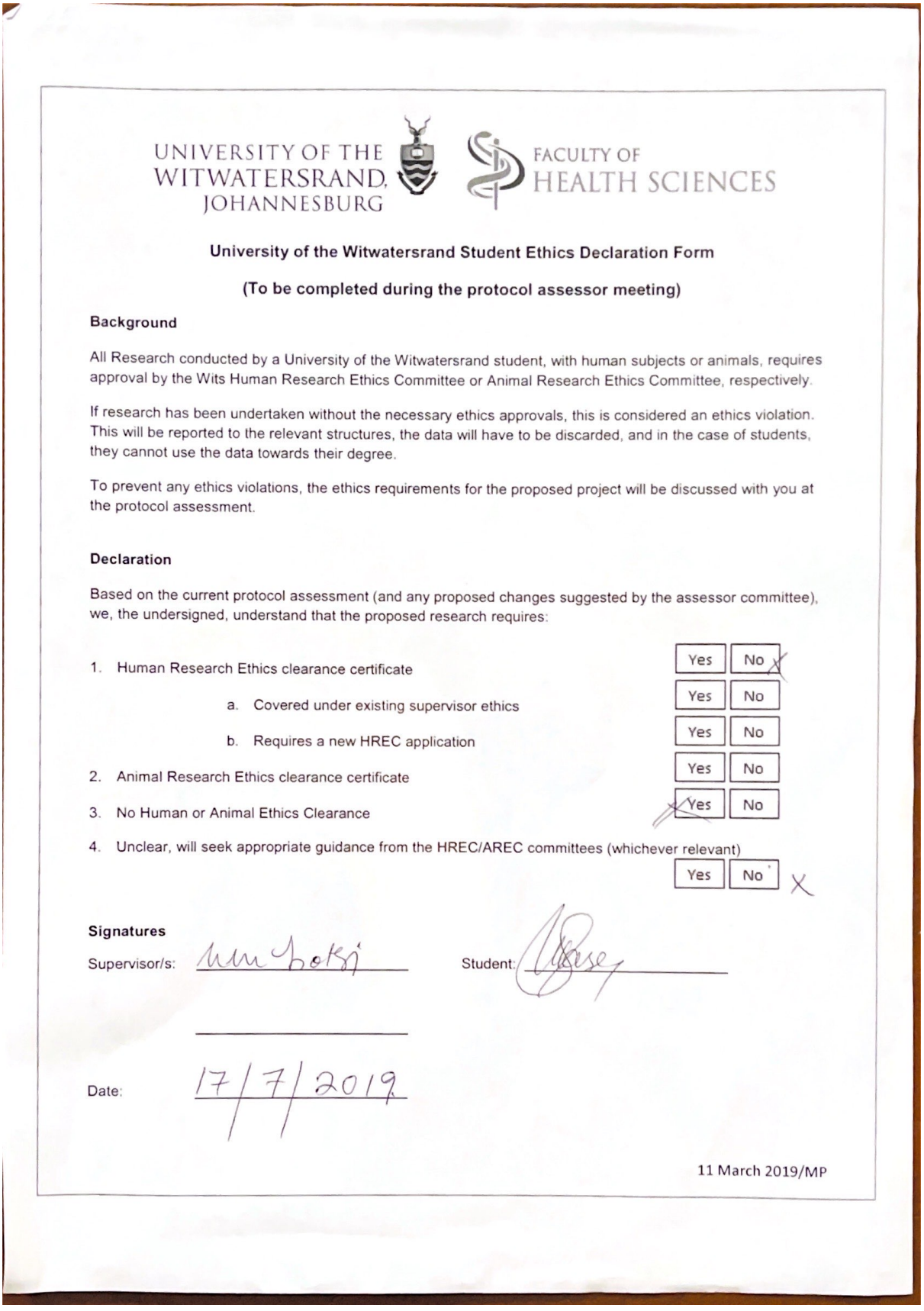
ETHICS



UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

University of the Witwatersrand Student Ethics Declaration Form

(To be completed during the protocol assessor meeting)

Background

All Research conducted by a University of the Witwatersrand student, with human subjects or animals, requires approval by the Wits Human Research Ethics Committee or Animal Research Ethics Committee, respectively.

If research has been undertaken without the necessary ethics approvals, this is considered an ethics violation. This will be reported to the relevant structures, the data will have to be discarded, and in the case of students, they cannot use the data towards their degree.

To prevent any ethics violations, the ethics requirements for the proposed project will be discussed with you at the protocol assessment.

Declaration

Based on the current protocol assessment (and any proposed changes suggested by the assessor committee), we, the undersigned, understand that the proposed research requires:

1. Human Research Ethics clearance certificate — Yes / No X
   a. Covered under existing supervisor ethics — Yes / No
   b. Requires a new HREC application — Yes / No
2. Animal Research Ethics clearance certificate — Yes / No
3. No Human or Animal Ethics Clearance — Yes X / No
4. Unclear, will seek appropriate guidance from the HREC/AREC committees (whichever relevant) — Yes / No X

Signatures

Supervisor/s: _____ Student: _____

Date: 17/7/2019

11 March 2019/MP

TURNITIN REPORT

Attached

Submission date: 26-Jan-2022 09:05AM (UTC+0200)
Submission ID: 1748428468
File name: 6-a65e-6544b3f67519_Final_Resubmission_24_January_2022-_NEW.docx (339.09K)
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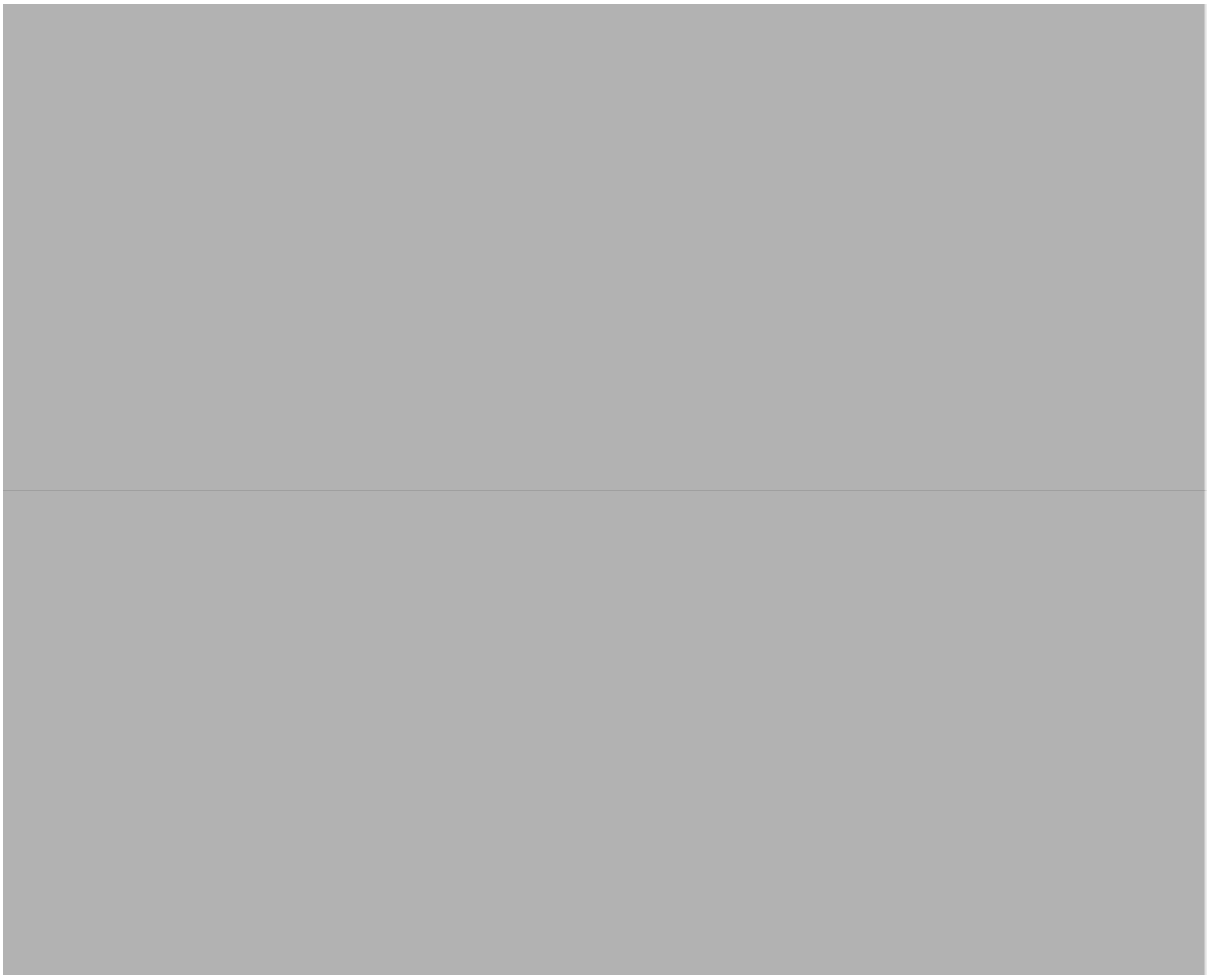

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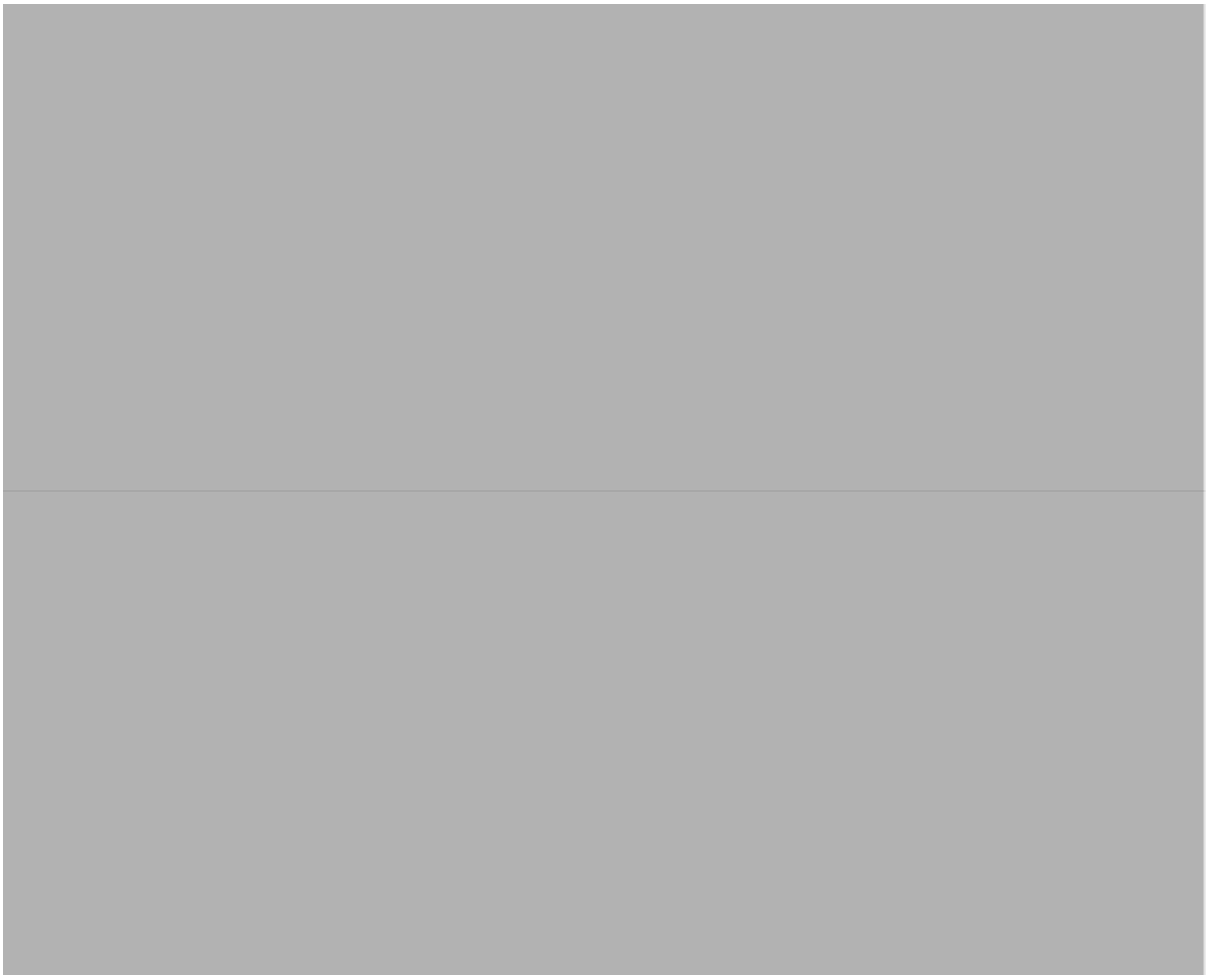

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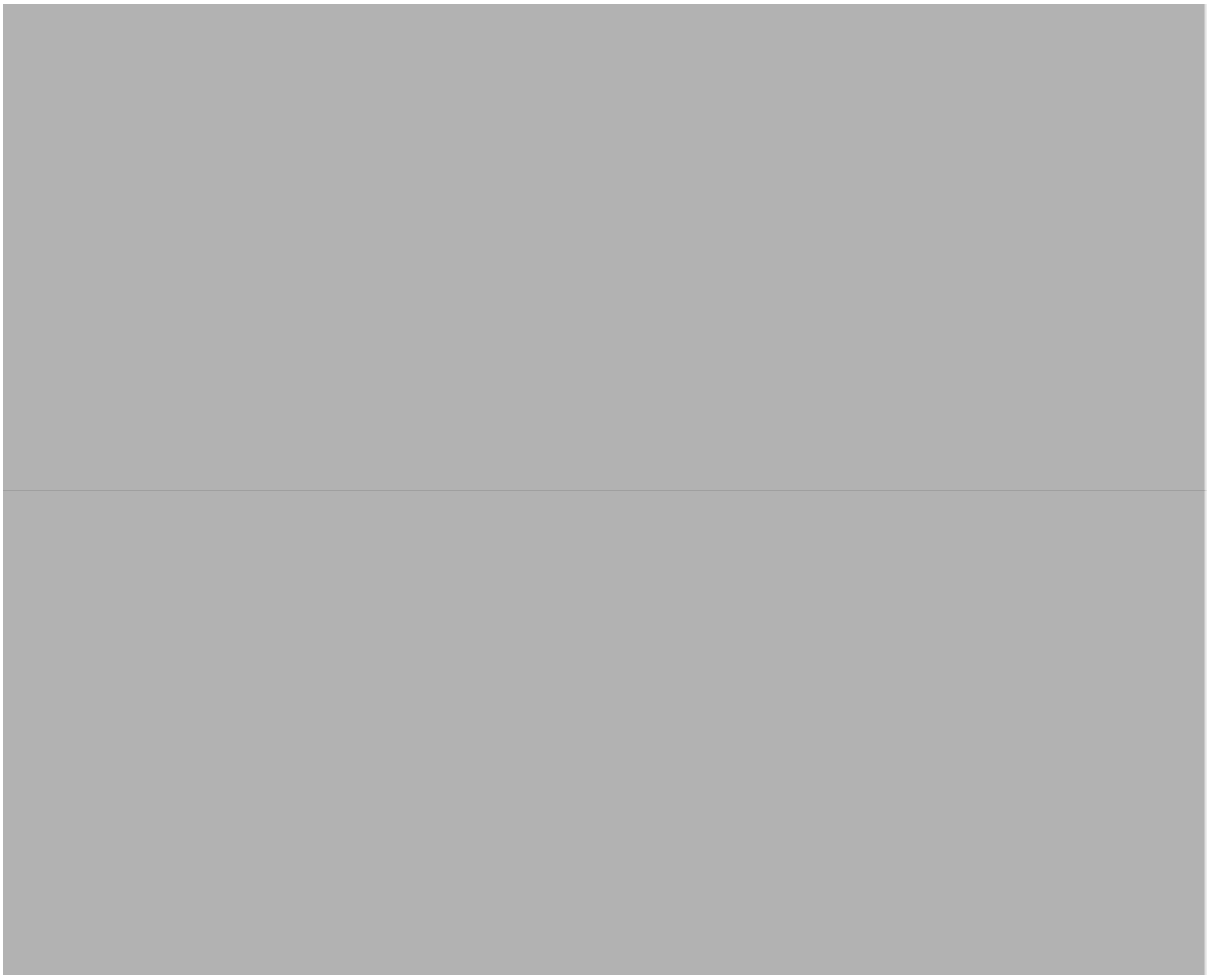

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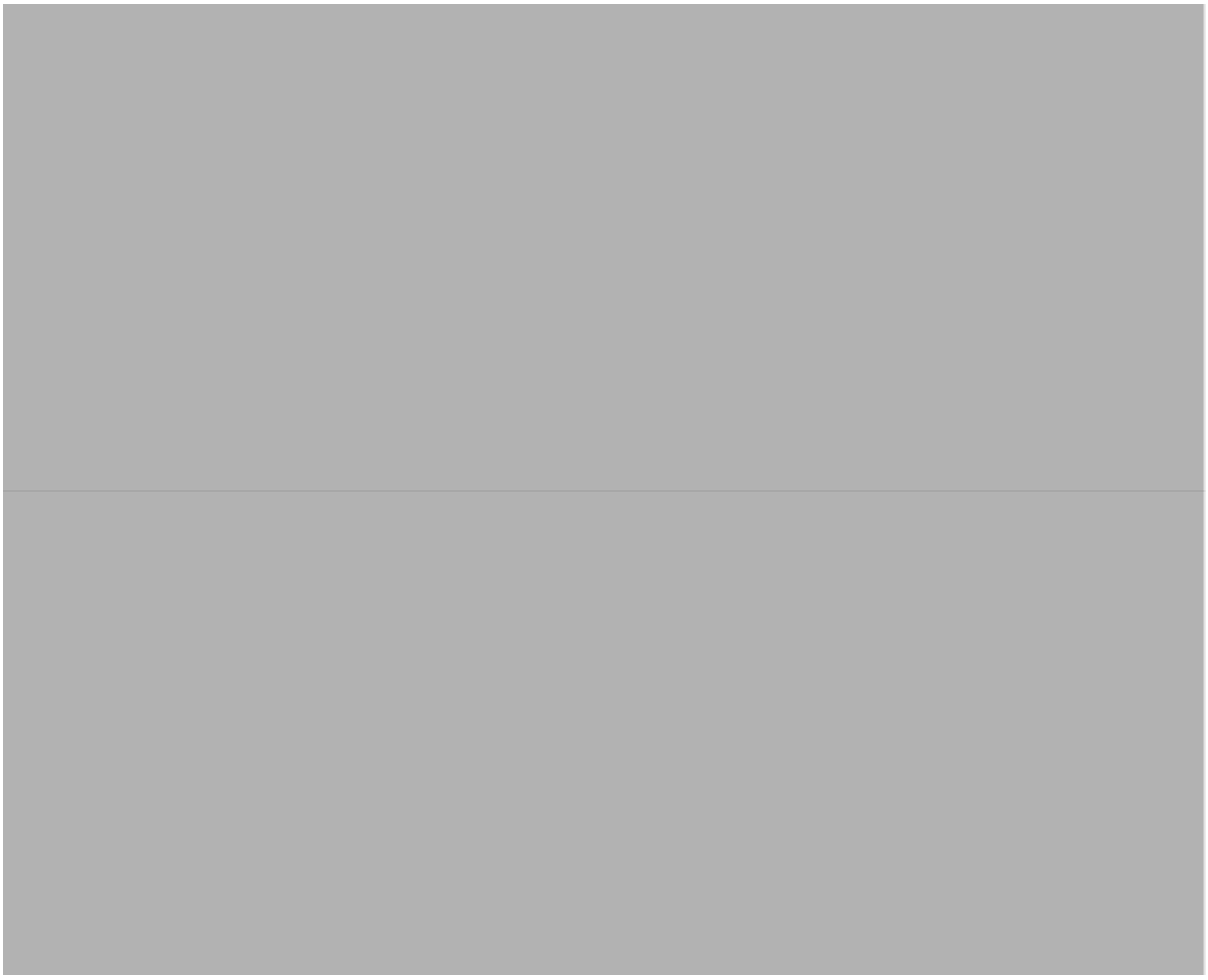

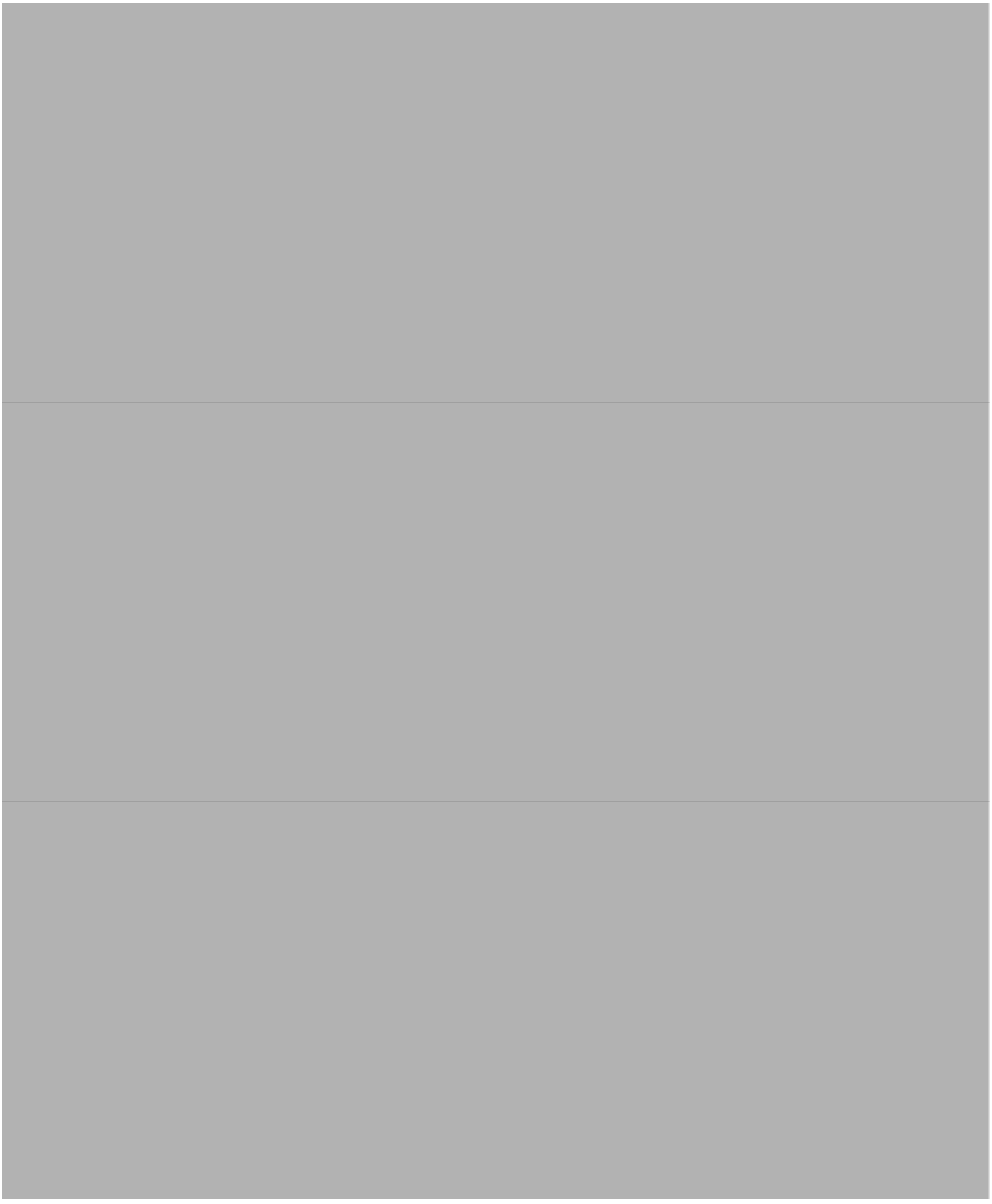

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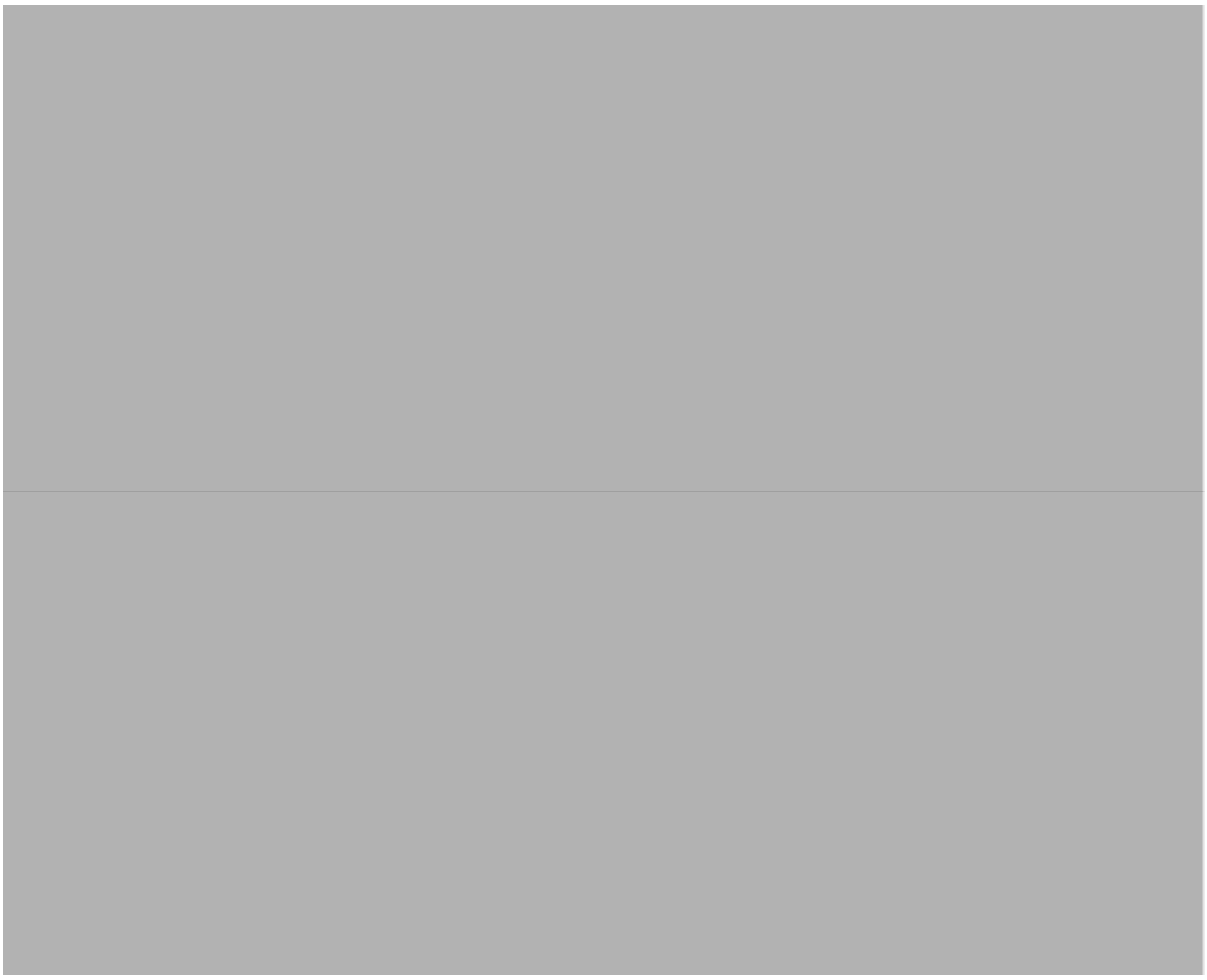

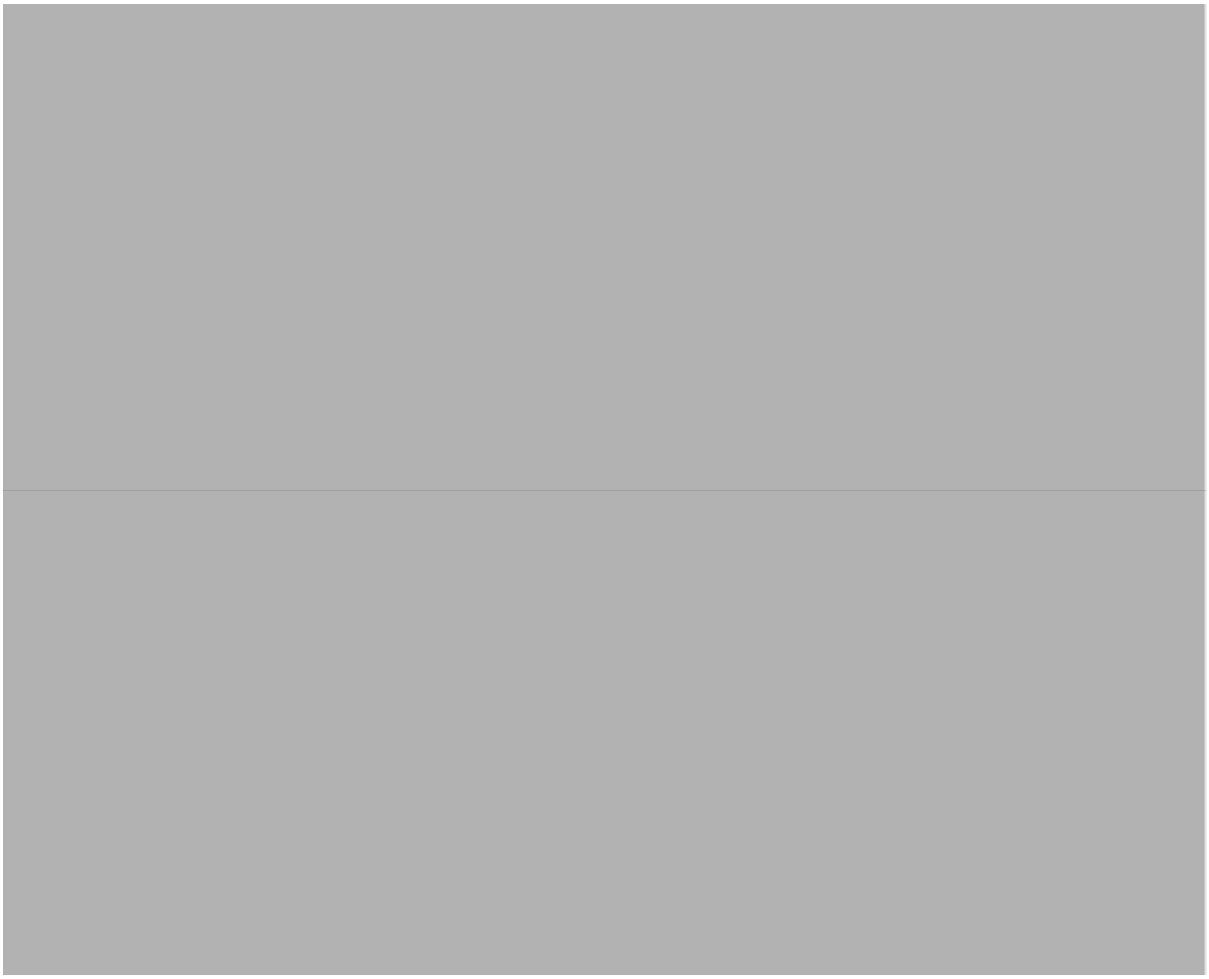

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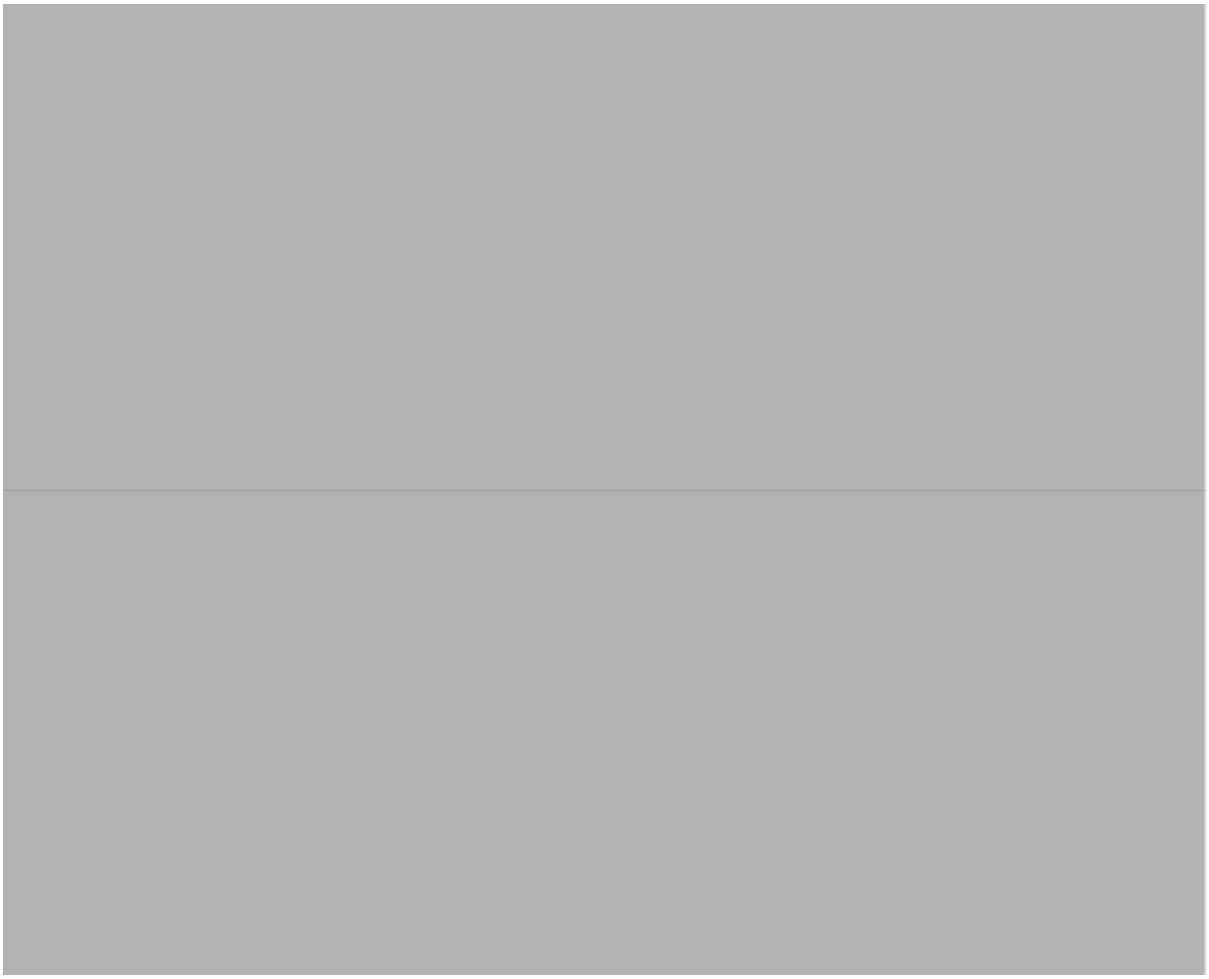

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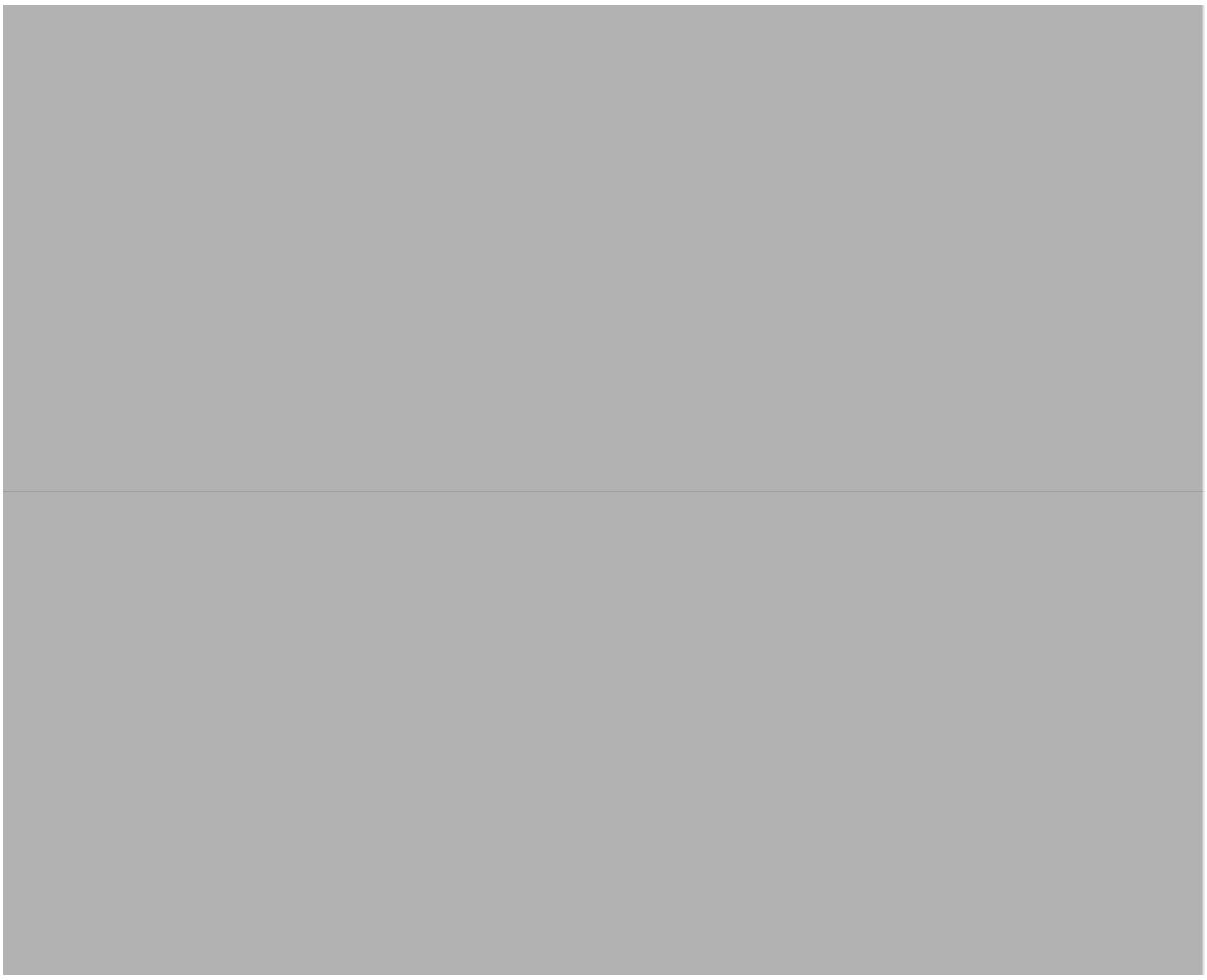

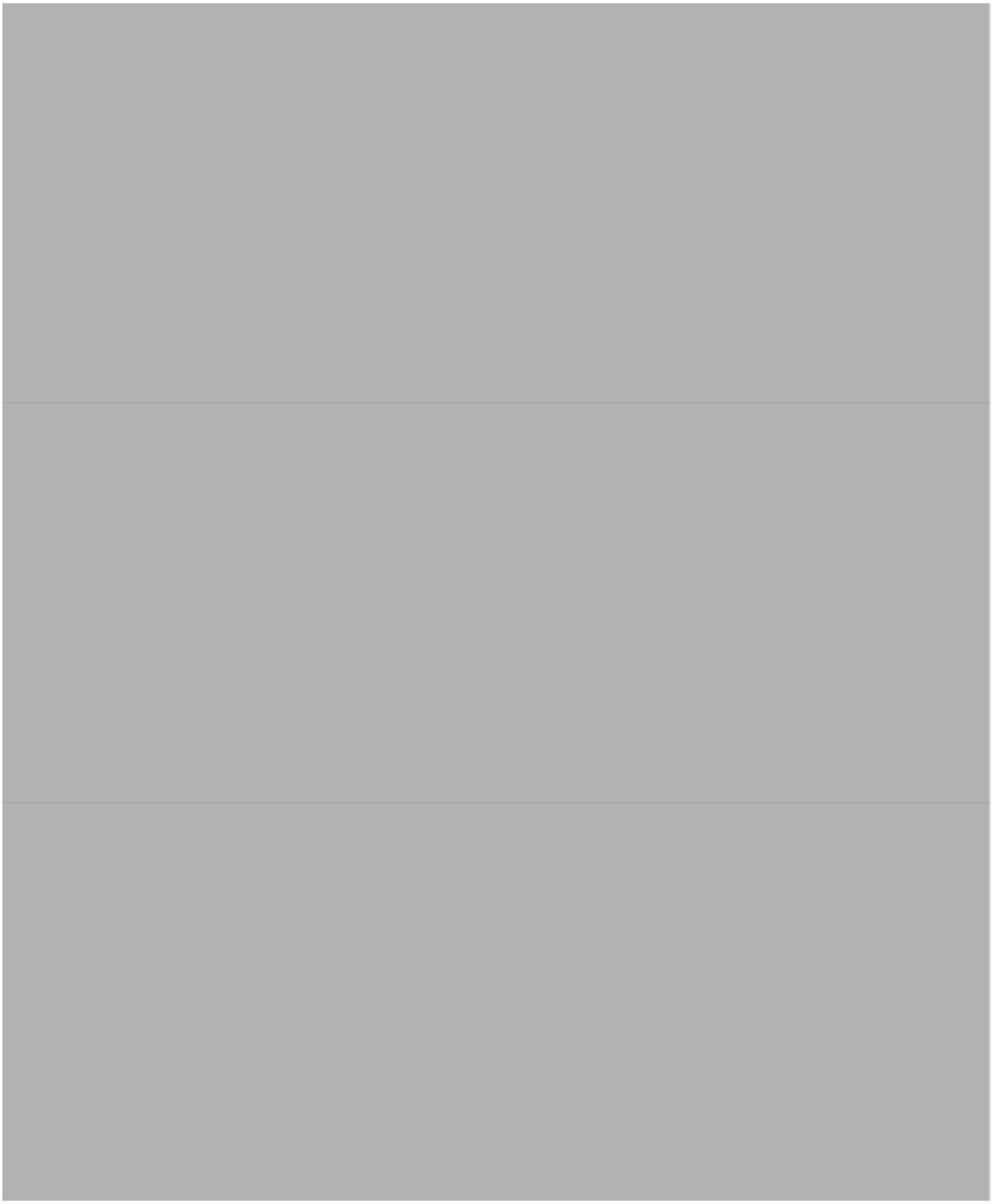

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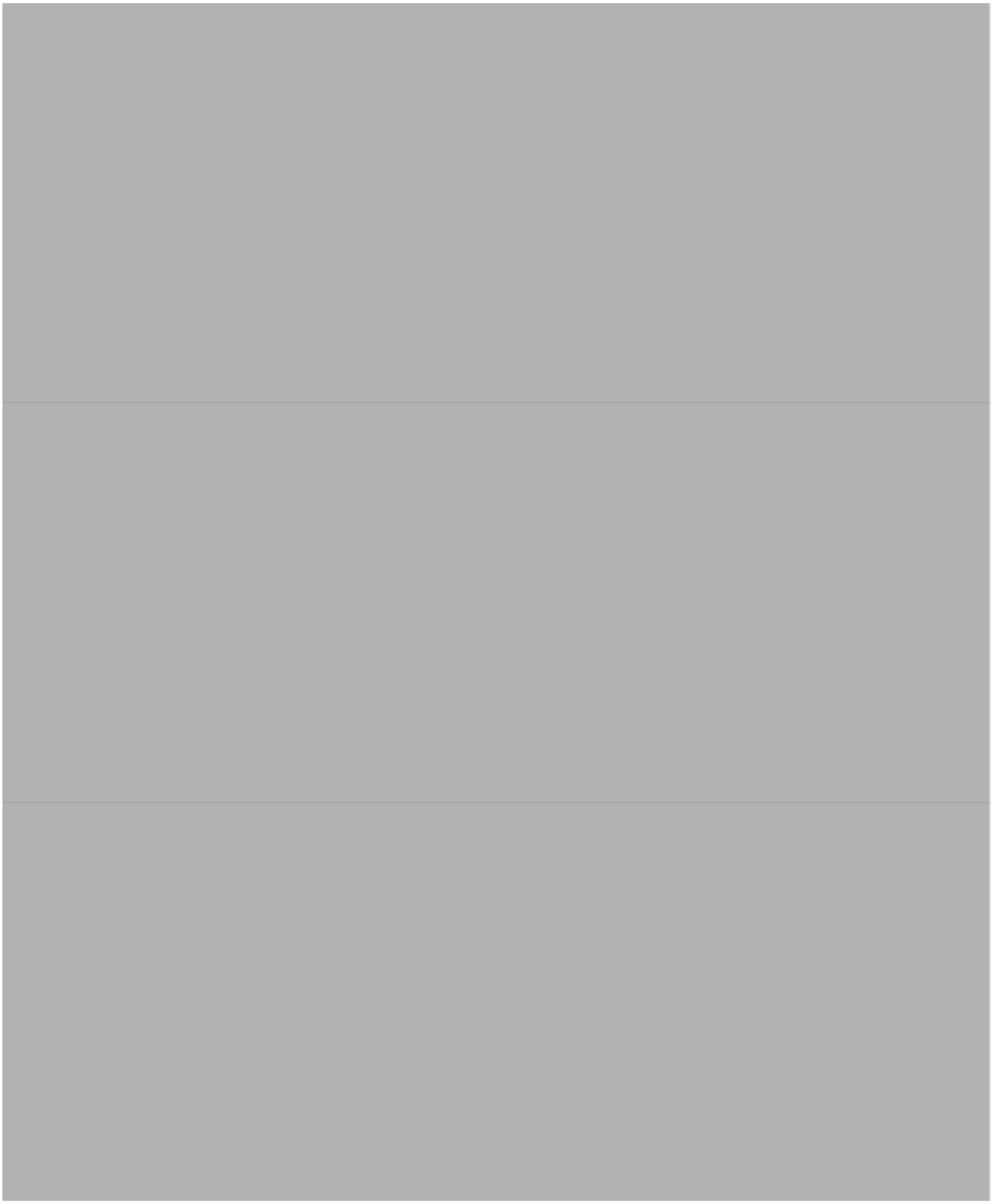

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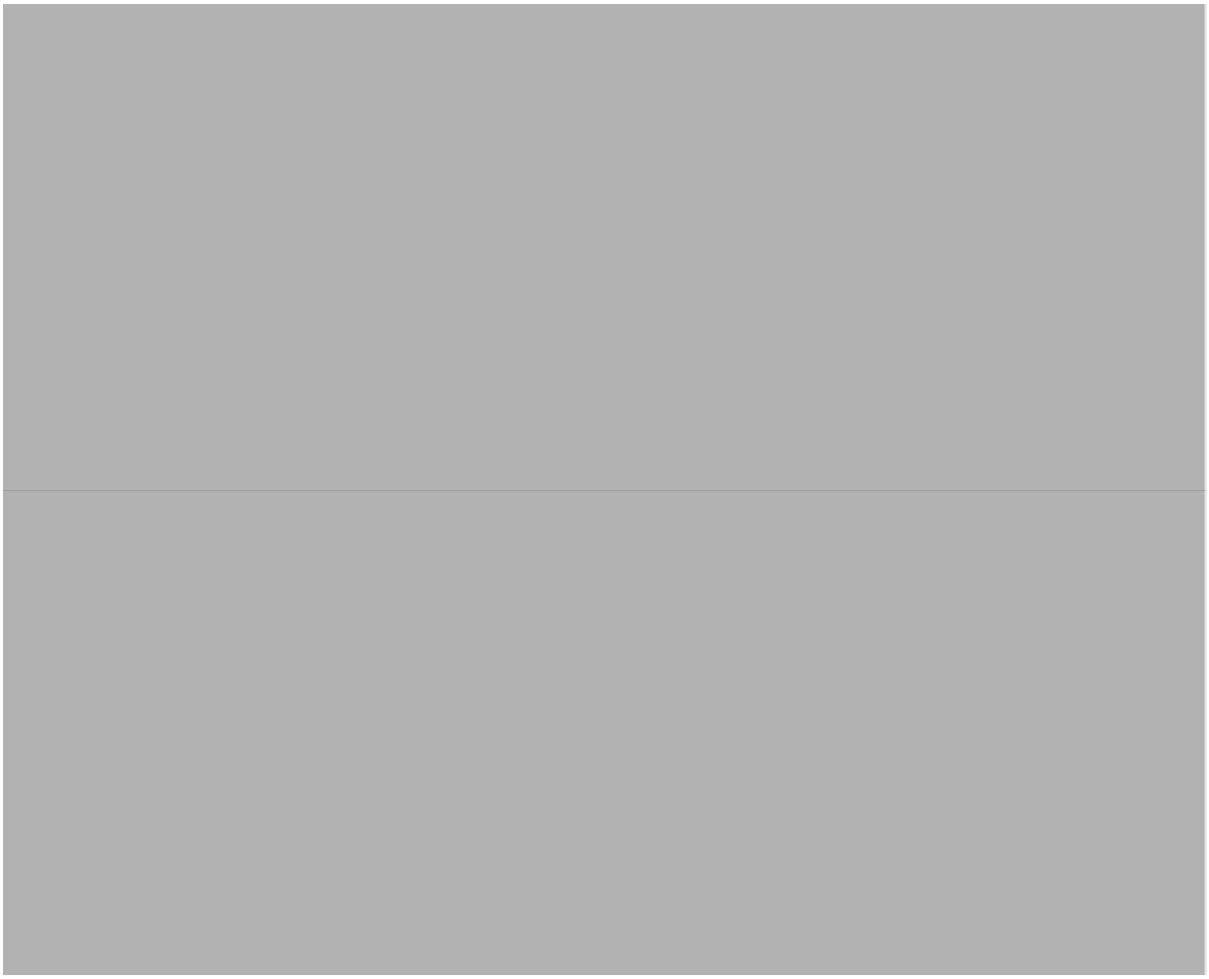

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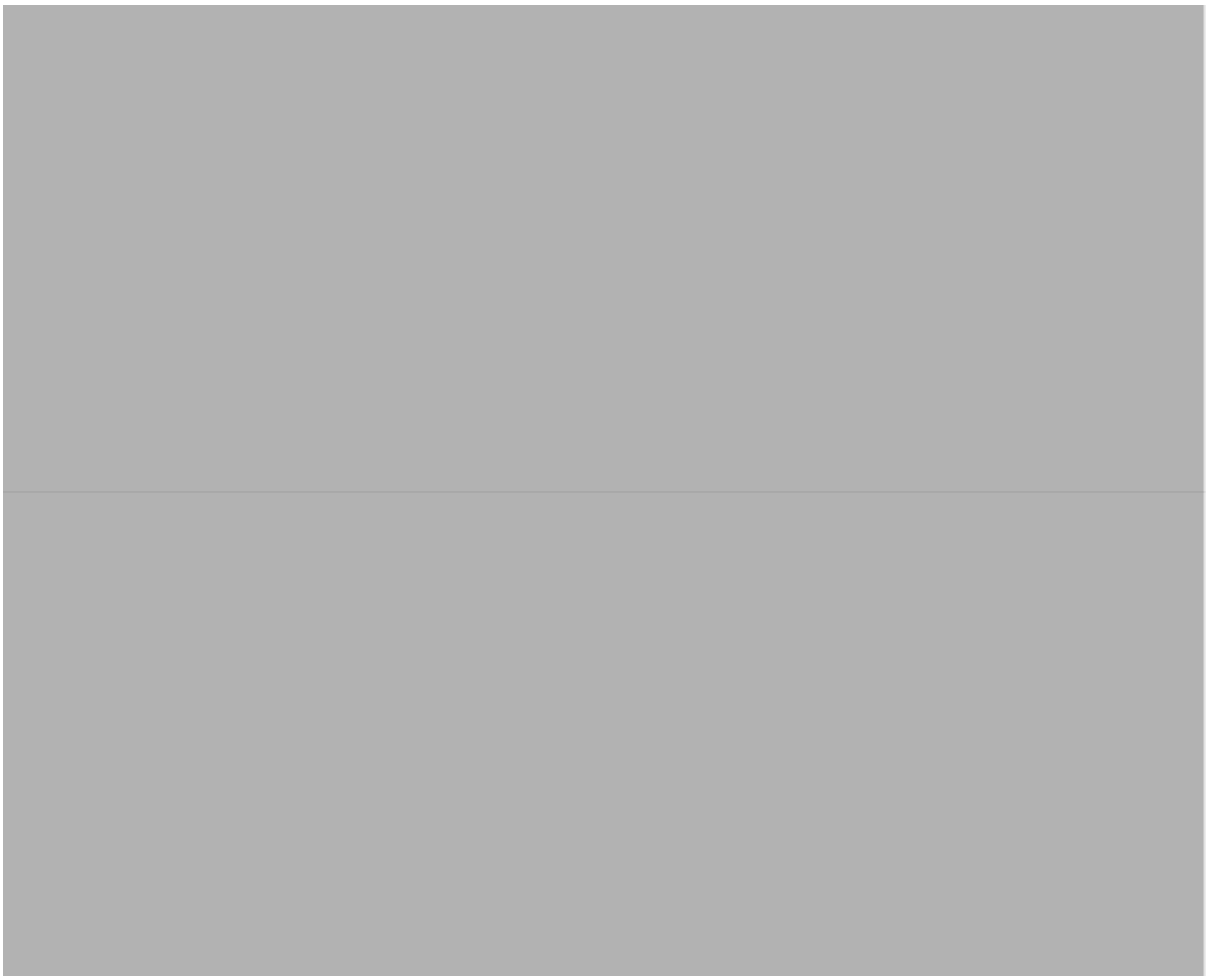

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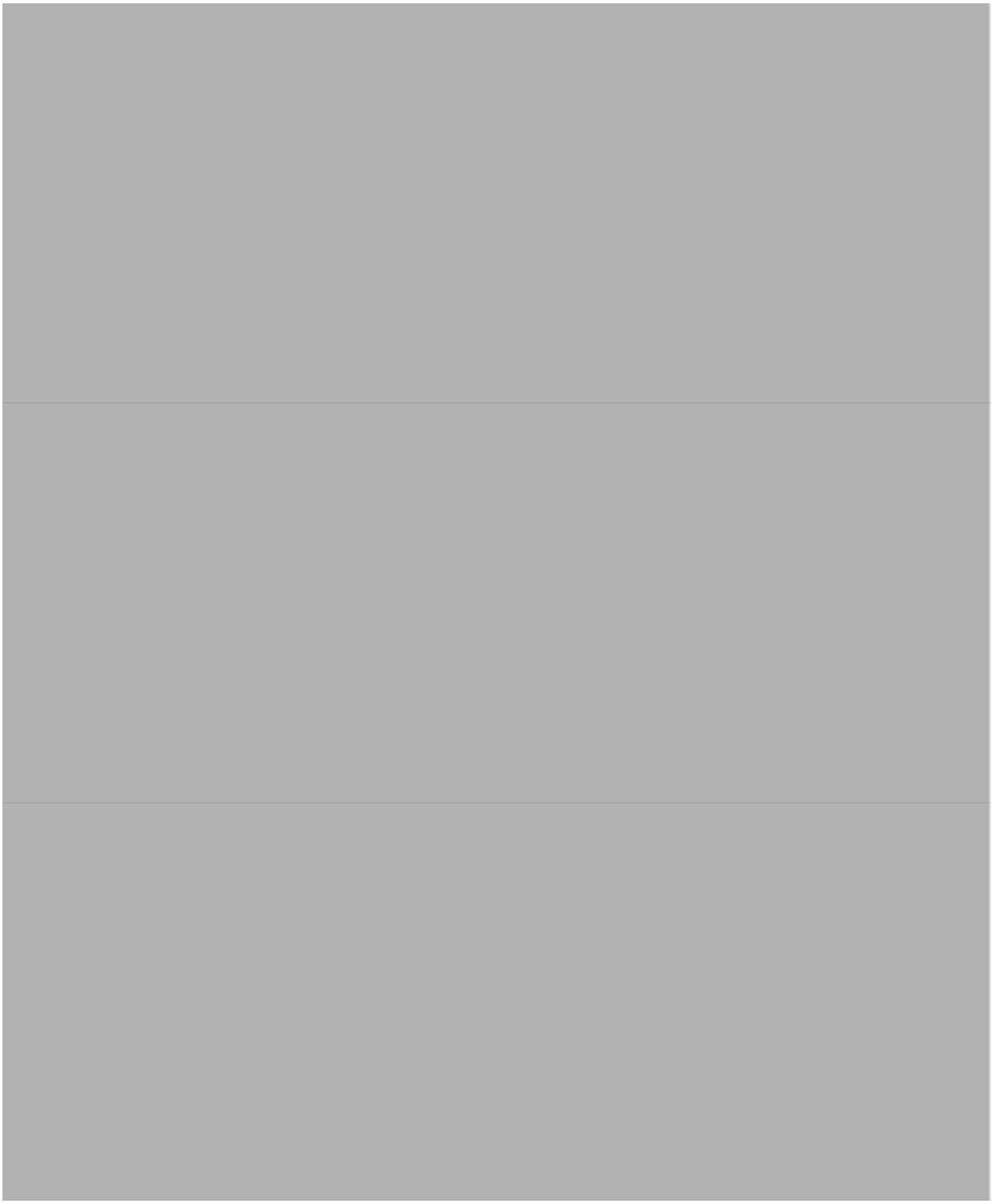

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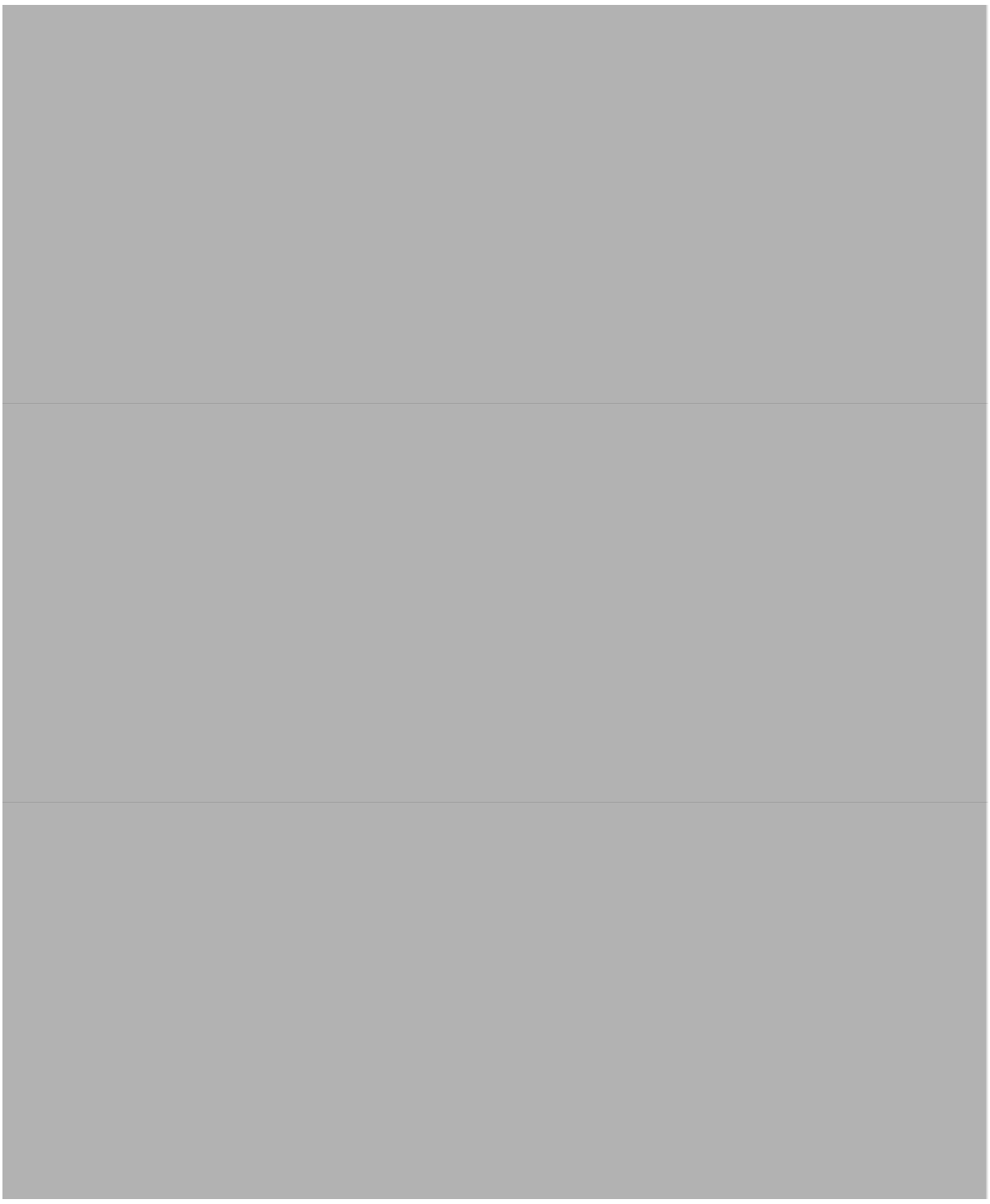

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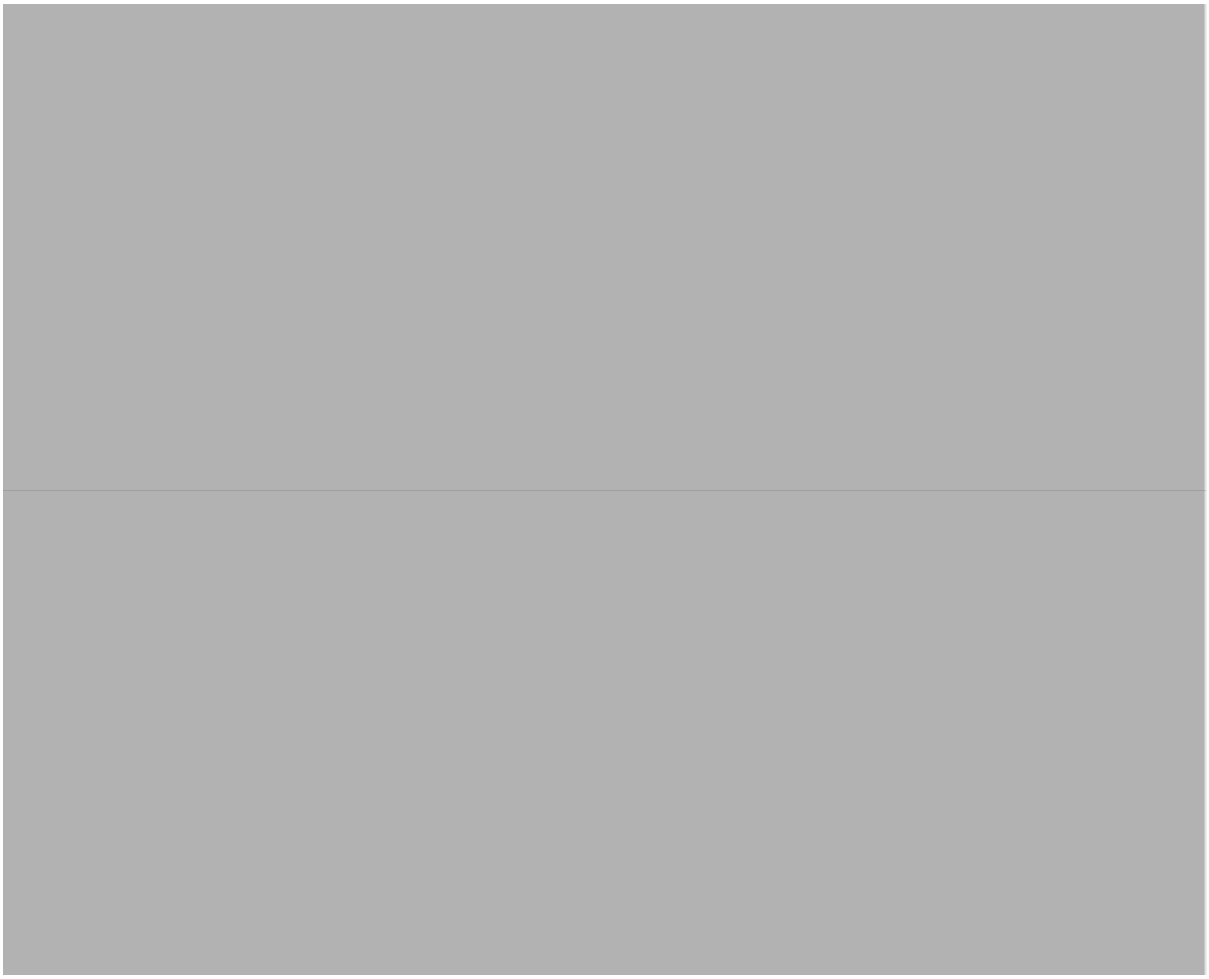

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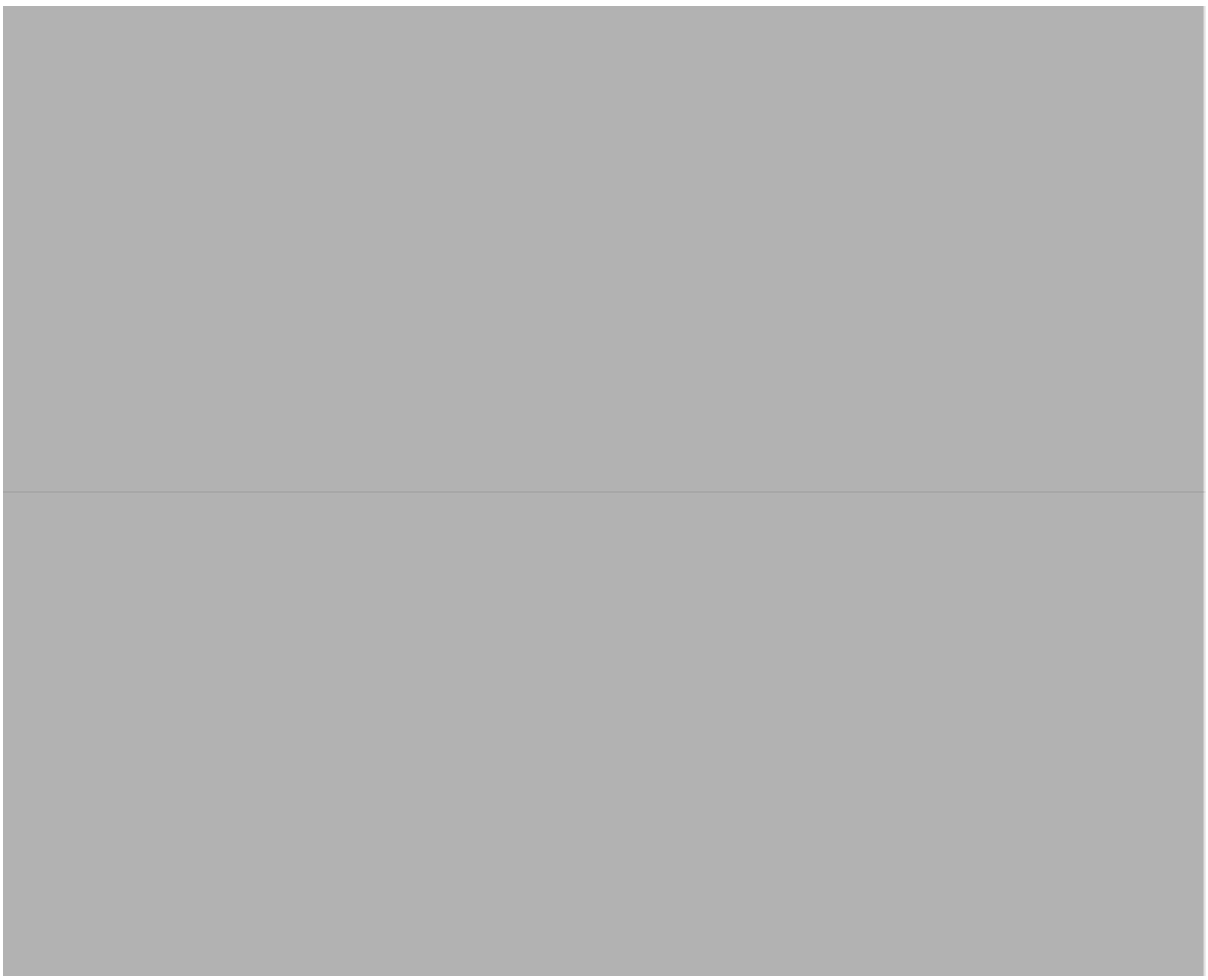

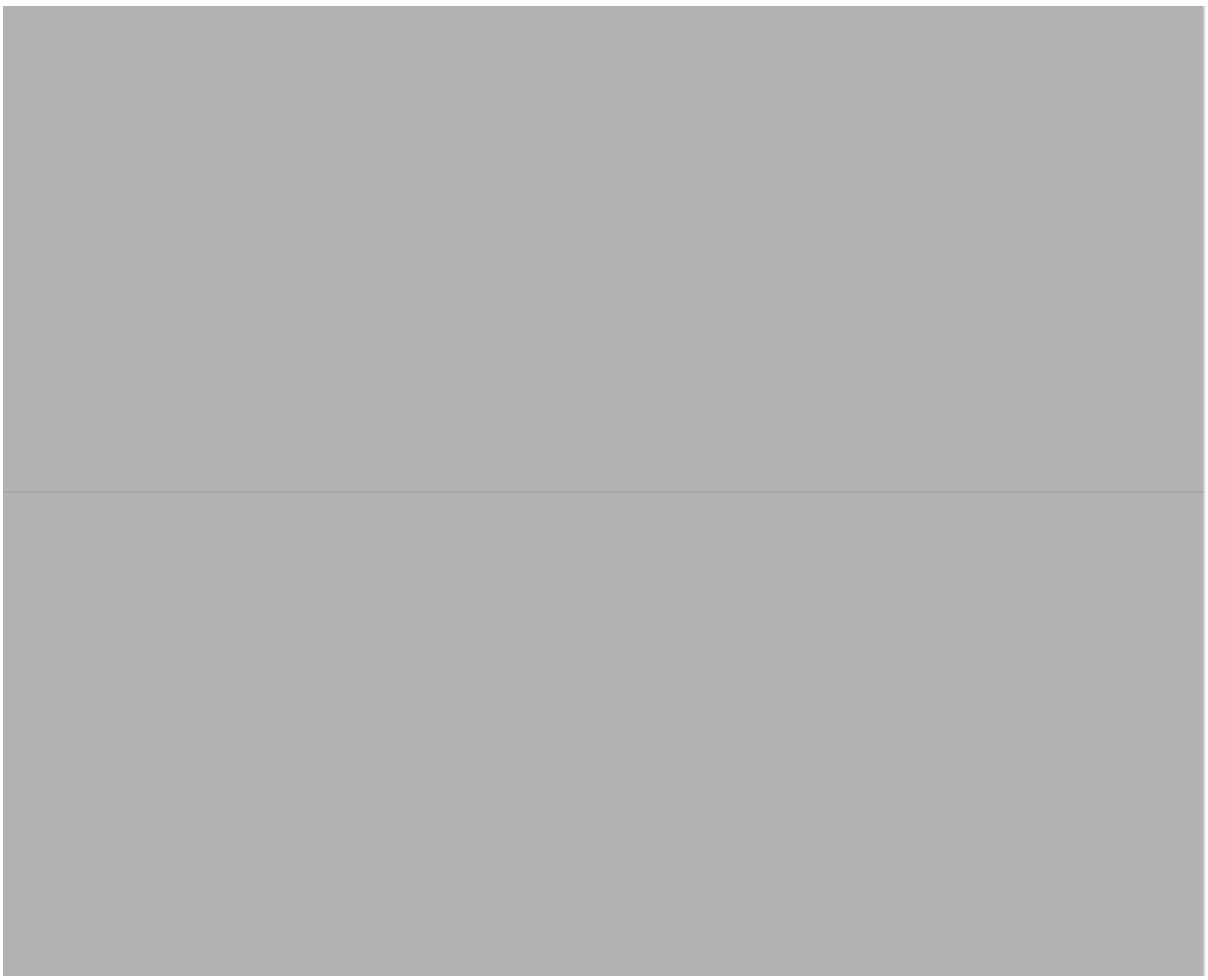

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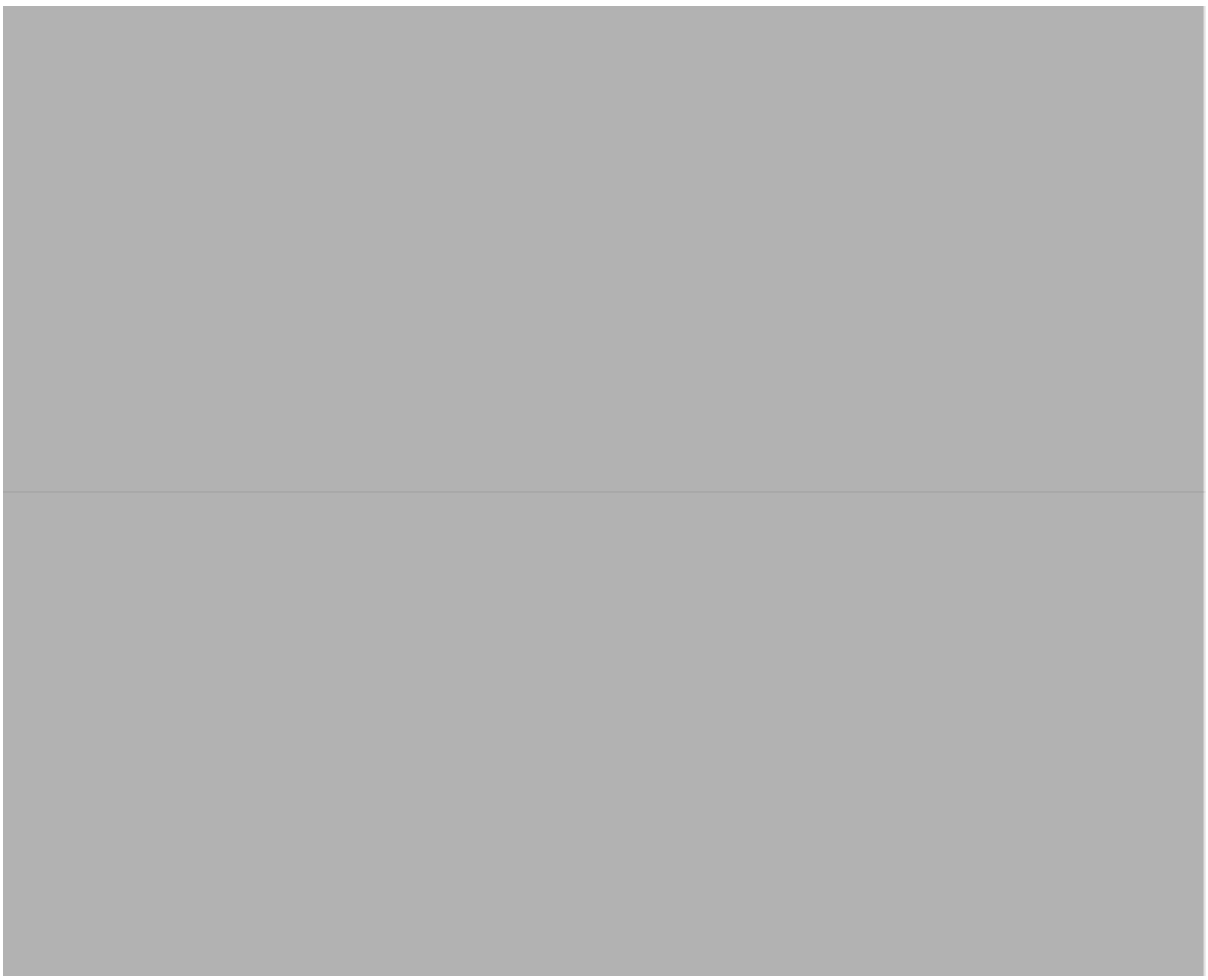

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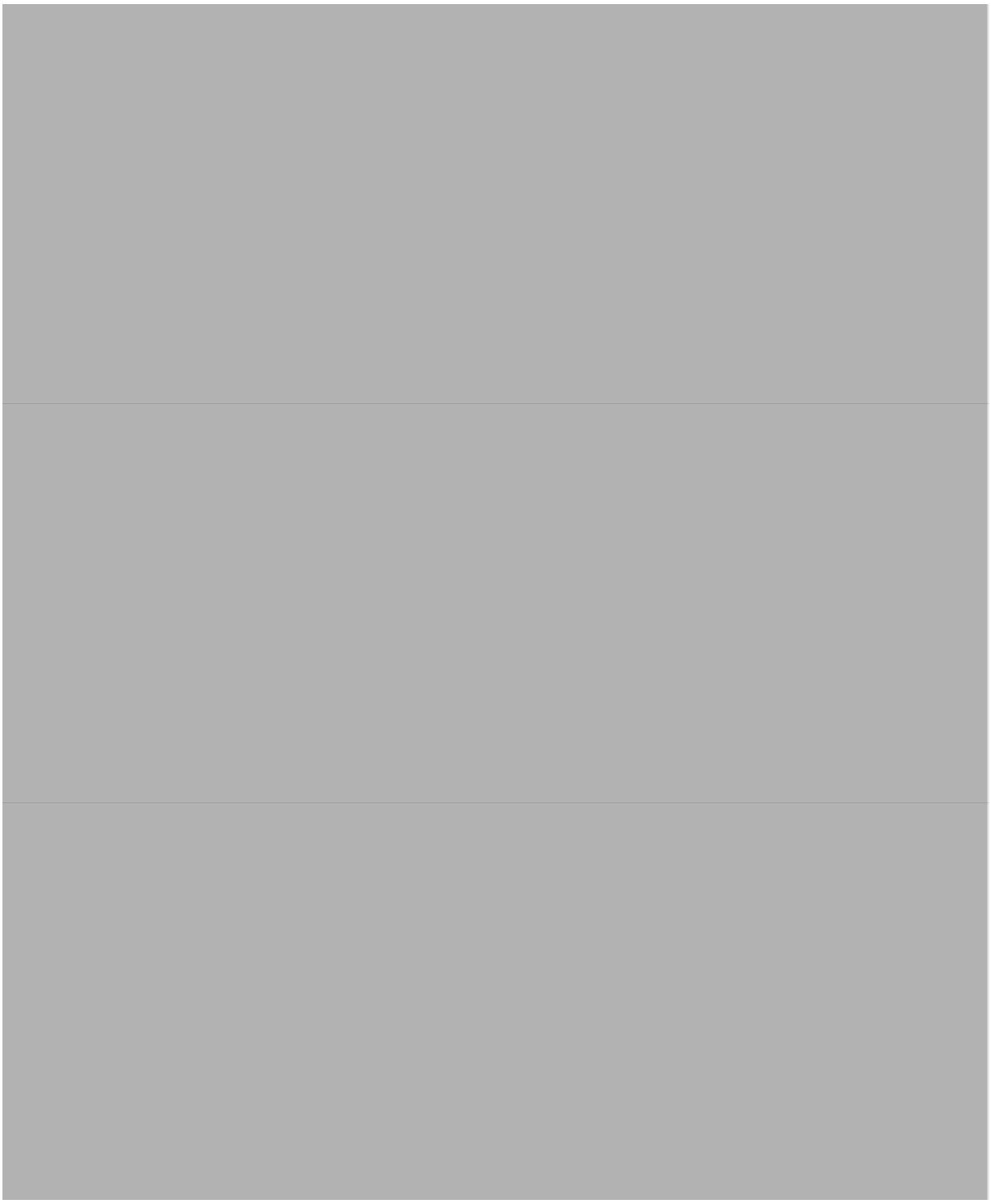

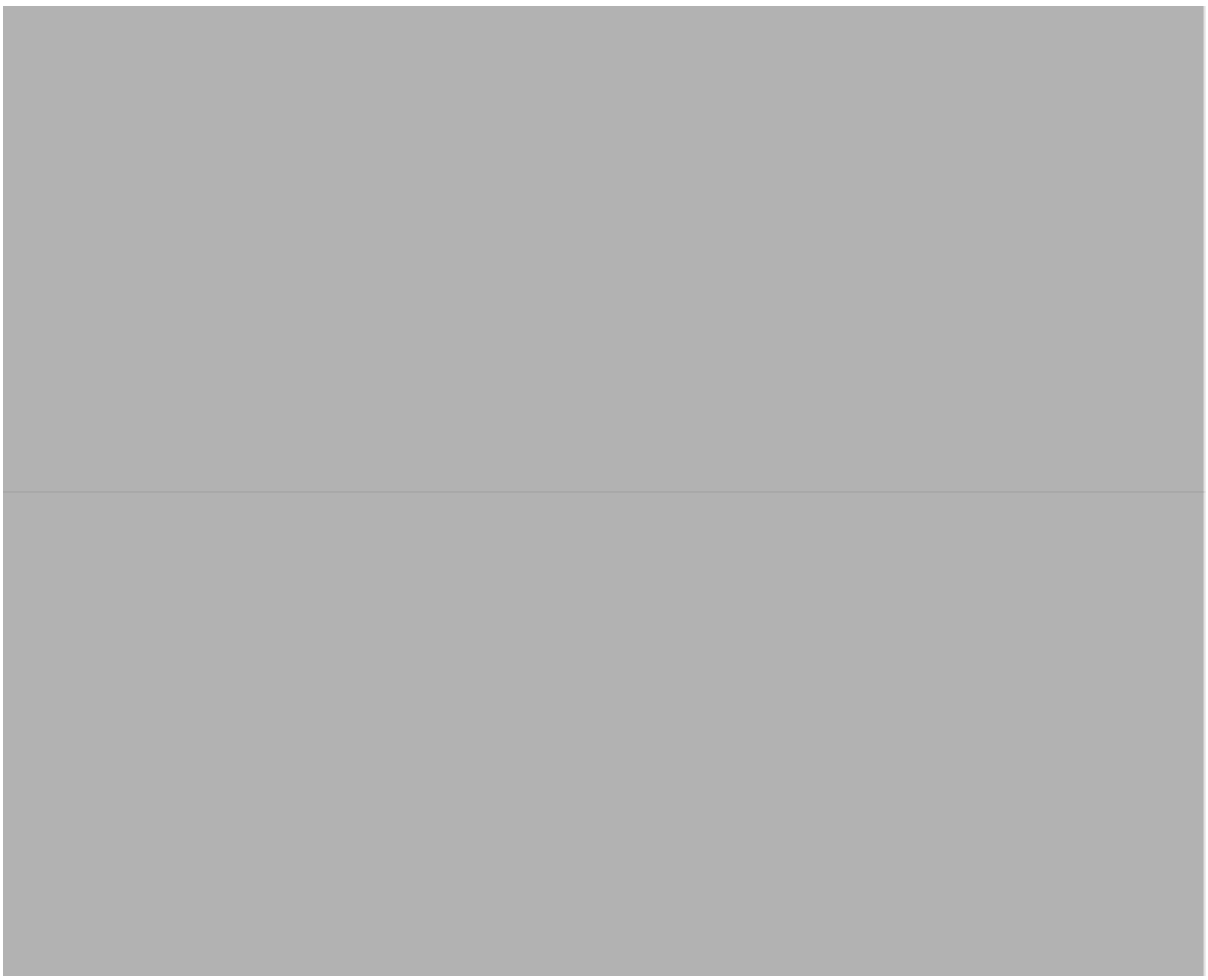

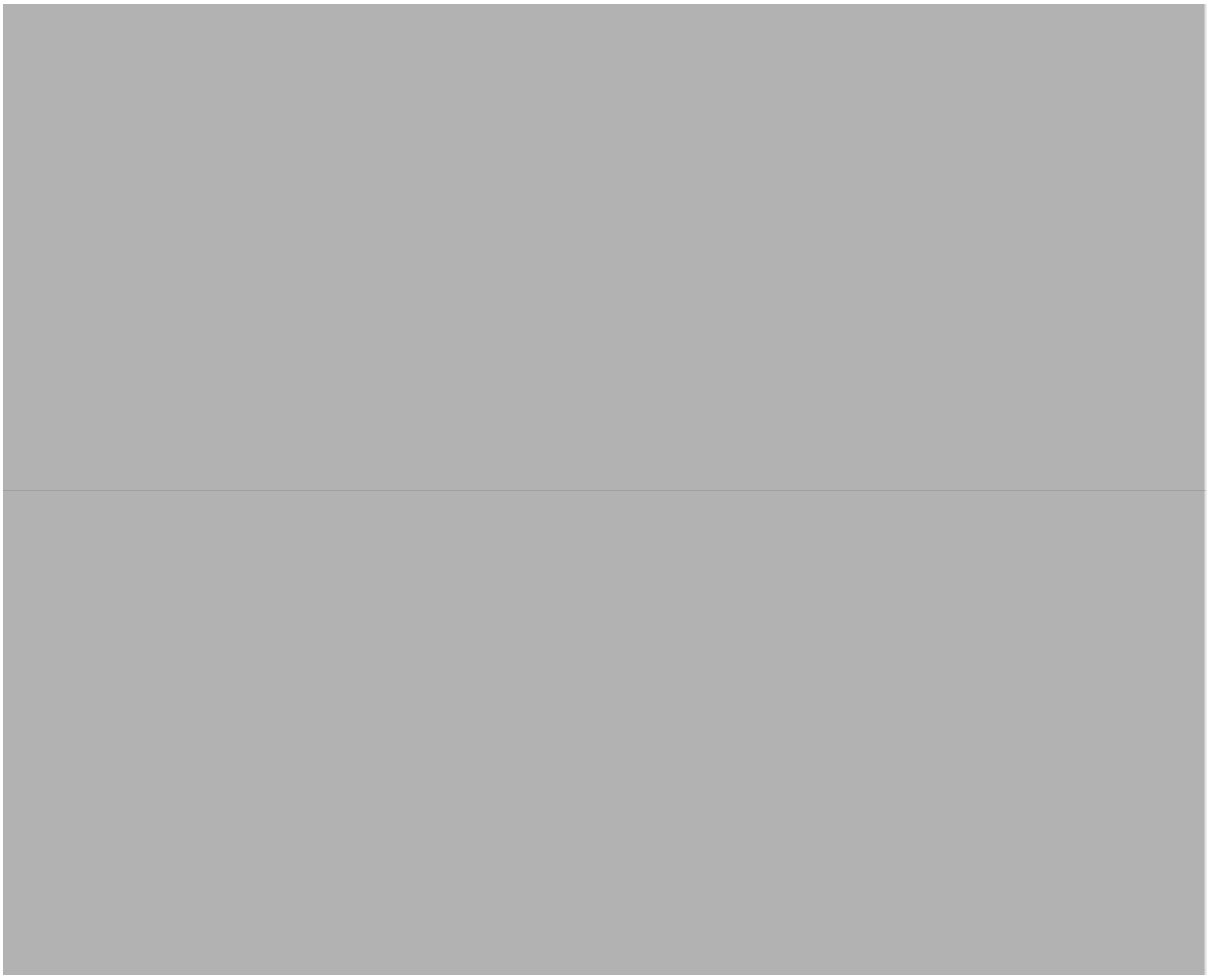

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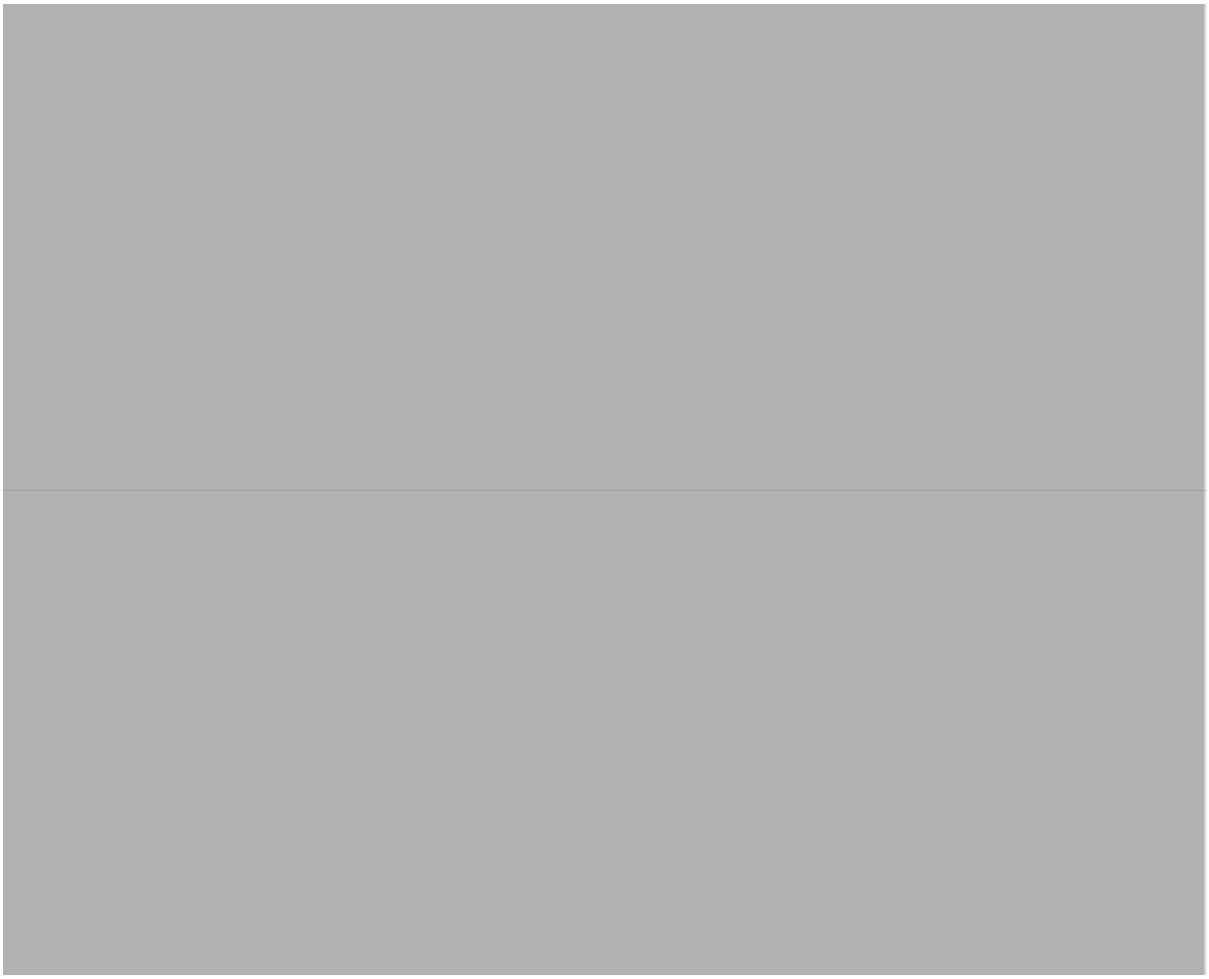

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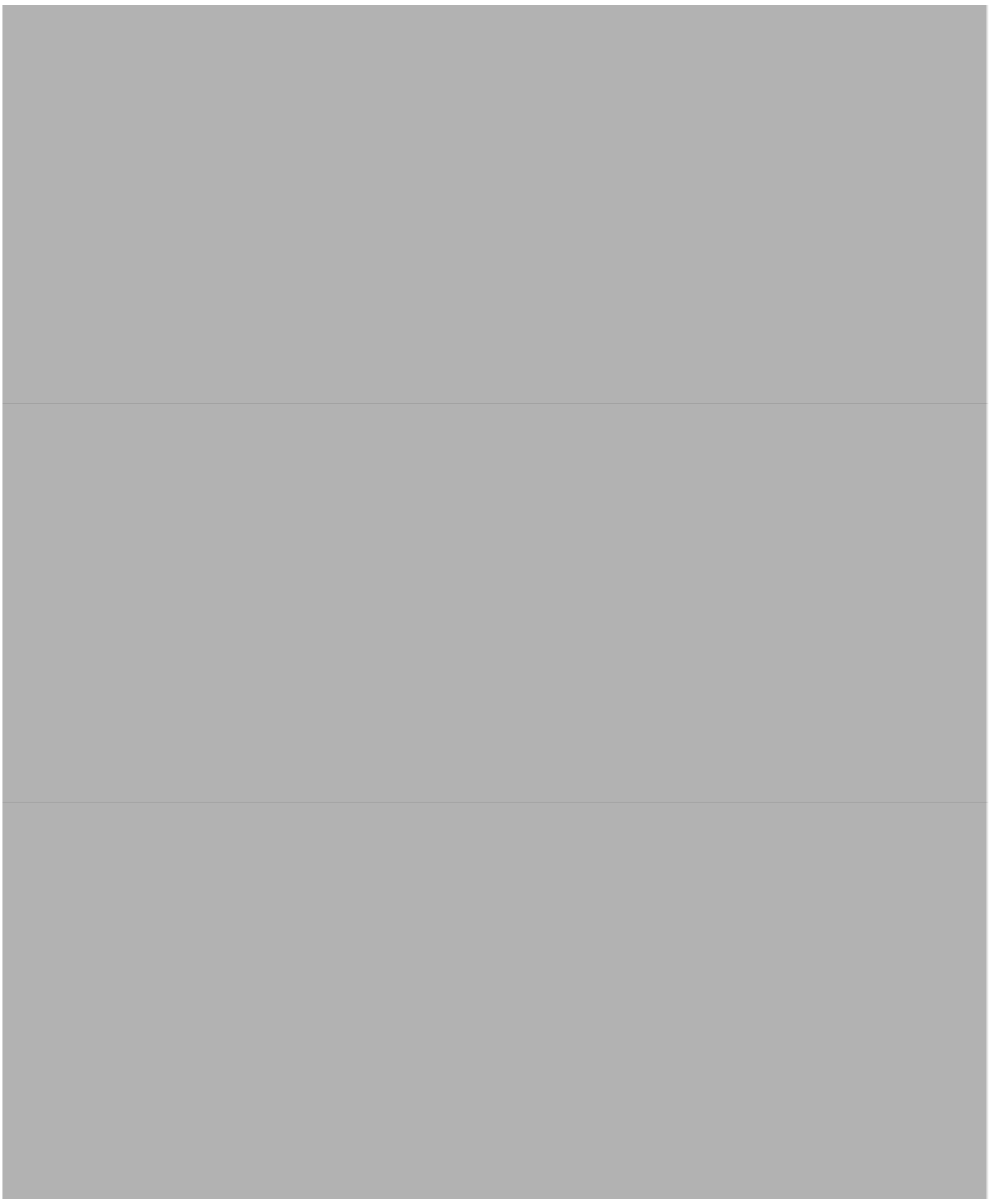

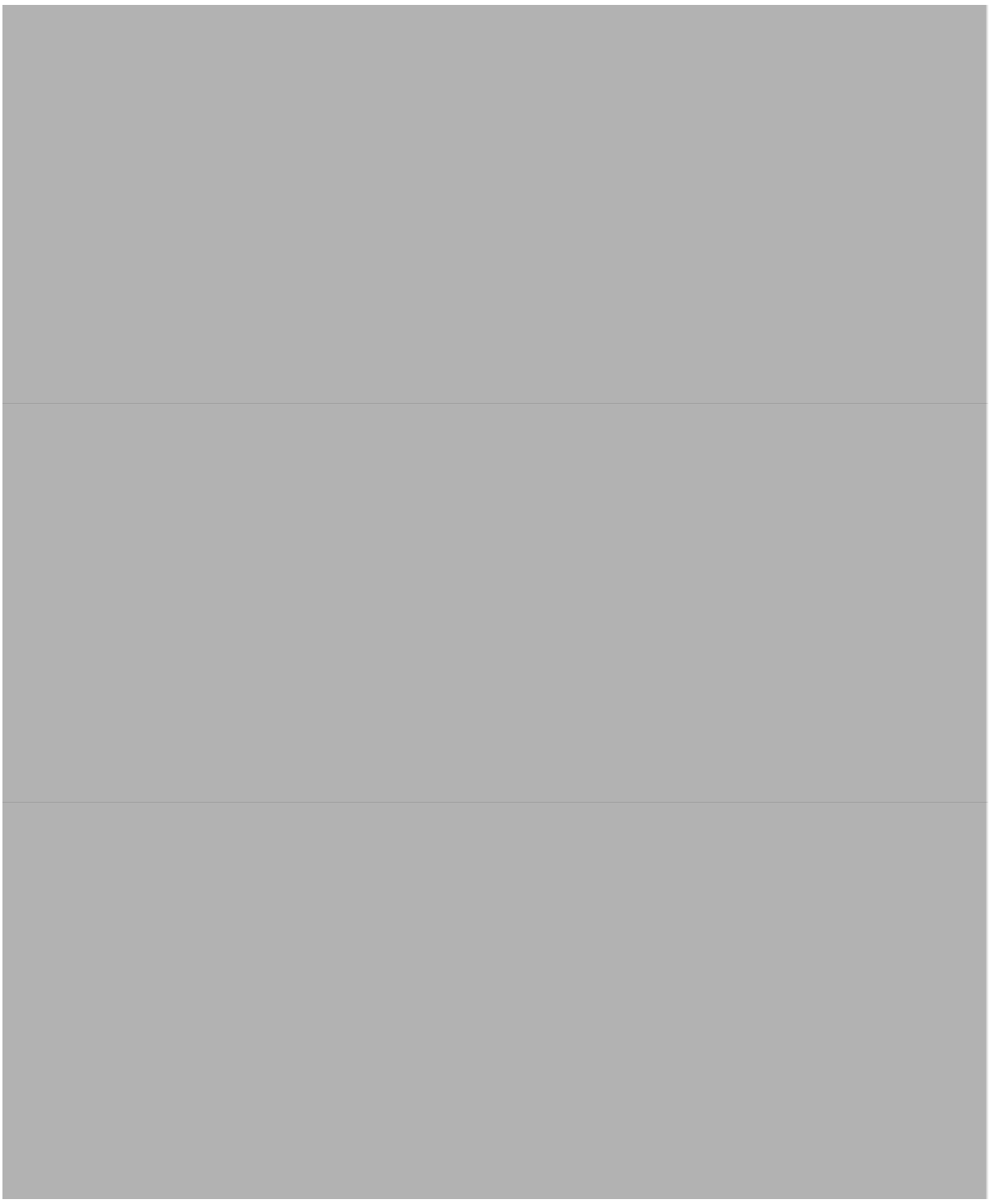

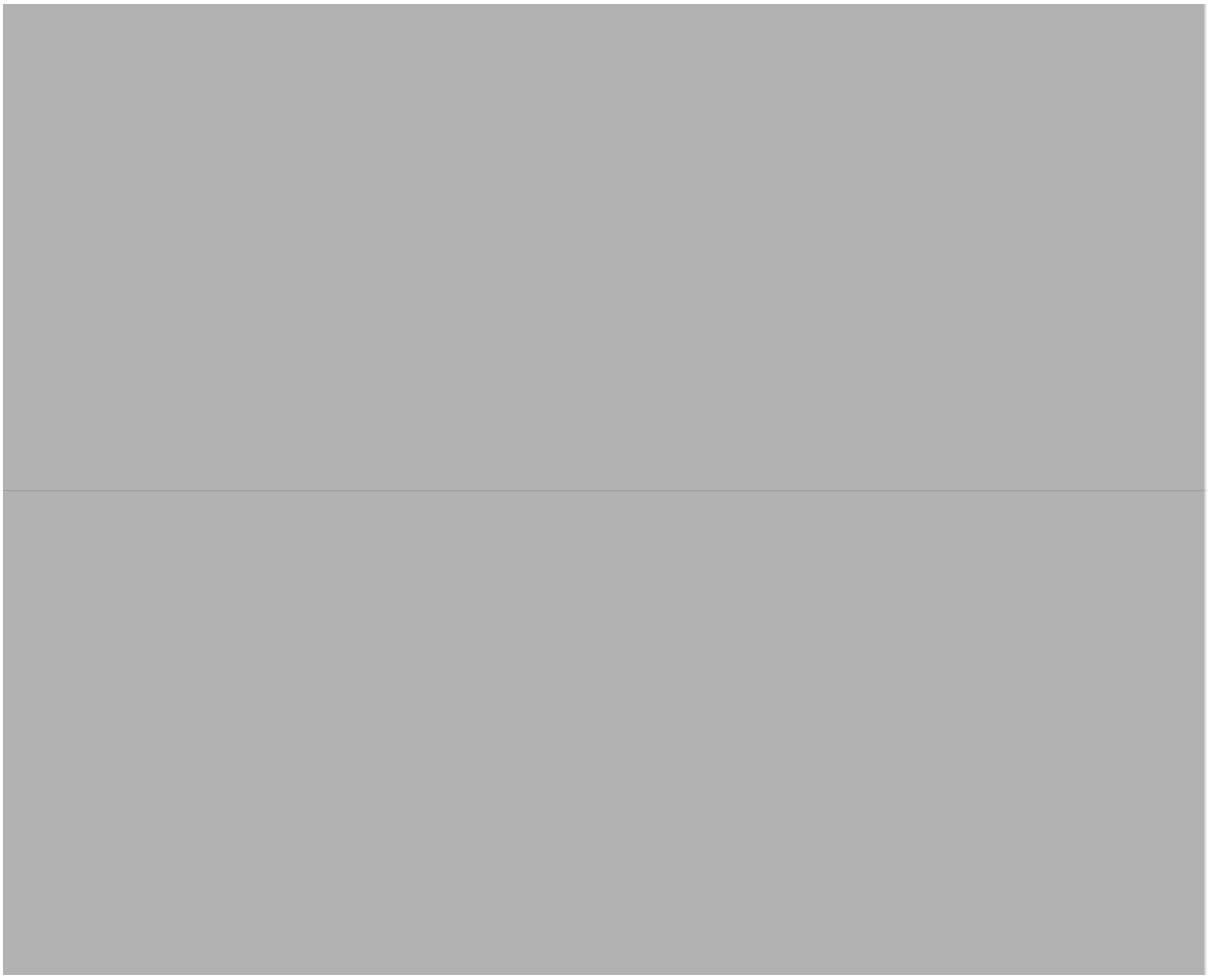

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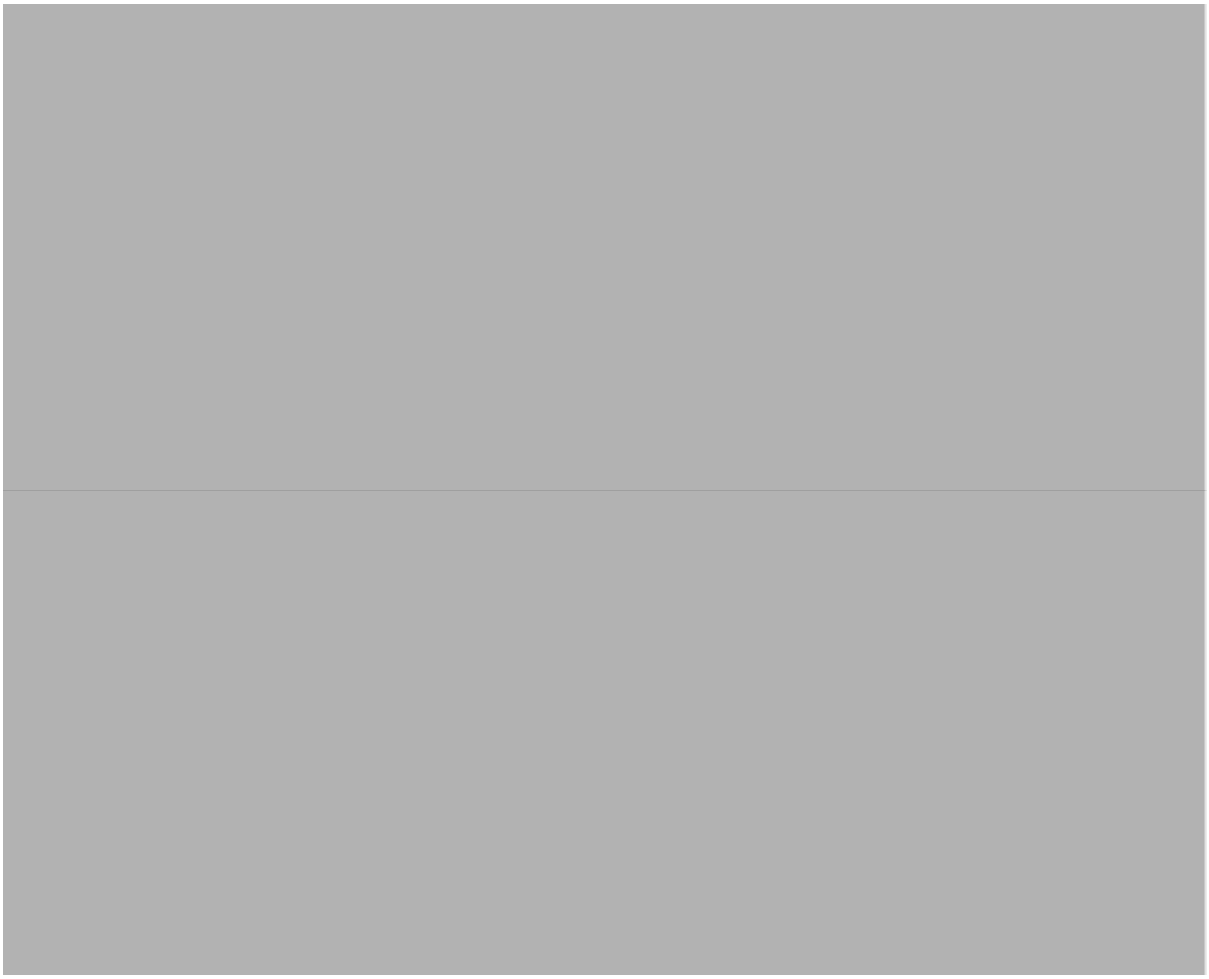

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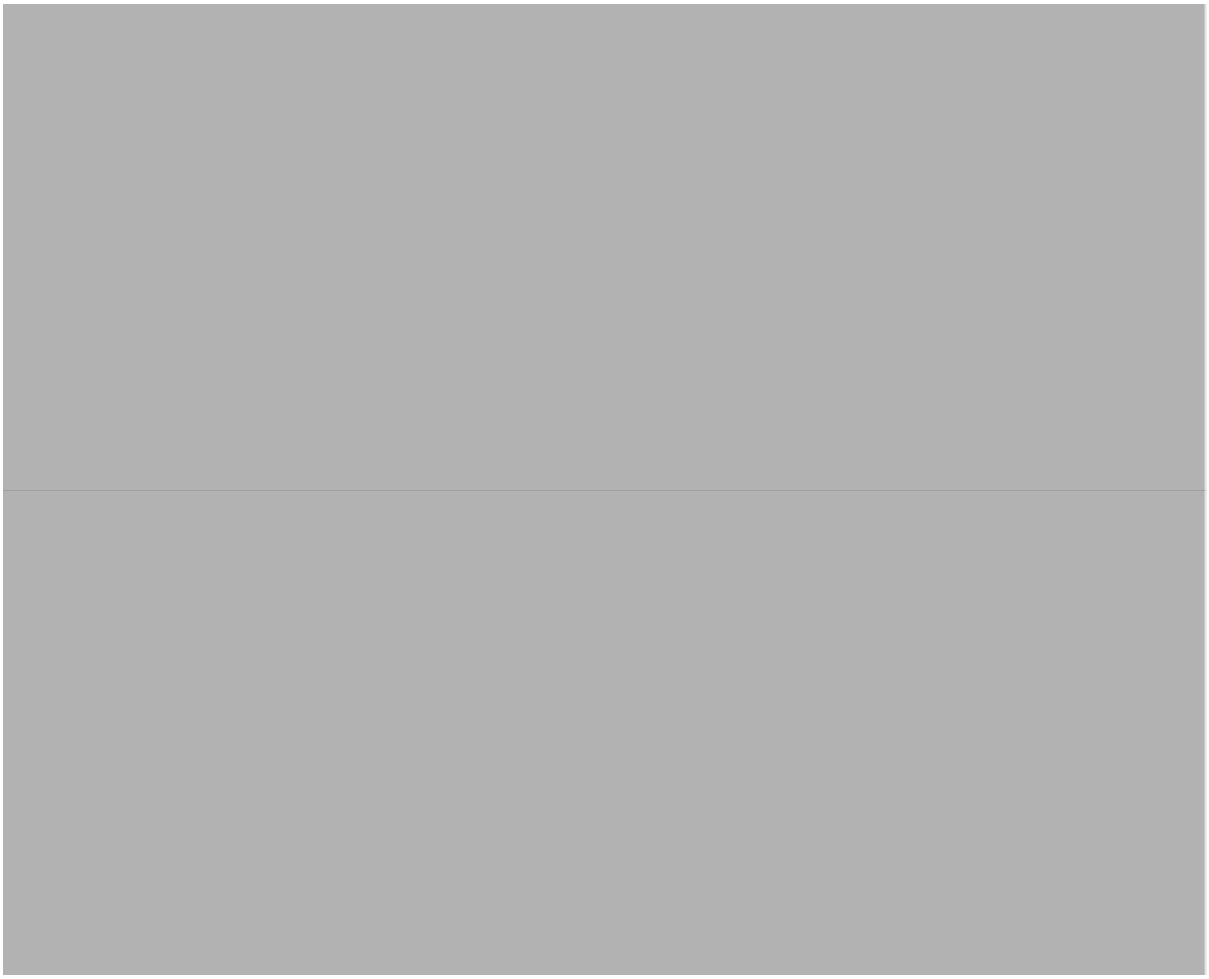

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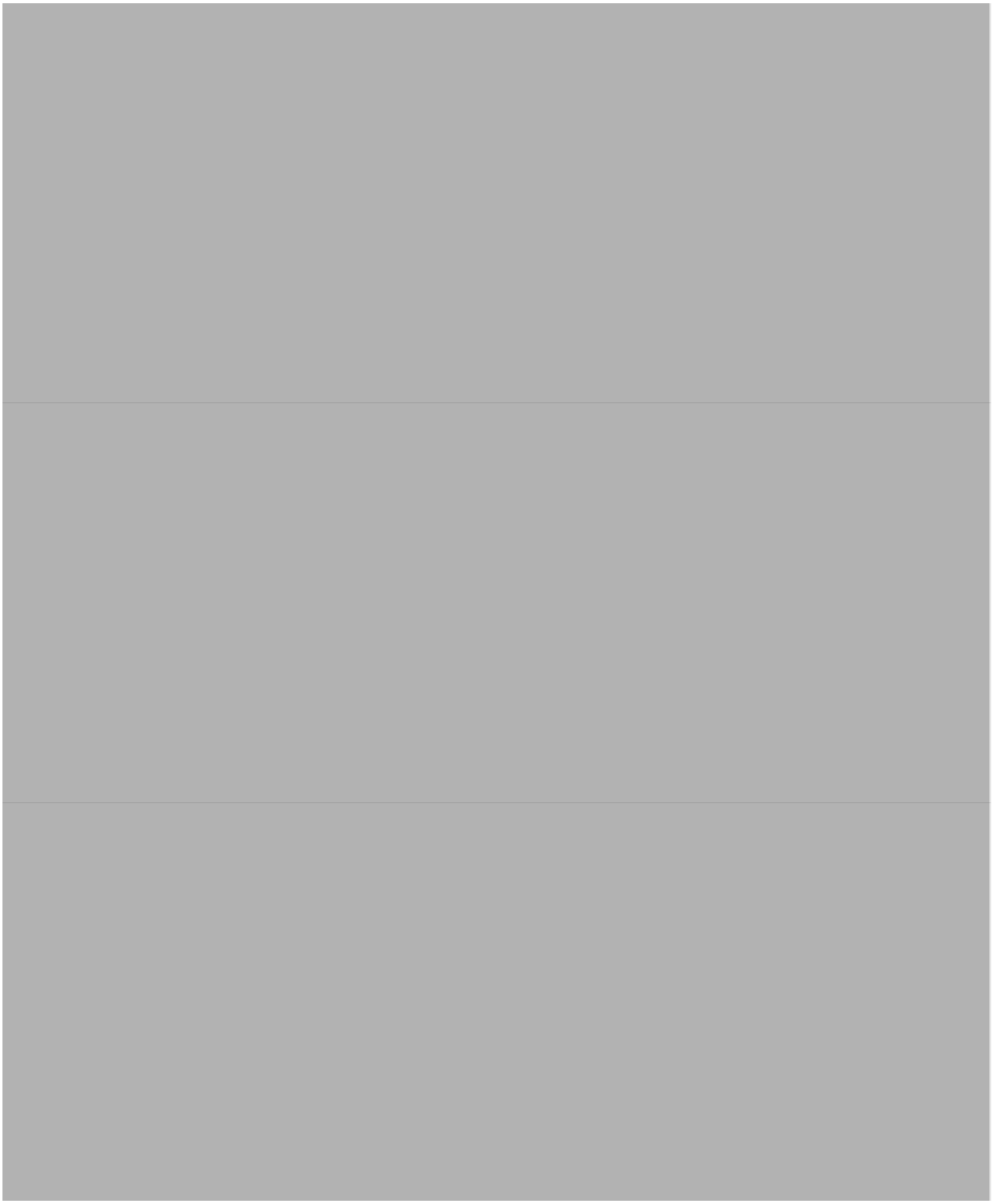

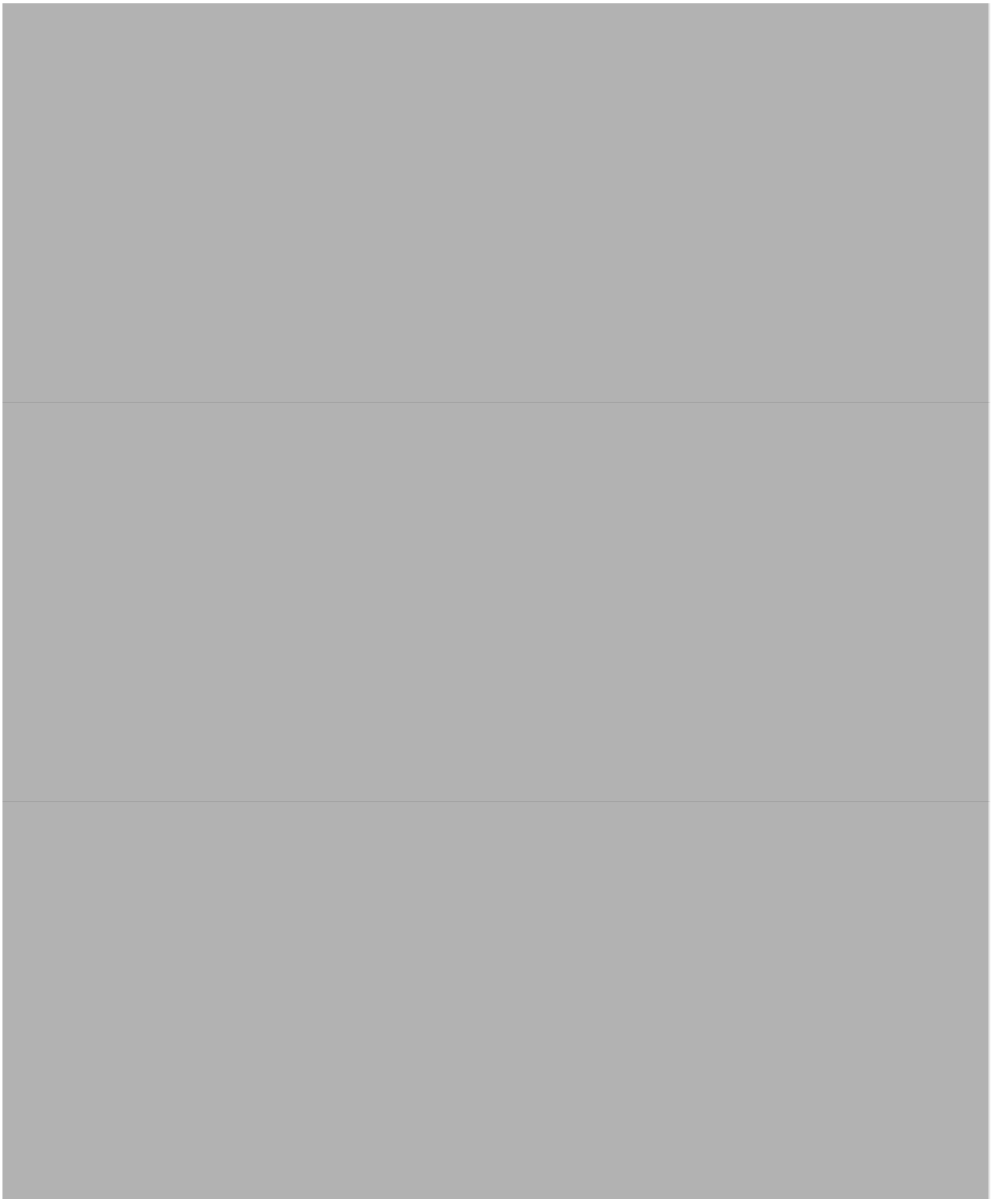

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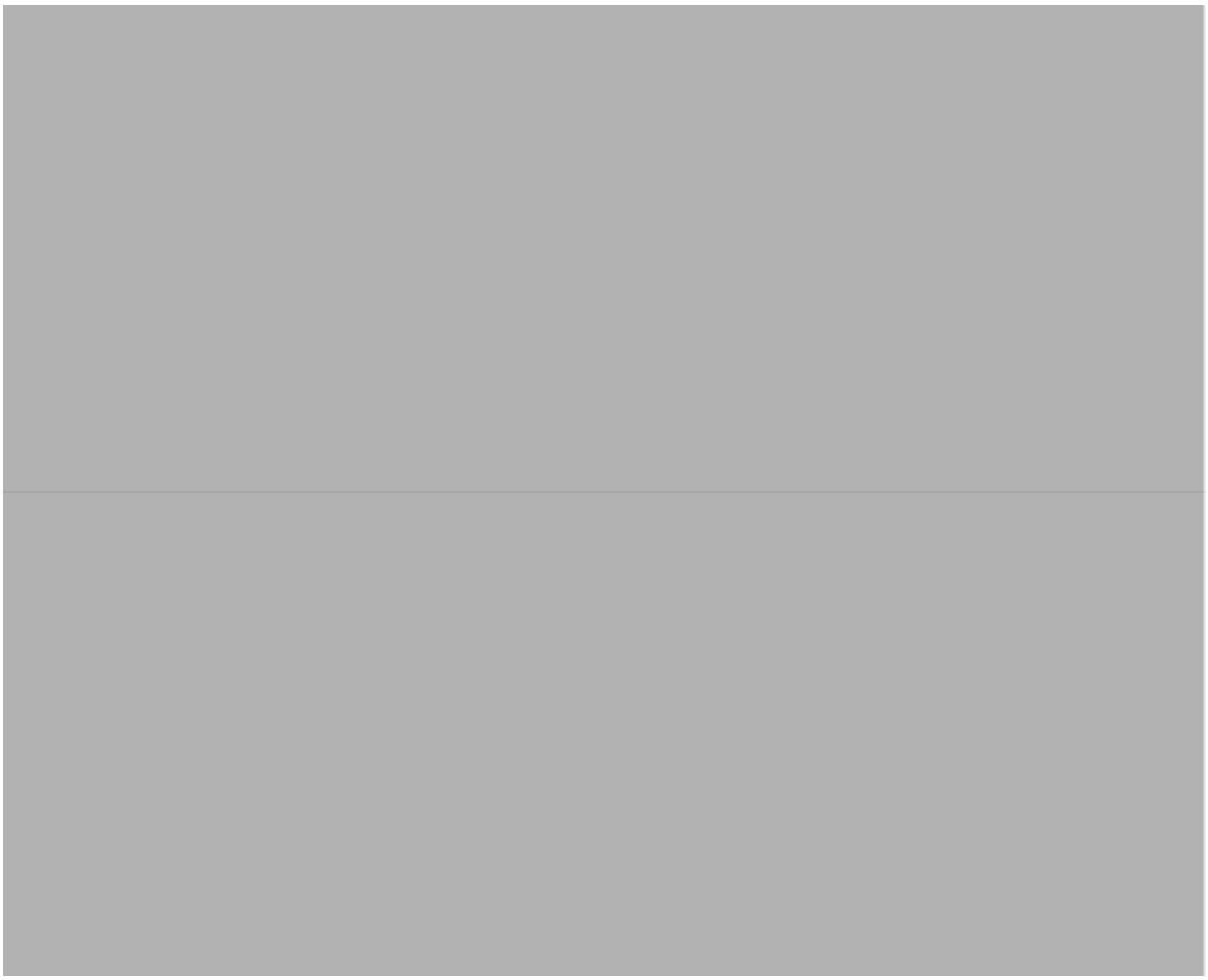

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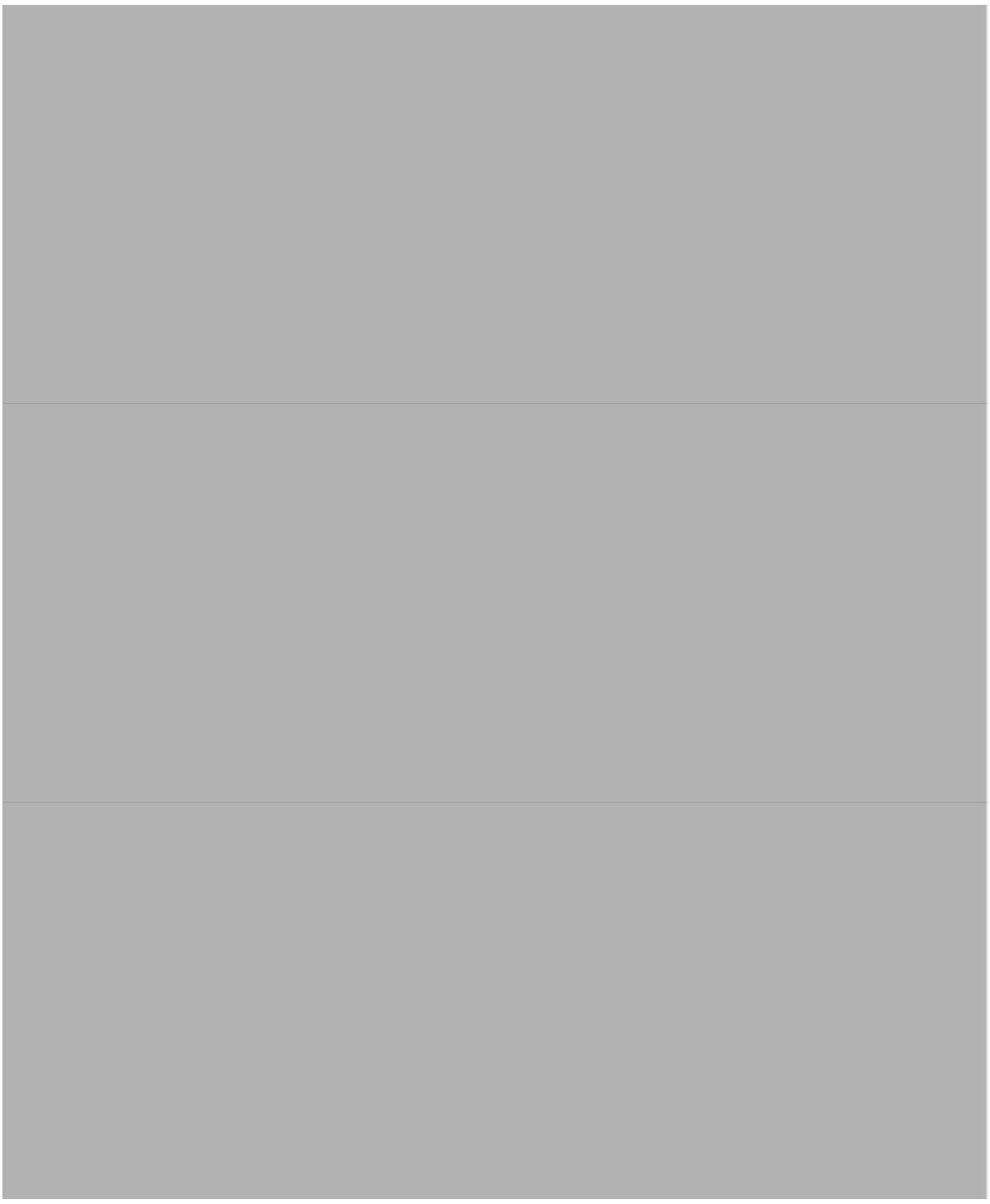

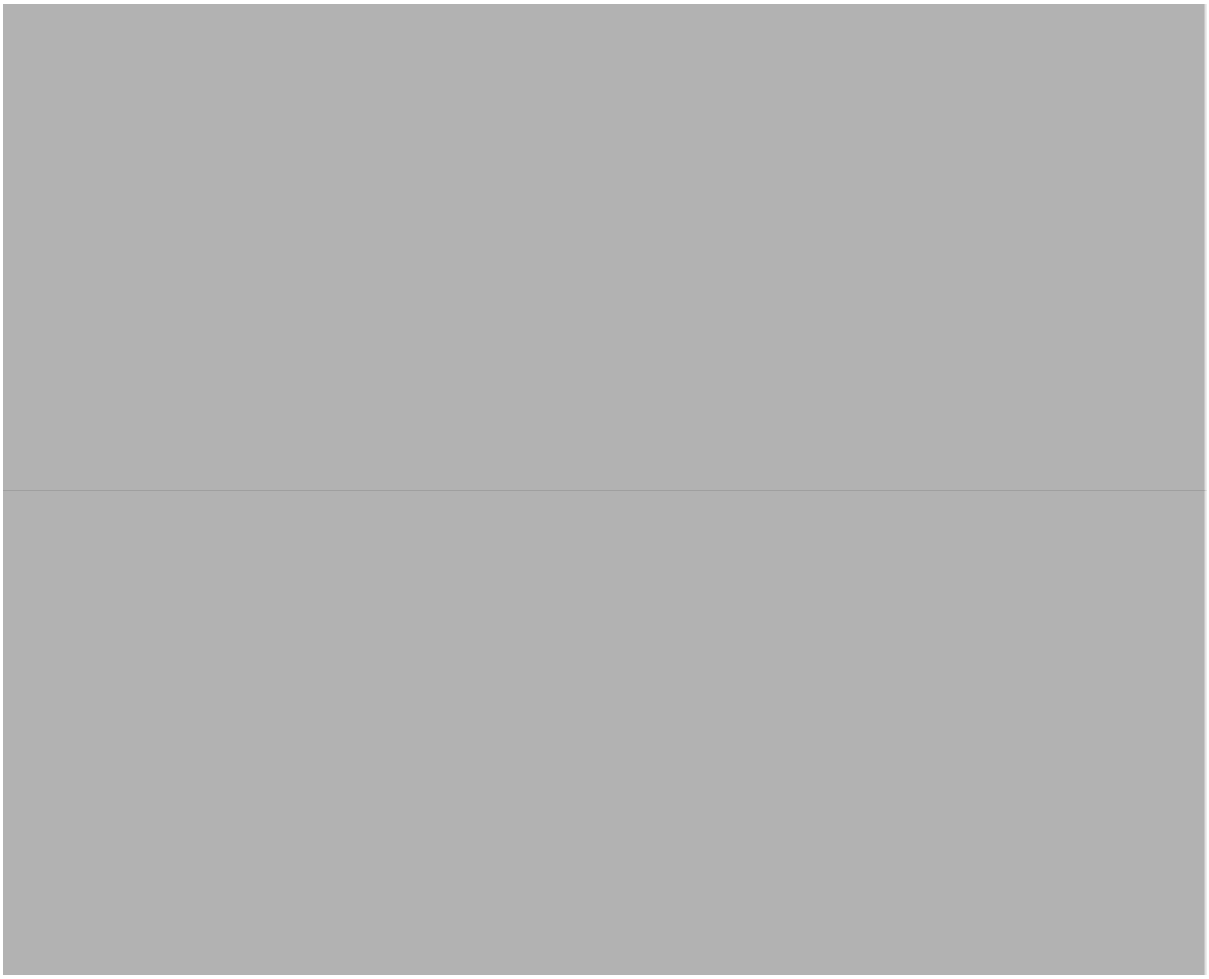

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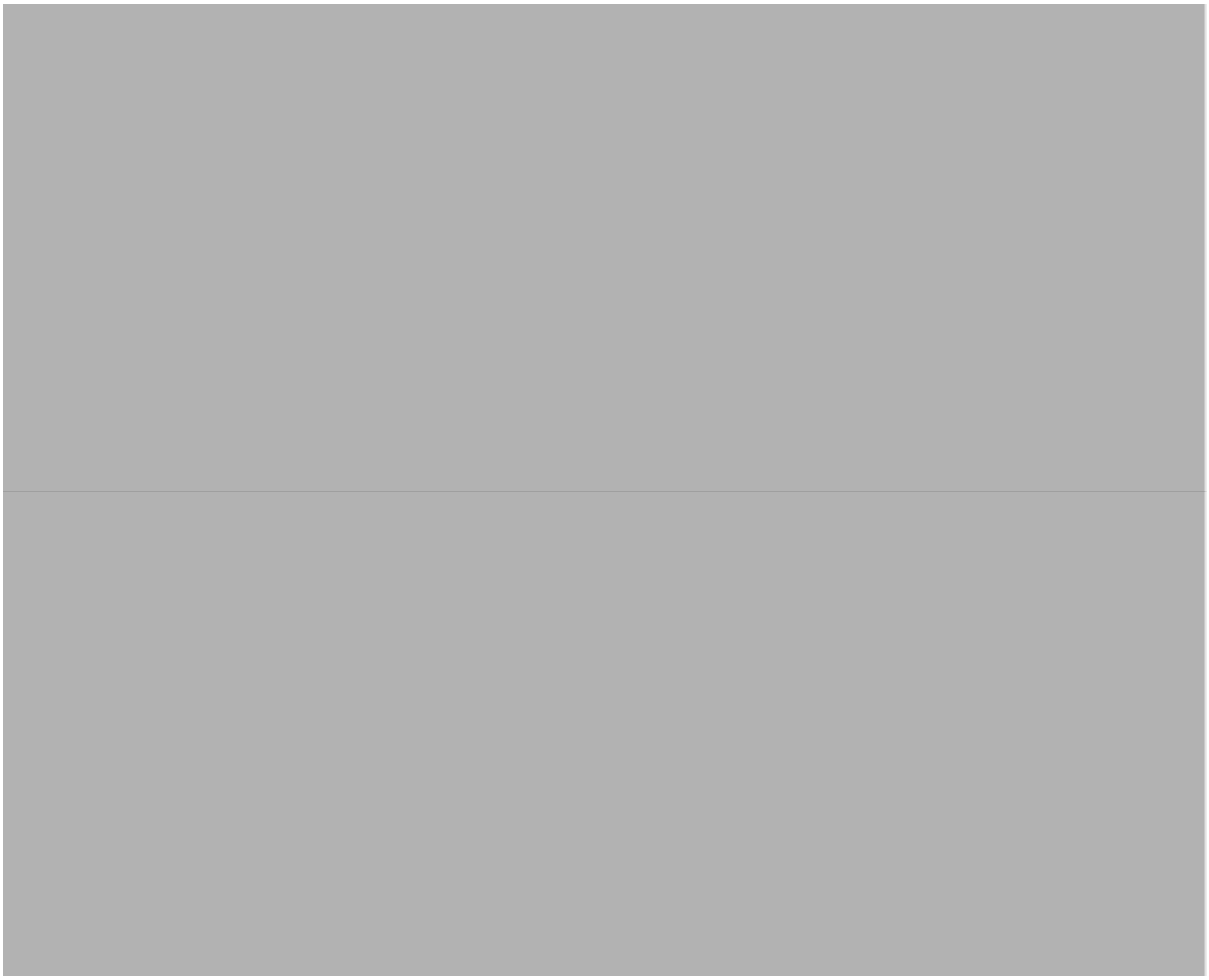

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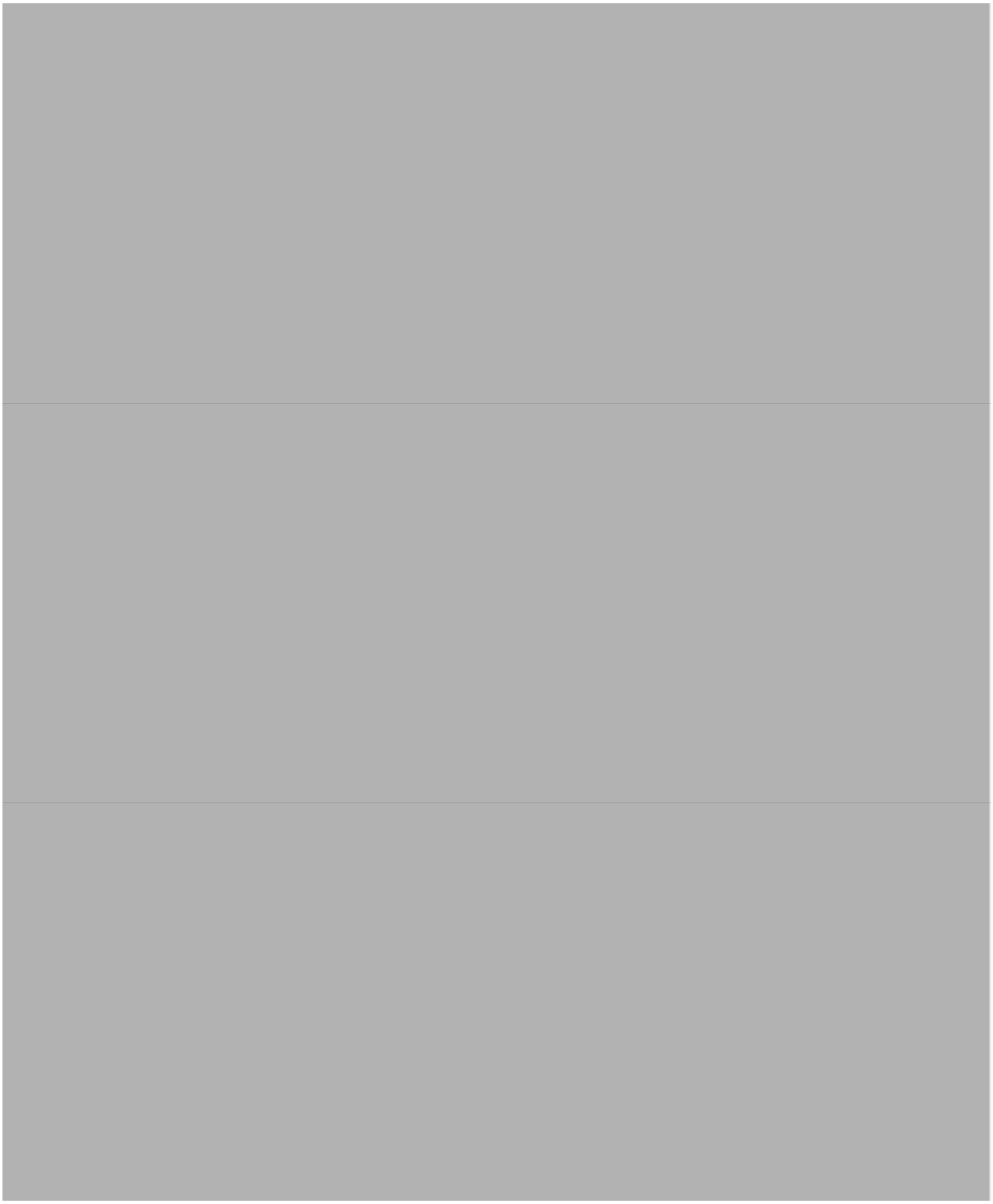

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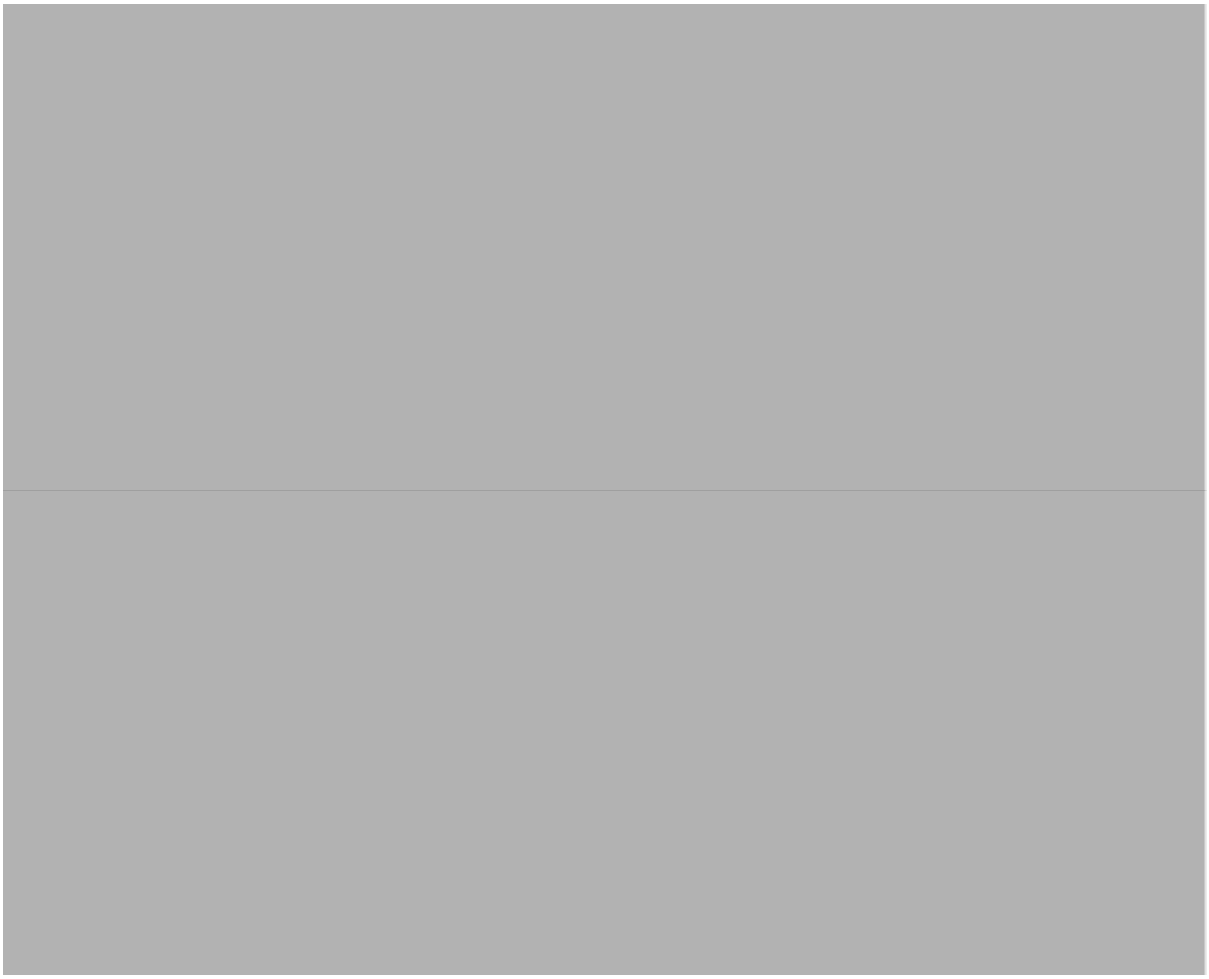

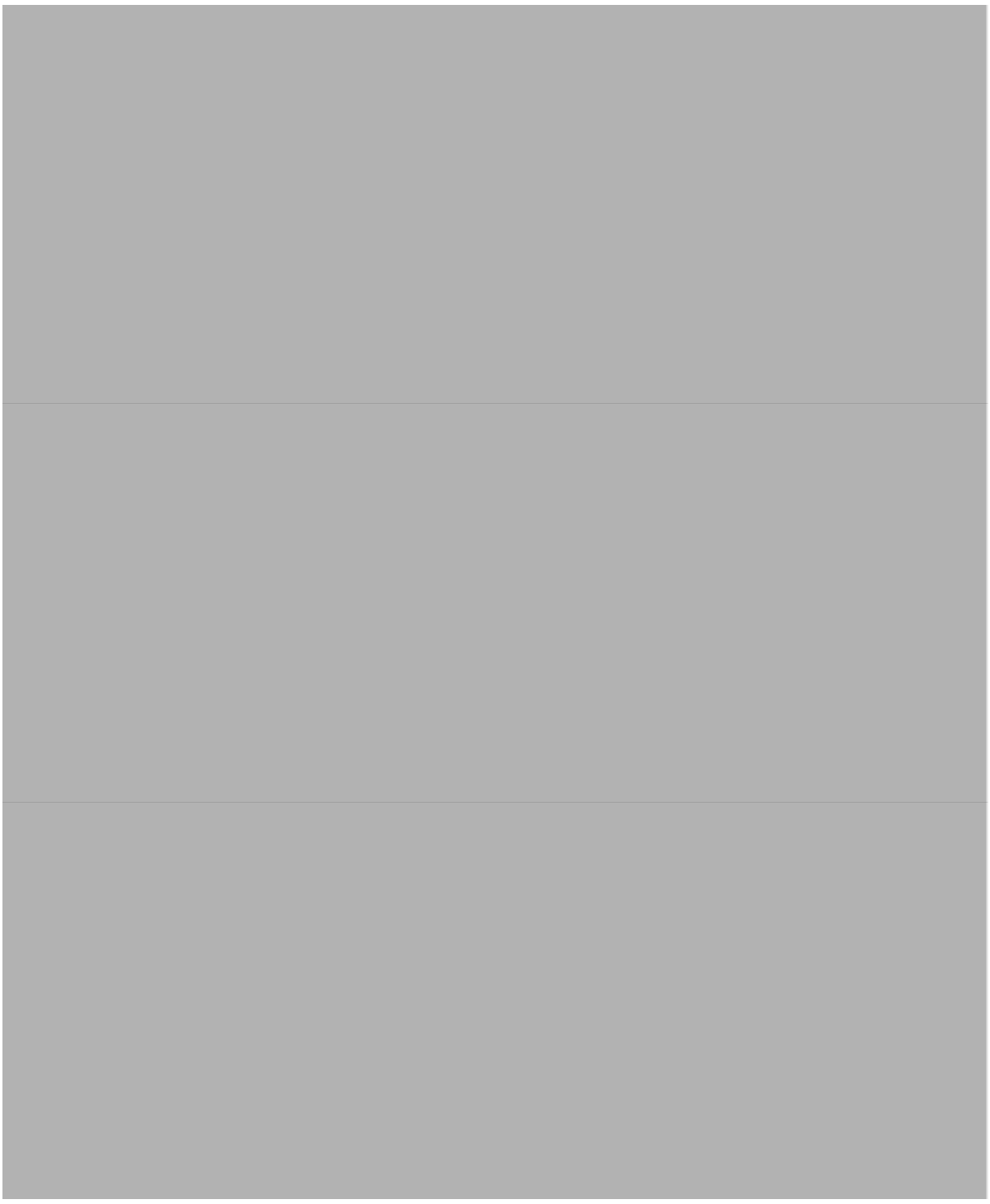

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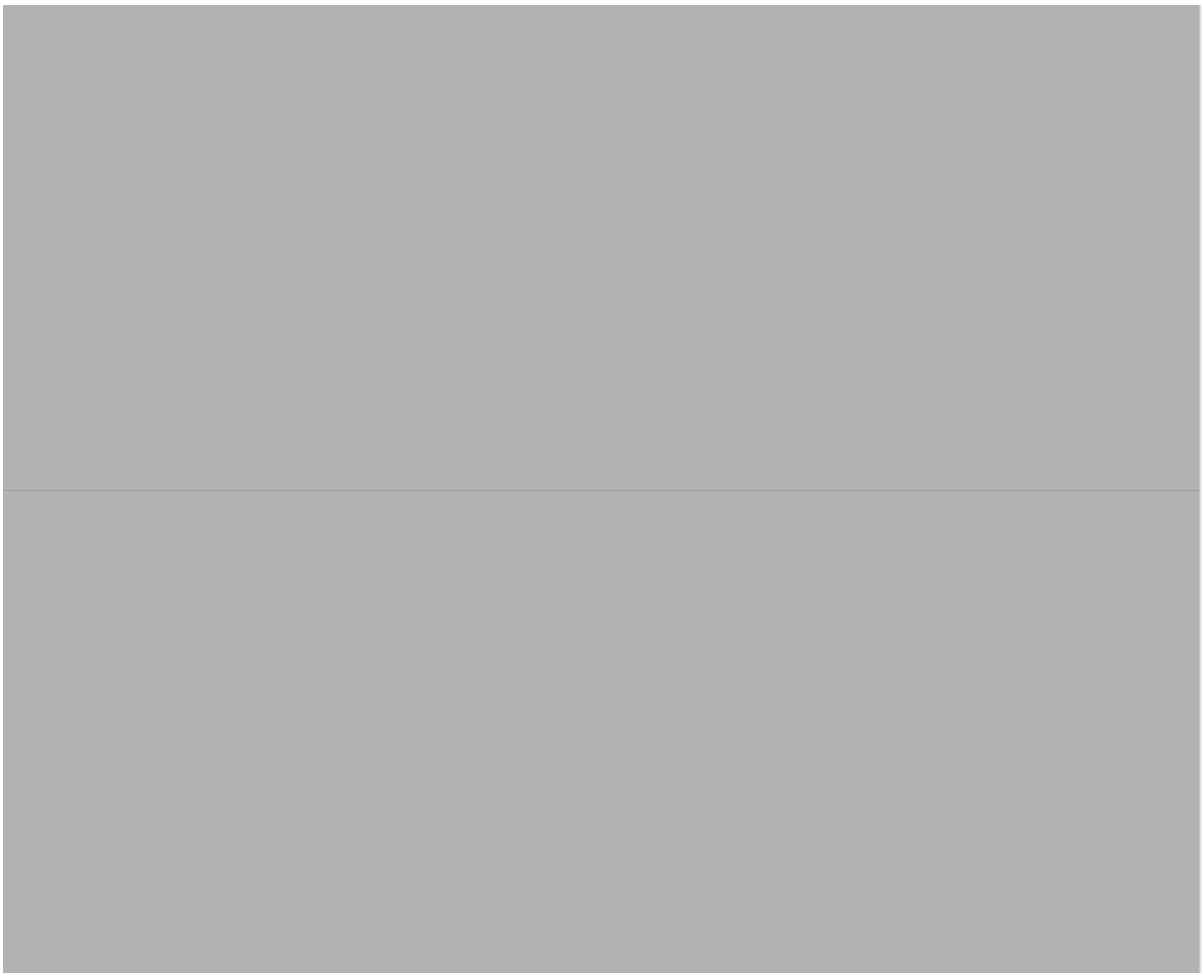

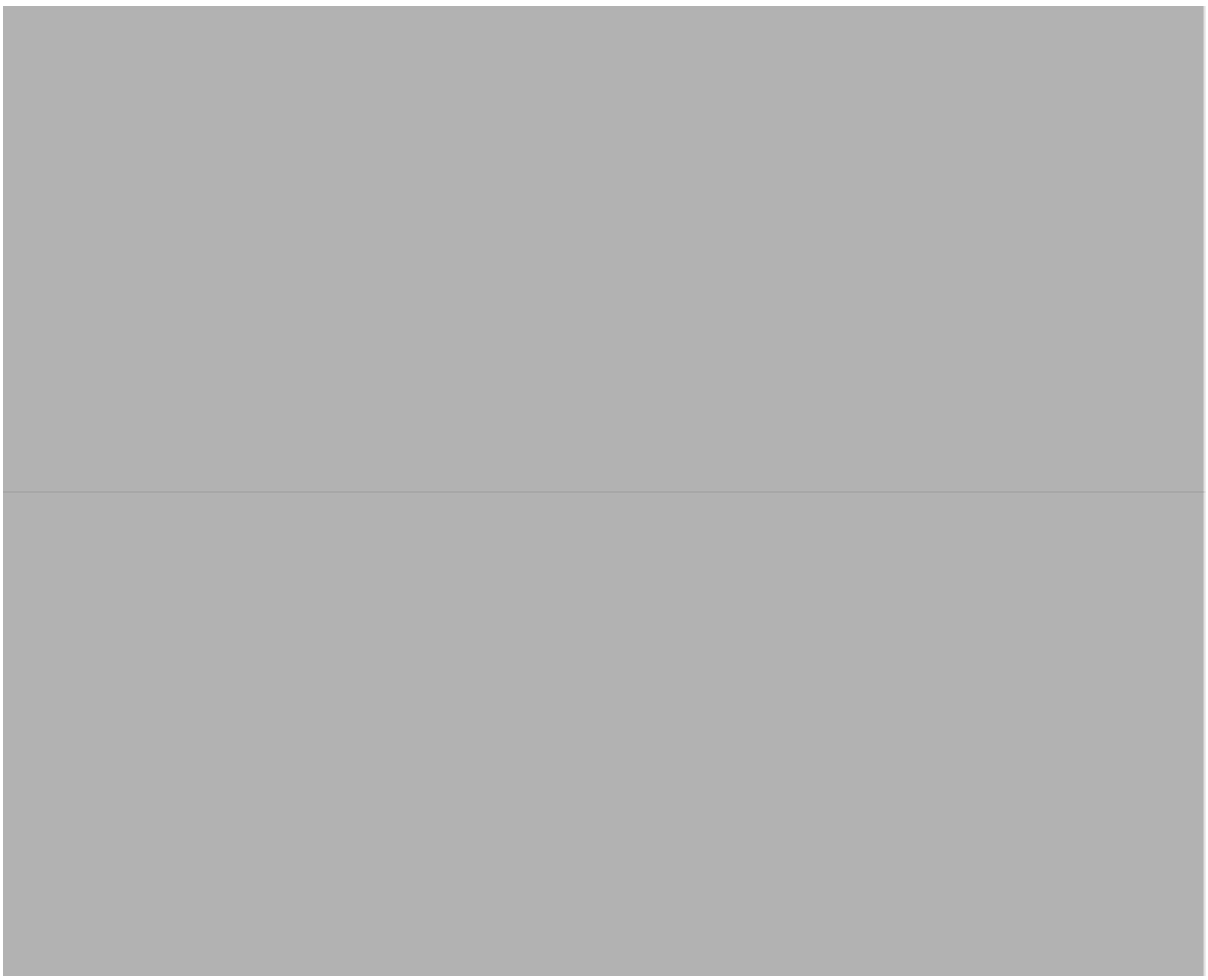

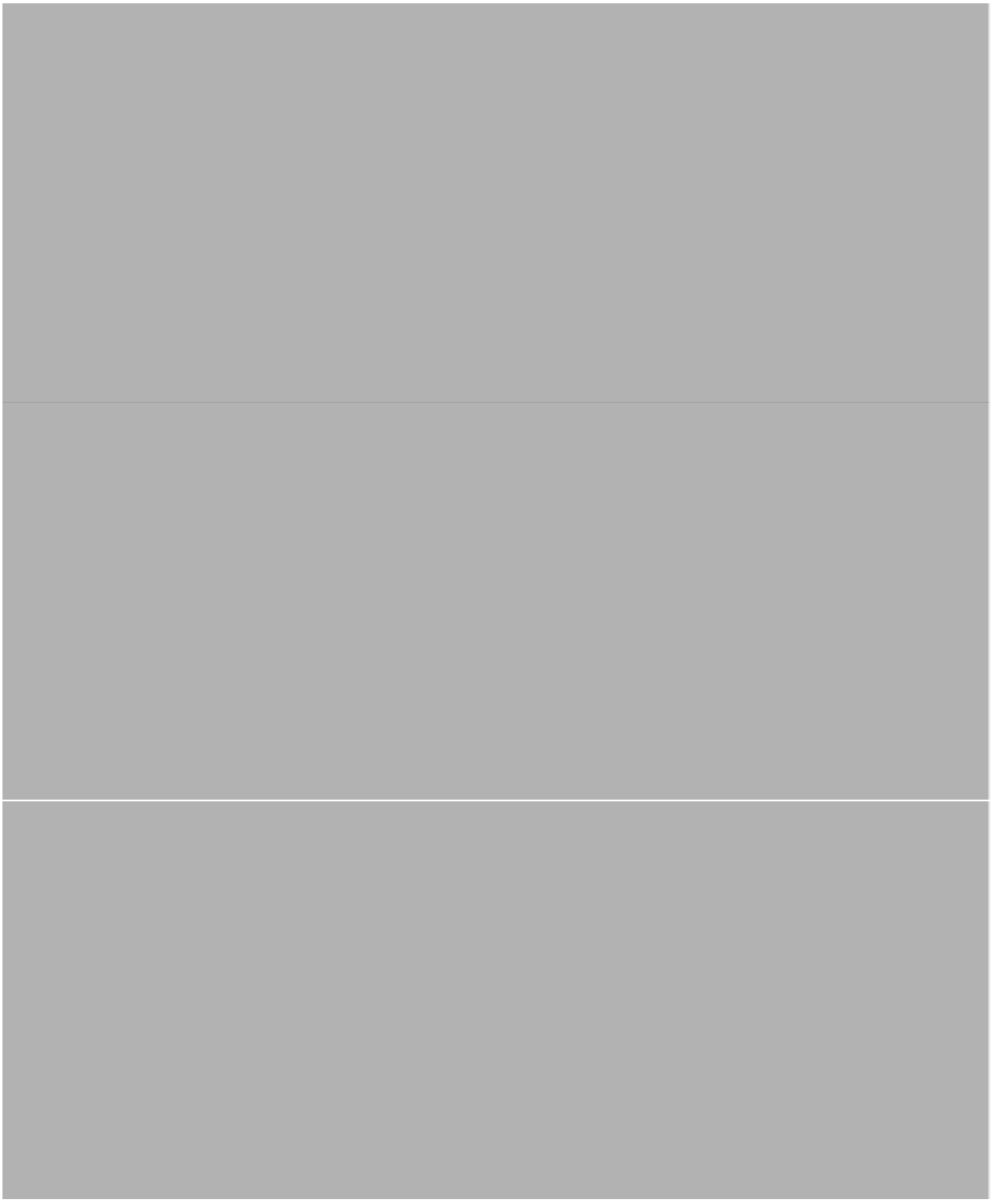

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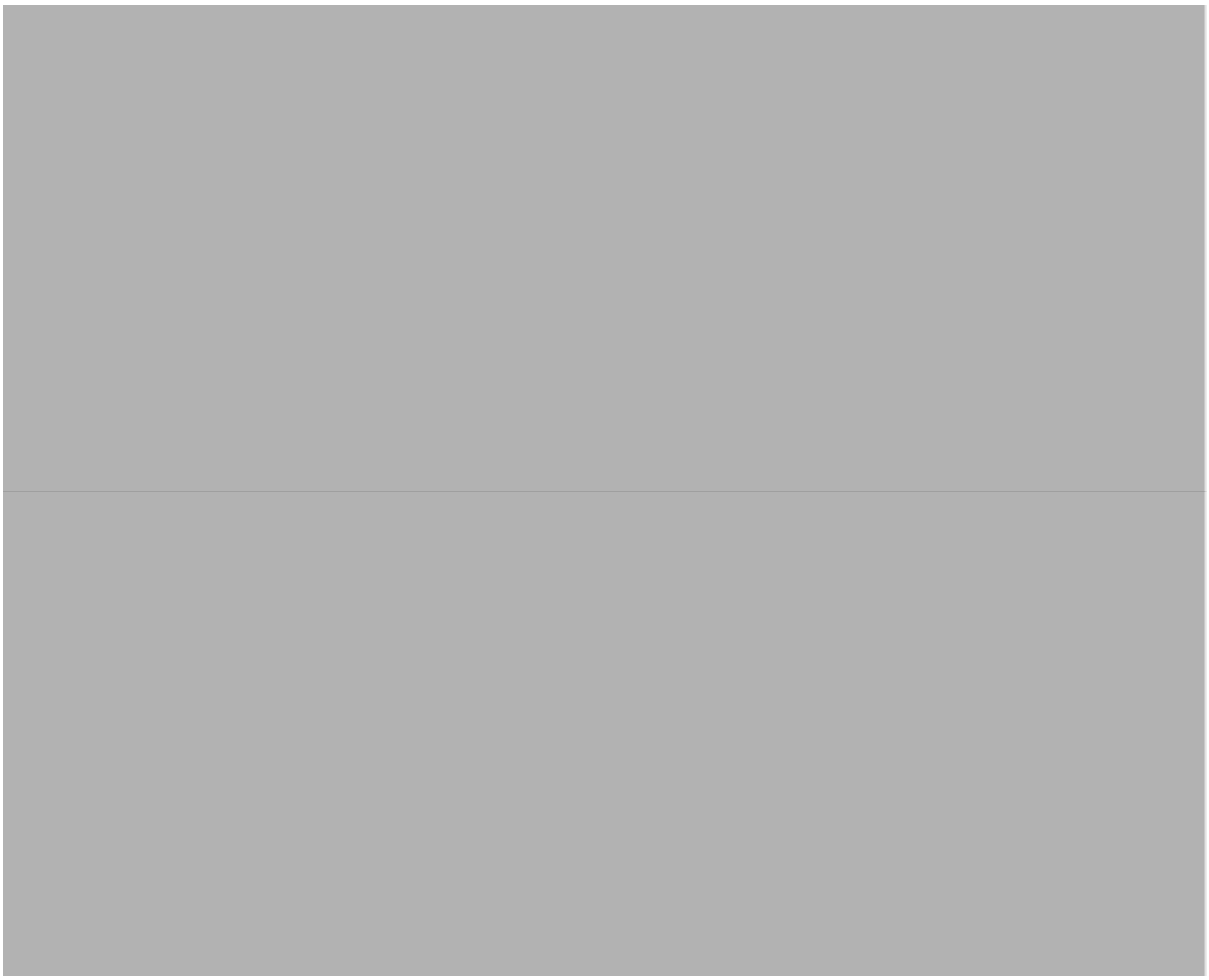

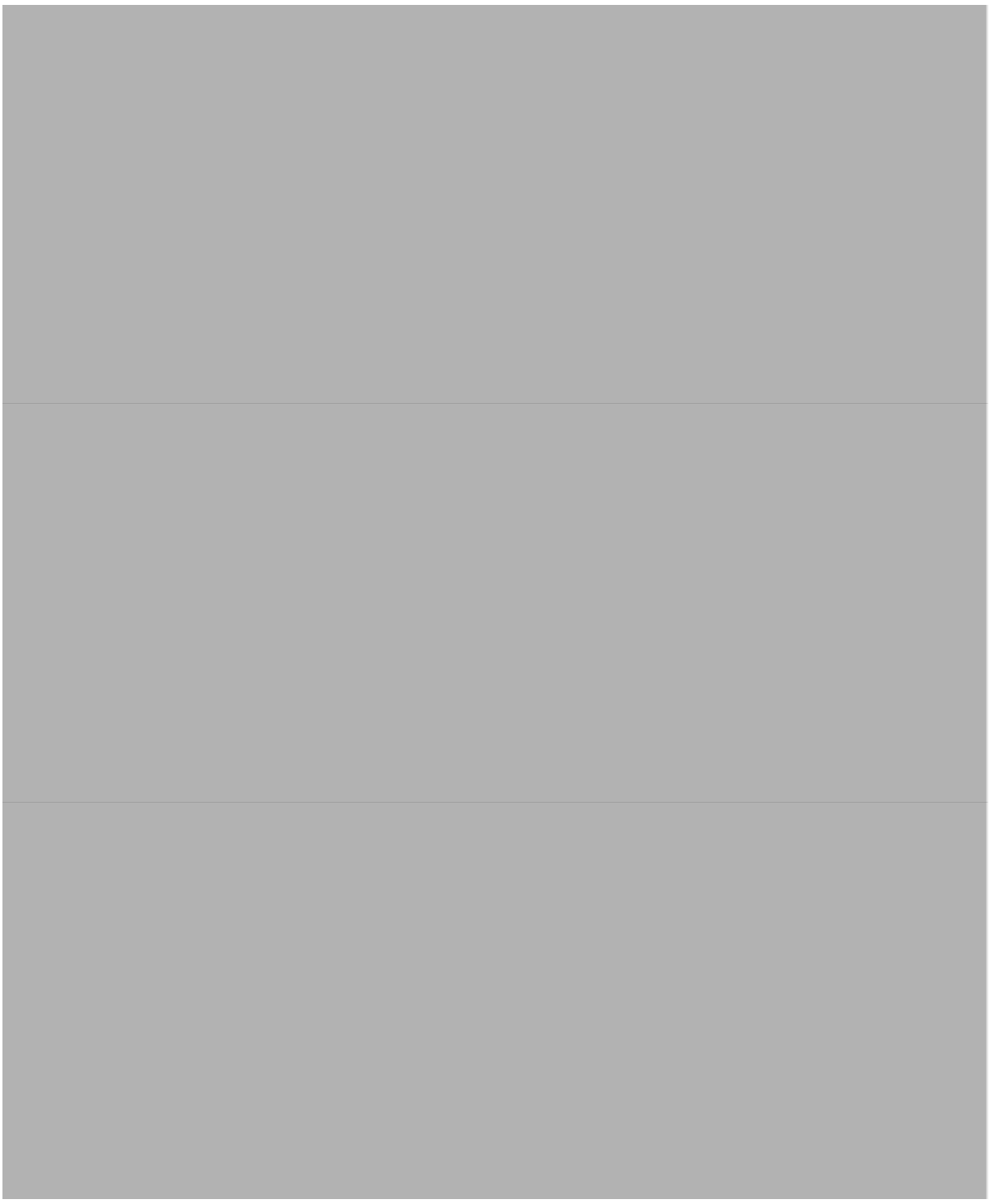

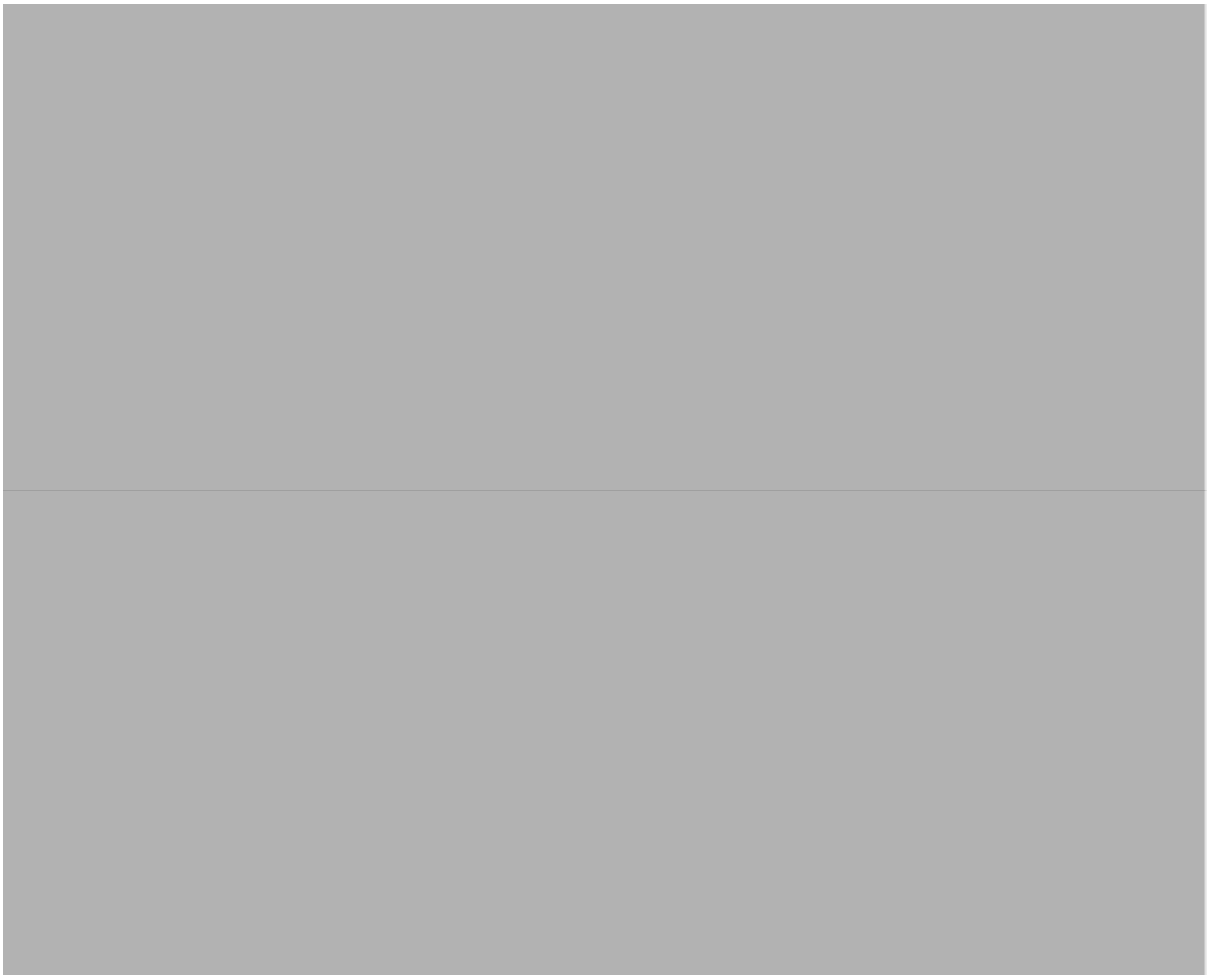

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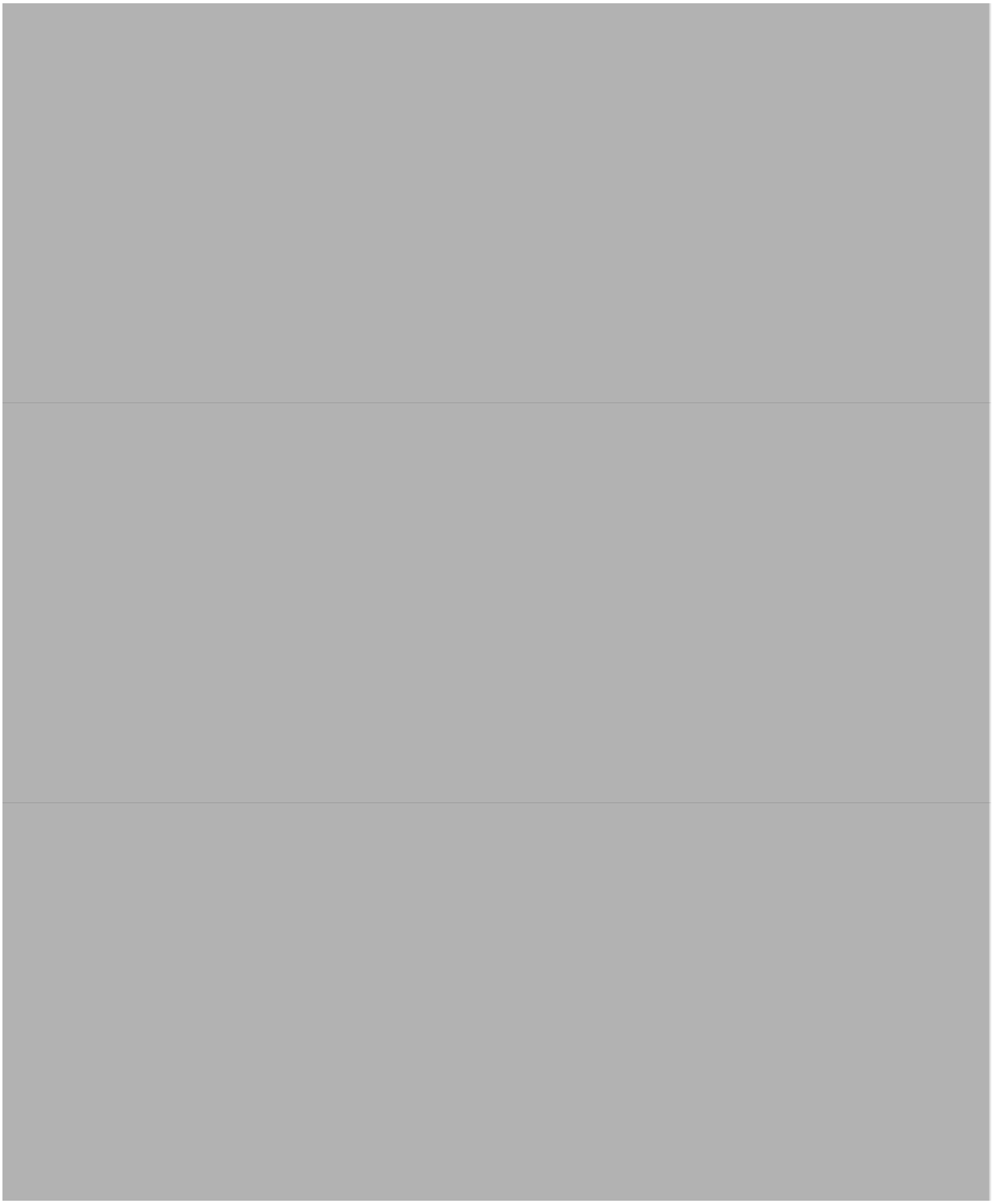

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