Virtual Mentor
American Medical Association Journal of Ethics

February 2013, Volume 15, Number 2: 99-182.
The Hospital: Business and Public Service?

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 101-103.

FROM THE EDITOR
"No Margin, No Mission" Is Too Simplistic

The modern hospital grew from public nonprofit institutions, such as almshouses, that provided charity care to the ailing poor. It wasn't until the twentieth century that chains of for-profit hospitals made their debut in the U.S. Now, according to the American Hospital Association's 2010 survey data, more than a third of community hospitals in the U.S. are for-profit [1]. The changing face of the American hospital has led to significant questions about what the role of a hospital is and should be. Is a hospital a business, focused on profit margins and the bottom line? Or is it a mission-driven public resource, working to improve the health of a community? And are these two roles as diametrically opposed as they seem at first glance? The response to these questions is often "no margin, no mission"—in other words, if a hospital doesn't make enough money to keep its doors open, its higher purpose is moot—but this is too simplistic a view to take of the inherent tension between hospitals as businesses and hospitals as a form of public service.

In this issue of *Virtual Mentor*, we explore this tension in the context of a changing economic landscape in the U.S. With the advent of health care reform and an increased national focus on hospital costs, the way that both for-profit and nonprofit hospitals operate is changing: they are reevaluating their existing business practices in order to survive and thrive. As the authors of this issue describe, this has far-reaching implications for patient care, hospital organization, physician autonomy, and medical ethics.

Hospitals have important relationships with three key stakeholders: their customers (patients), their employees (hospital staff and, increasingly, physicians), and their shareholders (board members, in the case of private hospitals, and the community, in the case of public hospitals). This month's case commentaries focus on different aspects of these stakeholder relationships. Shivan Mehta, MD, MBA, and David Asch, MD, MBA, explore the case of a physician employed by a hospital, who is unsure about her own autonomy when the CEO publishes physicians' ordering information by cost. Chuck Peck, MD, an expert in physician-hospital joint ventures, provides another point of view in a separate commentary. Susan Dorr Goold, MD, MHSA, MA, examines the ethics of altering the so-called standard of care to spare a patient high hospital fees. In the final case commentary, Richard Thompson, MD, discusses the ethics of giving perks to wealthy patients as a way to garner philanthropic donations from grateful patients. Can the hospital/employed physician relationship work for the benefit of both parties and patients, too? Faith Lagay, PhD, reviews a 2012 journal article by hospital administrator David M. Belde who

believes it can, as long as the relationship is built on "socially directed" ideals shared by the medical profession and health care organizations.

The health care reform debate has led to an increased awareness of the cost of medical care and different ways to address these costs. Neel Shah, MD, gives an overview of how costs have become so high and how Cost of Care's Teaching Value project aims to help health care professionals master the complex cost landscape. In the medical education section, Stefan Timmermans, PhD, and Hyeyoung Oh describe the effects that an increased focus on hospital inpatient costs is having on medical education, given that medical students are trained on the wards. In the state of the art and science section, Devan Kansagara, MD, MCR, Brian Chan, MD, MPH, David Harmon, MD, and Honora Englander, MD, take a hard look at care transitions, an area that has been a focus of health care reform efforts. Cristie M. Cole, JD, reviews the effects of the Affordable Care Act on self-referral to physician-owned hospitals, previously suspected of driving costs up. Self-referral is also covered in this month's excerpt from the *Code of Medical Ethics*.

Accountable care organizations, or ACOs, are hospital or health system collaboratives that explicitly tie health care outcomes and cost reductions to physician reimbursement. ACOs already exist in the U.S., and many people have suggested that they are a perfect way to simultaneously achieve the dual goals of improving health care quality and reducing health care costs. However, as with any new development in hospital management or technology, there are ethical issues that need to be considered. Matt DeCamp, MD, PhD, writes an article in the policy forum section detailing some of the ethical considerations ACOs confront. In a medical narrative, Matthew McNabney, MD, gives guidance to physicians who will need to adapt to work in ACOs.

As the business of medicine continues to evolve in the U.S., and as more and more doctors become hospital employees, it will be increasingly important for physicians and future physicians to fully understand the environments in which they work. It was a pleasure and honor to work on this issue of *Virtual Mentor*, which I hope will serve as a resource as we navigate this changing landscape.

Alessandra Colaianni
MS-3
Johns Hopkins University School of Medicine
Baltimore, Maryland

References

1. American Hospital Association. Fast facts on U.S. hospitals. http://www.aha.org/research/rc/stat-studies/fast-facts.shtml. Accessed January 10, 2013.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 104-106.

ETHICS CASE
Is the Standard of Care Always Worth the Cost?
Commentary by Susan Dorr Goold, MD, MHSA, MA

Mrs. Howard was writhing in pain on the paper-covered bed in the emergency room. She clutched her abdomen. “Yes, I’ve had this pain in the past,” she said to Dr. Murphy, the resident taking her history. “I know I have gallstones. My right side usually aches after I eat greasy foods, but it’s never been this bad before.”

“Okay,” said Dr. Murphy, after performing the physical exam. “I’m almost certain that you have cholecystitis, but we’ll order an ultrasound just to confirm. Most likely, we’ll start you on some antibiotics and fluids until the inflammation goes down, and then we’ll take the gallbladder out with surgery.”

“Wait a minute,” said Mrs. Howard, sitting up in bed. “I’m on a health savings account, and I haven’t spent my deductible yet. Can we just go ahead with the antibiotics and fluids and skip the ultrasound? We already know I have gallstones, so this test is just taking money out of my pocket.”

When Dr. Murphy went to discuss Mrs. Howard’s case with his attending, he asked whether they could skip the ultrasound due to Mrs. Howard’s finances.

His attending wasn’t pleased. “The standard of care in this hospital is to get a confirmatory ultrasound,” she said, “regardless of the patient’s preference to not spend $200 out of her HSA. If you start changing the way you treat patients based on their payment preferences, you’re in dangerous territory.”

“We’re not denying her care or skipping a crucial step because she’s unable to pay, or because we’re trying to cut costs for the emergency room,” Dr. Murphy argued. “We’re just trying to save her money. We could see it as part of acting her best interests.”

The attending fired back, “You know, failing to meet the standard of care feels better when it’s to directly benefit a patient, but the bottom line is, you need to be consistent about the way you practice medicine. The cost of a test shouldn’t enter into your thinking when you’re trying to diagnose a patient—especially not when there’s a standard of care to be followed. You’re a doctor, not her accountant.”

Commentary
“The standard of care.” That phrase, used often in medicine, warrants a close inspection.

The standard of care. Use of "the" rather than "a," "our," or "my" provides a sense of absolutism, an implicit claim that there is only one. Certainly there are some clinical situations in which the evidence of benefit from a particular intervention is so overwhelming (aspirin after heart attack, say) that exceptions should be few and far between and for very good reasons (aspirin-sensitive asthma, say). And there are many medical situations in which evidence favors a particular course of action for the usual patient, but exceptions are easier to justify because the evidence is more questionable (perhaps an intervention studied in adults younger than 65 being applied to a 66-, or 76-, or 86-year-old). There are other medical situations in which the benefit, even if well established, is small enough to readily justify exceptions to "the standard." In the case described, to assert that an ultrasound is the (only) standard of care, one would have to claim not only that unquestionable evidence confirms that ultrasounds are needed to diagnose acute cholecystitis but also that, even in a patient with known gallstones and a history and physical exam consistent with "almost certain" cholecystitis, an ultrasound provides essential and substantial benefit.

The *standard* of care. There is a suggestion of fairness in the idea of standardization, of treating like cases alike. When treating individual patients, however, doctors need to individualize care recommendations based on a unique history, personality, and, yes, economic context. This patient may differ from the usual patient presenting to the emergency department with suspicion for cholecystitis, since she has known gallstones and typical symptoms and signs. As for considering cost, most doctors have cared for uninsured, a.k.a. "self-pay," patients and have faced requests for cheaper medications, more limited testing, and less frequent doctor visits. Likewise we have seen patients with ample resources who request unnecessary services (e.g., antibiotics for viral sore throat, unnecessary x-rays).

When the benefit of a recommendation is well proven and substantial, doctors try to persuade reluctant payers that an intervention is worth the cost. Sometimes that payer is the patient (e.g., my uninsured patient with chest pain who did not want to incur an emergency room bill), sometimes it is an insurer (e.g., for coverage of a nonformulary medication when formulary options don't work), and sometimes someone else faces the cost (a hospital with an uninsured inpatient, a colleague asked to consult). We make judgments about the need, about the anticipated benefit, all for individual, not standardized, patients.

There are few situations in which the standard of care is so clear-cut as to preclude any judgment by the physician. We decide all the time how urgent something is—does this patient need an ambulance or just a ride to the ER; can this one wait for a routine appointment or does he need to be seen today, this week, this minute? These are judgments about need—and the willingness to consider the degree of need (not just the standard of care) when asking a patient (or someone else) to spend money requires the same sort of judgment.

Standards also refer to integrity, to a moral and ethical code. Physicians' primary ethical obligation is to protect and promote the well being of individual patients [1]. At times that may entail persuading a patient to dip into his or her health savings account or wallet to enable him or her to receive the needed care. At other times it may mean recognizing that patients' preferences and values include nonmedical considerations; not just out-of-pocket cost but timing of an intervention, location, or other features. This has the added benefit of strengthening the patient-physician relationship: by taking into account patients' nonmedical preferences, we indicate to patients that we recognize them as something other than their conditions, and that we will treat them as individuals.

The standard of *care*. Without talking to this patient, putting my hands on her abdomen, and seeing her previous diagnostic evaluation, I couldn't say whether the physician should persuade her that an ultrasound is worth the cost. I can say, to quote Francis Peabody, "the secret of the care of the patient is in caring for the patient" [2], words as true today as they were in the early twentieth century, before ultrasounds became the standard of care for diagnosing acute cholecystitis.

References

1. American Medical Association. Principle VI. Principles of Medical Ethics. https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page. Accessed January 10, 2013.
2. Peabody FW. The care of the patient. *JAMA.* 1927;88(12):877-882.

Susan Dorr Goold, MD, MHSA, MA, is a professor of internal medicine and health management and policy in the Center for Bioethics and Social Sciences in Medicine at the University of Michigan in Ann Arbor.

Related in VM

To Scan or Not to Scan? March 2006

Patient Self-Rationing, a Health System Problem, November 2012

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 107-113.

ETHICS CASE
The Physician as Hospital Employee
Commentary by Shivan Mehta, MD, MBA, David A. Asch, MD, MBA, and Charles A. Peck, MD

Dr. Gowen sighed as she sat down in the physician's lounge to go through her accumulated e-mail. "Good grief, 50 unread e-mails in 8 hours?" she said to her colleague, Dr. Hassan, who was sitting next to her. He rolled his eyes.

"I know," said Dr. Hassan. "I love this hospital but the number of 'all-employee' e-mails is overwhelming." Suddenly he drew in his breath. "Have you seen this?"

Dr. Gowen peered over his shoulder at a spreadsheet sent out by the hospital's CEO that listed the average monthly ordering costs for each physician on staff, by name, including lab requisitions, prescriptions, and diagnostic tests. She scrolled up to find a perfunctory introduction about trying to "do what we can" to cut costs. "Are they serious?" she said incredulously. "They're trying to shame us into ordering less?" She flipped back to the spreadsheet and reddened when she saw her name. Her monthly costs were among the highest in the hospital.

"Looks like you've got some explaining to do," joked Dr. Hassan. Dr. Gowen laughed, but her mind was racing. She didn't think that her patients were sicker or had more complicated medical problems than the patients of her peers, and she trusted her clinical judgment—she had often been praised for her acumen in knowing what tests to order to clinch a difficult diagnosis. She certainly didn't order tests that she thought were unnecessary or "just in case."

She started to fire off an e-mail to the administration voicing her concerns, but then stopped. At her former practice, a physician-owned office, she would have brought the issue up with her partners and they would have discussed it together. But now, she was one of many salaried physicians on staff—did she want to come off as a difficult employee? Did she have the clout to refuse to comply? Uneasy, she signed out of her computer and packed up to go home.

Commentary 1
by Shivan Mehta, MD, MBA, and David A. Asch, MD, MBA
More than half of all practicing physicians in the United States are employed by hospitals or health delivery systems [1]. This trend towards the physician as employee has been ongoing, recently driven by changing reimbursement models, regulatory requirements, and perhaps an increased emphasis on work-life balance on the part of new physicians, who seem to favor work flexibility and administrative

simplicity. While the physician's clinical and ethical responsibilities to patients remain the same, employment adds a practice management stakeholder, and often these new practice management structures have financial interests that are different from those of physicians who own their practices. These new arrangements reintroduce old questions in a new context: What are the physician's roles in balancing clinical duties with the financial demands of an ongoing practice? How much transparency is right, and which parties should see what information? These questions are fundamentally important to the new physician employee, but we suggest that they reveal tensions that have always been present. As newly structured health care organizations implement policies to address these tensions, implementing and structuring them well on ethical foundations will be essential.

The fundamental ethical issue is whether a physician can advocate for the patient if he or she is also expected to think about the personal and societal financial implications of treatment decisions. The patient-doctor relationship entails certain expectations, and the physician has a fiduciary duty to advocate for the patient's well-being. Does this mean that the physician should not consider the patient's individual costs when making medical decisions? Probably few would hold such a view—after all, patients often bear significant personal cost for health care through copayments, deductibles, co-insurance, and noncovered care. Patients care about their cost and their health, and good advocates ought to consider both.

But should the physician consider societal costs when making medical decisions? Physicians today typically do consider societal cost when making individual decisions [2, 3], but perhaps not as much as they should. Normatively, physicians ought to act as stewards of societal resources, since not doing so leads to limitless expenditures that no one would want, individually or collectively [4]. Moreover, what appears to be societal cost is often indirectly linked to individual cost, inasmuch as high health care costs generally put downward pressure on wages, which compete for health care spending as parts of total employee compensation, or downward pressure on other goods or services provided by the public sector [5].

These principles of stewardship are often made explicit, for example, in the American College of Physicians Ethics Manual statement: "Parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely and to help ensure that resources are equitably available" [6]. But responsibilities to individuals and to society can be at odds, and there is no satisfying way to reconcile these conflicts. That is one reason why this case, in its various forms, is so timeless.

Hospitals and practice plans face similar conflicts, and those conflicts became more explicit in the mid-1980s, when prospective payment was introduced for Medicare hospitalizations and managed care practices increased financial tensions associated with clinical care in other settings. And new payment models may create more provider financial risk; for example, the Medicare Value Based Purchasing initiative will be using Medicare spending per beneficiary as a measure of hospital efficiency

of care [7]. Each of these systems is designed so that physicians, clinics, and hospitals feel the cost consequences of treatment decisions—consequences that in the past were considered to be borne only by society. For those reasons, it is not only within the scope of hospital operations to encourage efficient use of resources, it is also a societal obligation—as long as efforts to reduce cost are balanced with quality care goals. Stating such principles abstractly, however, provides no guidance on how such balance is to be achieved, or even what optimal balance means. And of course there is considerable inconsistency in how Medicare, for example, faces these social concerns: on one hand, the prospective payment system is deliberately designed to reduce the cost of inpatient care; on the other hand, Medicare itself is statutorily prohibited from considering costs in its coverage decisions.

So, what about Dr. Gowen? In this case, the tool that is used to promote cost consciousness by physicians is a list sent out to the hospital medical staff. As a promoter of cost containment, such a list provides feedback to individuals about their ordering styles, comparison with peers, and public pressure. Measurement and feedback are cornerstones for improvement, so their use is not controversial in this case. Indeed, one might instead criticize organizations that do not provide this sort of information. It establishes baselines and benchmarks, and it is the kind of information individuals can't easily collect for themselves but organizations can. Would you want to be the kind of physician who did not want this information? Would you want your doctor to be the kind of doctor who did not want this information?

But there are at least three other elements to this situation that give reason for pause. First, the feedback wasn't just disclosed to Dr. Gowen but was also distributed to her colleagues. Making the data transparent provides the potential to use peer pressure and "shaming" on the physicians. These approaches are not unprecedented; there are a variety of public report cards for physicians, including the Medicare Physician Compare website [7], and for many years many states have reported health care quality "scores" for individual physicians. Comparative health care pricing information, too, is slowly but increasingly entering the public domain. Rather than decry such trends, we should recognize that, if we are asking patients in high deductible health plans to make informed decisions about how much to spend on what elements of their care, comparative information on cost is as essential as comparative information on quality.

The problem with these efforts is that, even if they are well-meaning attempts to inform and improve behavior, evidence is lacking on their ultimate effects. Experience with publicly reported quality information is mixed. Public reporting of coronary artery bypass surgery mortality in New York State, for example, inadvertently led to a widening of racial health disparities for that procedure when surgeons avoided operating on nonwhite patients [8], perhaps because of a mistaken view that such patients had a higher risk of mortality and therefore were more likely to make them look bad. In Dr. Gowen's case, public reporting (or peer shaming) of physicians in her hospital might lead to a detrimental race to the bottom in use of

services or perverse deselection of patients to avoid those who are expected to incur high costs.

At the same time, we might take a step back and view this from a patient's perspective. If hospitals have comparative information on the quality of physicians' care, would we think it appropriate for them to keep *that* information to themselves? There are clearly ways in which that information could be destructive if not thoughtfully presented, but we probably would not like the idea of maintaining a kind of conspiracy of silence about quality. Given that cost is also important, should we not have a similar view about comparative cost data? More generally, anyone arguing against transparency bears a heavy burden. In this case, however, the data were not disclosed to patients, only to other physicians. How can that be explained except as a way to induce peer pressure or shame?

Second, no mention is made about what is to be done with these data. Is the spreadsheet meant to be tied to compensation, to education or remediation, to removal from practice? What does it mean that those in the system must "do what we can?" as suggested by the e-mail message Dr. Gowen received? Paradoxically, the absence of any clear direction makes it seem even more ominous. Why not have some clear goals? And certainly those goals should not be merely cost-based but value-based—meaning that they should incorporate not just what services cost, but also what they deliver. Leaving that out lets the imagination wander to less defensible hospital goals.

Third, it seems as though this e-mail was the first time this issue was brought up, or at least it was not previously communicated effectively. Regardless of the ethical challenges (or even professional imperatives) of providing this information, an unanticipated broadcast e-mail was simply a clumsy and probably self-defeating way to do it. Based on the physician responses, such an approach seems likely to widen the distance between medical staff and hospital leadership and undermine the trust that is so essential for effective organizations. Such trust is particularly critical for addressing challenging issues like these that require significant cultural change.

So, how should Dr. Gowen respond? Of course, it is within her rights to voice her concerns about this policy. However, as an employee of a large organization, she most likely has less influence than she would have in a small practice. And of course her concerns would have seemed less self-serving had she had the opportunity to raise them before she was identified as an outlier. Indeed, that is one of the best reasons for discussing principles in the abstract from the start—to make sure there is a clear understanding of those principles, and their consequences, before they are implemented. Implementation is as important as innovation and, because of such poor implementation, the hospital is also weakened. A more considered approach might have revealed the hospital's efforts as a thoughtful response to the important goal of being stewards of society's collective resources. But a botched communication job, and nonparticipatory process, makes the medical staff reconsider the motives going forward. Everyone loses.

References

1. Kocher R, Sahni NR. Hospitals' race to employ physicians--the logic behind a money-losing proposition. *N Engl J Med*. 2011;364(19):1790-1793.
2. Asch DA, Ubel PA. Rationing by any other name. *N Engl J Med*. 1997;336(23):1668-1671.
3. Ubel PA, Jepson C, Baron J, Hershey J, Asch DA. The influence of cost-effectiveness information on physicians' cancer screening recommendations. *Soc Sci Med*. 2003;56(8):1727-1736.
4. Asch DA. Basic lessons in resource allocation: sharing, setting limits, and being fair. *Pharos Alpha Omega Honor Med Soc*. 1995;58(2):33-34.
5. Polsky D, Grande D. The burden of health care costs for working families—implications for reform. *N Engl J Med*. 2009;361(5):437-439.
6. Snyder L; American College of Physician Ethics, Professionalism, and Human Rights Committee. American College of Physicians Ethics Manual: sixth edition. *Ann Intern Med*. 2012;156(1 Pt 2):73-104.
7. Medicare. Hospital Compare web site. www.hospitalcompare.hhs.gov. Accessed January 10, 2013.
8. Werner R, Asch DA. The unintended consequences of publicly reporting quality information. *JAMA*. 2005;293:1239-1244.

Shivan Mehta, MD, MBA, is an instructor of medicine in gastroenterology at the Perelman School of Medicine at the University of Pennsylvania in Philadelphia. He is also director of operations at the Penn Medicine Center for Innovation and has an interest in health system improvement and behavioral economics.

David A. Asch, MD, MBA, is a professor of medicine and health care management at the Perelman School of Medicine and the Wharton School of the University of Pennsylvania in Philadelphia, where he is executive director of the Penn Medicine Center for Innovation. He is also a physician at the VA Center for Health Equity Research and Promotion in Philadelphia.

Commentary 2
by Charles A. Peck, MD

Dr. Gowen faces many ethical, behavioral, and attitudinal challenges, as do her colleagues. The first step in becoming an employed physician is to understand the "price of equity." What is different about my expectations not just as a clinician but as a partner, business person, team player, and collaborator? How do I move from being the autonomous, 1-to-1, solo decision maker to a collaborative team player, 1-to-n, strategic thinker, and group problem solver? How do I make the transition from "owner" of my practice to "steward" of my hospital's, patients', and group's outcomes both clinically and financially? At the end of the day, culture always eats strategy for lunch.

The following are differences between physicians and administrators/managers that both must learn to appreciate if situations like the one Dr. Gowen faces are to be handled successfully in the future.

Administrators/managers	Physicians
planners	doers
1:n	1:1
proactive	reactive
delayed gratification	immediate gratification
delegators	deciders
participative	independent
problem solving: team	problem solving: solo
business stewards	business owners
value collaboration	value collegiality

As a physician, I have always been bound by the imperative "do no harm." The financial pressures of the day must never persuade us to violate this principle. Being both a physician and a steward of resources is not an either/or proposition but rather an "and/too" one. It is about value—how to provide the best possible care and outcome at the most efficient cost—for everyone, because it's the right and moral thing to do. It should not be about shaming physicians into ordering less, but about teaching physicians to understand, consider, and decide how best to utilize tests, supplies, drug choices, admissions, and other high-cost items in a smart, efficient, and clinically effective way that leads to the highest-quality outcome for the patient. The literature is rife with examples of how expensive implants and therapies actually lead to inferior or more dangerous results than older, more tested interventions. Demand-matching pharmaceuticals and implants to the specific condition of the patient is rather new but required of all of us.

Dr. Gowen should expect to receive more complete data than just a cost spreadsheet. Her quality outcome rating for this set of patients should have accompanied the cost analysis. She should expect to learn whether or not her patients' clinical pictures were more complicated by seeing how her case mix compared to that of her peers. Improving care quality should be the driver, not pure cost benchmarking. How does Dr. Gowen know whether her test ordering is appropriate or "just in case"? Have standardized clinical guidelines been developed, and are they utilized both by her and the entire medical staff? Does a point-of-care ordering system exist as part of her EMR to allow her to see the cost consequences of her ordering decisions and how she might amend them? If the hospital CEO is going to demand new behaviors, he or she must provide all physicians with the tools necessary to allow for and incentivize change.

Dr. Gowen should take her concerns to the quality-of-care committee first. This committee should develop cost and quality guidelines, targets, pathways, and a comprehensive strategy for implementation and deliver it to the hospital's chief operating officer. The COO's span of control within the hospital typically includes service line operations, quality management, and implementation of cost-saving measures. This plan should include cost and resource needs. It should also include

sample report formats that are doctor-recommended. The final recommendations should be presented to the full medical staff to obtain their buy-in. It is then the responsibility of the physician leadership to hold all physicians accountable for hitting the quality and cost targets.

Physician leadership in the hospital should consider developing a physician contract that outlines the expectations of all physicians at the hospital. Until everyone, including Dr. Gowen, truly understands the "price of equity," change will be difficult and the knee-jerk reaction of "firing off e-mails" will remain the norm.

Charles A. Peck, MD, is a board-certified internist and rheumatologist who is managing director of Navigant Consulting. His background includes being CEO of a surgical and physician services company and a large academic multispecialty physician group, regional president of a national managed care company, and partner in a global health care consulting firm.

Related in VM

The Physician-Employee/Hospital Partnership, February 2013

Physician-Owned Hospitals and Self-Referral, February 2013

The American Medical Association *Code of Medical Ethics*' Opinions on the Physician as Businessperson, February 2013

Are Physicians Ready for Accountable Care? February 2013

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 114-118.

ETHICS CASE
Profiling Patients to Identify Prospective Donors
Commentary by Richard E. Thompson, MD

As Dr. McGrath entered Mr. Drew's hospital room, he bumped into a pleasant-looking woman in a suit walking out. "I beg your pardon. I'm Dr. McGrath, Mr. Drew's physician. Are you his wife?" he asked.

"No," she replied, "I'm Dana, I'm with the hospital's foundation. I was just paying Mr. Drew a visit to see how he is enjoying his stay, and if there's anything we can do to make him more comfortable."

"Oh," said Dr. McGrath, surprised. "Is he a hospital donor?"

"Not yet," she smiled. "We do daily wealth-screening of the patient census—it's just software that checks what ZIP code they're from—and then we visit patients from traditionally wealthier ZIP codes, trying to ensure that they have a pleasant hospital stay. If they want, we arrange for a newspaper to be delivered daily, and we send a welcome basket with snacks and flowers. We rely on grateful patients for a lot of the donations we receive, so this is a way to identify and impress potential donors early."

Dr. McGrath was nonplussed. "So if it looks like he could possibly donate, he gets special treatment? That doesn't seem right to me."

"He's not getting better medical treatment, Dr. McGrath," said Dana. "And if we impress him and he donates money to the foundation, we can use that money to cover the costs of indigent patients, or to improve the hospital. Just last year, a donor we identified through wealth screening gave a daVinci Robot for the surgical floor."

In the physician's lounge, Dr. McGrath brought up his concerns with Dr. Frosch, a highly respected cardiologist.

"Oh sure," said Dr. Frosch, "It's no different than the 'VIP floors' that a lot of top-tier hospitals have for their super wealthy patients—you know, with famous chefs and marble floors and what-not. Dana actually has me keep one or two appointment slots open every week for donors: if we can keep them happy with our hospital, they're much more likely to donate to the foundation, and that translates to better care for everyone."

Commentary

You can easily judge the character of a man by how he treats those who can do nothing for him.
Ralph Waldo Emerson

On routine rounds, Dr. McGrath has accidentally discovered his hospital's version of the twenty-first-century fundraising activity known as wealth screening. Dr. McGrath is nonplussed, speechless, bewildered.

A wealthy acquaintance of mine, an attorney-ethicist, had the same reaction when I asked him to comment on this scenario. With raised eyebrows and a skeptical look, he said, "Wow!" After a few moments he added, "Whatever happened to the Hippocratic Oath?"

I, like Dr. McGrath, am nonplussed. Should we accept without further questioning the assurances of Dana and Dr. Frosch that this is an appropriate, sensitively applied fundraising technique?

I think not. This situation rises to the status of genuine ethical dilemma, meaning one in which more than one judgment may be reasonable and defensible, given the disparate stakeholder interests. Recognition and analysis of this scenario's ethical aspects will only be complete if informed by expansion in the scope of health care ethics concerns.

Twenty-First-Century Health Care Ethics

To the critically important traditional medical ethics issues—privacy, truth telling, professionalism, end-of-life decision making, intentional interruption of pregnancy, to name a few—twenty-first-century advances in medical biotechnology—gene therapy, stem cell therapy, nanomedicine, and assisted reproductive techniques—have added new ethical questions. Moreover, in the face of growing disparities in health status among sectors of the U.S. population, health care policy decisions emphasize social justice in new ways [1]. Finally, the changing business of health care introduces a variety of ethical concerns. As stated by Robert Hall, "Health care institutions are, in fact, business organizations, with most of the problems faced by corporate management in other fields. They differ, however, in that health care holds a special place among human needs" [2].

Hospital Philanthropy, Then and Now

Hospital philanthropy is as old as hospitals themselves. Many health care campuses and regional networks owe their beginnings to early-twentieth-century collaboration between local physicians and wealthy citizens. Beneficence, concern for community, social conscience, vision, self-satisfaction, and duty are among ethical principles reflected in this highly respected collaboration. As Dr. Frosch points out in the case scenario, some hospitals build special rooms or suites specifically for the use of hospital benefactors when they require hospitalization.

Bequests from grateful patients, some wealthy and some not, were once unsolicited. More and more, however, nonprofit organizations actively seek to build a list of patrons. Software vendors now offer products to assist that effort. Available databases provide information such as size of a family's fortune, current philanthropic activity, and specific financial holdings. This is the twenty-first-century activity known as wealth screening.

Recently these software companies have begun urging hospitals to apply wealth screening to hospitalized patients. One such company promises hospitals will be able to "screen your prospects against 25 databases that provide comprehensive wealth and philanthropic information, in full compliance with HIPAA regulations…. Send us the names of your newly admitted patients at the end of your workday, and you'll have comprehensive philanthropic profiles waiting for you the next morning…" [3].

Although soliciting donations from patients is defended on the grounds that the funds pay for the care of those who are unable to pay and improve the quality of care that the community receives, this mixture of wealth screening and patient care raises several ethical issues.

Professional ethics. Parts of the Hippocratic Oath are obsolete, but it remains symbolic of the profession's commitment to patients [4]. In health care, the professional ethic means "respect for truth telling, confidentiality of personal information, and refusal to exploit others' problems to achieve personal gain" [5]. Mixing patient care and fundraising can be construed as attempts on the hospital's part to exploit patients and, hence, as unprofessional behavior.

Now hospitals are not physicians, and the physicians are not themselves asking patients to become benefactors. But the patient-physician-hospital relationship is key to patient trust, and the integrity of that relationship is put at risk when the physician's role in patient care is mixed in time and place with the hospital's attempts to raise funds. I am certain that this risk is the heart of Dr. McGrath's discomfort.

Ethics of exclusivity as fairness to patients. The justice, or fairness, of special treatment for donors that we see in the case scenario comes under a concept I call the "ethics of exclusivity" [6]. When does special attention to Mr. Drew become unfair because other patients are excluded from receiving services provided to Mr. Drew? I do not begrudge Mr. Drew his free newspaper. However, the hospital must believe that providing this perk improves Mr. Drew's hospital stay in some measure. So is it truly possible to separate nonmedical perks from patient care activities? Patient care, after all, means caring for the whole person, not just treating the person's disease.

More troublesome is the exclusionary practice Dr. Frosch mentions of asking physicians to hold unscheduled appointment time for wealthy patients. This special access deprives other patients of equal opportunity to appointments. Shorter waiting

times are not just a matter of convenience. Delay in medical or surgical intervention can increase some patients' risk of an adverse medical outcome.

The ethics of exclusion as fairness to physicians. Hospital-medical staff relations are notoriously fragile exactly because of scenarios like this one. Dr. McGrath is unpleasantly surprised to find Dana involved with his patient. He is perhaps even more surprised that Dr. Frosch is not only familiar with the practice but also participates in it. Why has the entire medical staff not been oriented to the reality of wealth screening? The hospital may risk losing the trust of excluded physicians.

What Should Dr. McGrath Do?

I have not argued that wealth screening is *per se* unethical. Rather, I have suggested that ethical reasoning validates Dr. McGrath's intuitive uneasy feeling. Dr. McGrath should pursue his concerns. But how?

This case demonstrates the need for physicians to learn and understand how organizations work. Dr. McGrath will get nowhere if he tries to handle this matter himself. Even if it pains him, he must follow organizational protocols (go through channels).

Dr. McGrath should explain his discovery and his concerns to the vice president for medical affairs (VPMA). The VPMA is ordinarily an MD or DO who has chosen to be a hospital executive, providing a useful bridge between business-trained executives and clinically trained medical staff members. The VPMA's duties usually include helping physicians understand how to use organizational machinery to get a variety of concerns effectively addressed.

The VP for medical affairs should suggest involving the ethics committee. By now, most hospital ethics committees have expanded in composition and charge to encompass all aspects of twenty-first-century health care ethics, including ethical aspects of organizational behavior. "This committee's efforts to help keep organizational systems and goals ethical can be a key to gaining much-needed public and political support, and even market share" [7].

The ethics committee, in turn, should strongly recommend development of a wealth-screening policy, with input from hospital foundation staff, medical professionals, and ethics committee members. Guidelines in the policy should balance the interests and concerns of all stakeholders in this activity.

In sum, I argue that if wealth screening and patient care must be mixed, then the activity would be safer and more effective if guided by a policy developed with practitioner input.

References

1. Thompson RE. *Healthcare Reform as Social Change: Why Successful Physicians and Health Care Executives are Retooling the Health Care Industry*. Tampa, FL: American College of Physician Executives; 1993.
2. Hall RT. *An Introduction to Healthcare Organizational Ethics*. New York: Oxford University Press; 2000: vii.
3. DonorSearch. Healthcare fundraising: challenges and opportunities. http://www.donorsearch.net/NonProfit/healthcare.html. Accessed October 29, 2012.
4. Thompson RE. I swear by Apollo, the Hippocratic Oath is obsolete. *Physician Exec*. 2004;30(2):60-63.
5. Thompson RE. Assault on the professional ethic: will professionalism survive? *Physician Exec*. 2007;33(5):80-82.
6. Thompson RE. The ethics of exclusivity: should doctors practice concierge medicine? *Physician Exec*. 2009;35(5):96-99.
7. *So, You're on the Ethics Committee: A Primer and Practical Guidebook,* 65.

Richard E. Thompson, MD, has dealt firsthand with ethical dilemmas as a private practitioner, pioneer neonatologist, staff member of the Joint Commission, vice president of the Illinois Hospital Association, and hospital credentials and quality assessment consultant. He is an adjunct online instructor in health care ethics at Drury University in Springfield, Missouri. His publications include *So, You're on the Ethics Committee, A Primer and Practical Guidebook* (American College of Physician Executives, 2012).

Related in VM

Is Understaffing a Unit a Form of Rationing Care? November 2012

Balancing Practice Economics with Patient Need, August 2011

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 119-124.

BANDER ESSAY CONTEST
2011 Winning Essay
Secret Shoppers and Conflicts of Interest
Laura Blinkhorn

Scenario
Delta Health was one of three large health insurers that shared a Midwest multistate market. Recently all individual and group practices and clinics that were among Delta's preferred provider organizations (PPOs) received letters from the company informing them that Delta was about to perform a quality audit on some providers, in the hope that the objectively acquired and reported information would help the physicians maintain or improve the quality of care. Delta employees would be calling to schedule appointments and reporting on the ease of getting a timely appointment, the helpfulness of the telephone and office staff, the physician's attentiveness and response to their reasons for the visit, and the treatment recommendations. The results concerning a physician or clinic would be shared with that physician or clinic only.

Reaction to the Delta Health letter at one PPO, Mid-West Internal Medicine Clinic, was typical. At a specially called meeting, 12 of the clinic's 15 physicians met to discuss what steps they should take to prepare for Delta audits if, indeed, they were among the "providers" visited.

"This is a secret shopper attack," said the first speaker, "and we're not Wal-Mart, and our patients aren't customers. We have difficulty seeing everyone who really needs care in a timely manner. Now that patient is going to have to wait while we see a secret shopper who's not even sick. It makes no sense."

"I'm not worried in the least," said a second physician. "It's a one-time thing. They're not going to send these fake patients in week after week. And we could get some observations that would really help. I don't have a clue what patients expect when they first walk into the waiting room."

But others feared that what Delta Health called "information to help maintain or improve quality care" was really going to be economic profiling. A physician whose husband had been getting treated at the faculty practice organization associated with an academic health center in a neighboring state said that Delta had recently dropped that organization as one of its PPOs.

Commentary

A physician's central goal is to provide competent, compassionate care to her patients [1]. This principle of beneficence is paired with that of nonmaleficence: not only must a physician seek to benefit her patients, but she must also avoid harming them [2]. "Market forces, societal pressures, and administrative exigencies must not compromise this principle [of primacy of patient welfare]," states the American Board of Internal Medicine's "Charter on Medical Professionalism" [3]. Yet in a world of rapidly evolving medical science, evidence-based medicine, and complex health care payment systems, providing care is a challenging task. Every day physicians must balance cutting-edge technology with accessible treatments, clinical guidelines with gut feelings, patients in need with the clinic's bottom line. Certainly the Mid-West Internal Medicine Clinic would like to "maintain or improve quality care," the stated goal of this planned evaluation. It would be naive, however, to assume that the motivations of insurance companies coincide in all respects with those of medical practices. A covert economic profiling effort could have unjust and damaging effects for the clinic. It would be cynical, however, to dismiss this planned evaluation as a Trojan horse. Using the "Charter on Medical Professionalism" as an ethical compass, I will examine the plan cautiously, but in good faith.

Both the Mid-West Internal Medicine Clinic and Delta Health share the goal of patient satisfaction. And the clinic, like any clinic, has room for improvement. "Physicians must be dedicated to continuous improvement in quality of health care" [3], states the charter. Thus the Mid-West physicians should welcome the opportunity offered by an objective evaluation—if that is what Delta Health truly intends. Examining several aspects of the planned evaluation, I will assess whether the use of secret shoppers in a medical setting is ethical, whether the data they gather are valid, if those data could be useful, and if the planned evaluation is fair. For several reasons, I believe that Delta Health's planned evaluation should be opposed. I will suggest an alternative approach that would be more ethical and yield more useful results.

Is the Use of Secret Shopper Patients Ethical?

There are three obvious ethical critiques of the secret shopper method of evaluation: (1) secret shoppers take time and resources away from real patients; (2) the secret shopper method introduces deceit into the trusting patient-doctor relationship; and (3) the method violates the privacy of the physician's office. None of these three critiques is convincing.

The first suggests that secret shoppers violate the principle of nonmaleficence, but it overestimates the scale of the evaluation and underestimates the capacity of a primary care practice to balance high demand with adequate care for all. Presumably, the Mid-West Clinic both accepts new patients and sees regular patients for follow-up. Seeing new patients—even secret shoppers—should not change the care of regulars. If it would, the clinic should not take new patients. At the Mid-West Clinic, the risk seems to be less about compromising the care of existing patients than about wasting their time. One physician whose clinic was evaluated by secret shoppers describes such criticism as "short-sighted," arguing, "This is a miniscule amount of

time and it can help you to serve your clients [patients] better in the long term" [4]. In a bustling primary care practice, the presence of a few secret shoppers would not materially change the quality or timeliness of care.

The critique that such methods introduce deception into the patient-doctor encounter discounts the importance of assuring clinical excellence, a goal of the evaluation. "The traditional patient-physician relationship requires that both parties be open and honest," argues one physician [4]. While physicians are ethically bound to be honest with their patients [3], patients regularly lie to their doctors. They fib about diet, exaggerate symptoms to get sick notes, and fake pain to obtain narcotics. Doctors are trained to appreciate that things might not be what they first appear, but that they should nonetheless behave in a professional manner to all patients. Dishonesty may be present already in the patient-doctor relationship, but is it ethical for a payer to orchestrate a physician encounter that will certainly include deceit? There are precedents; concealment is introduced into the doctor-patient relationship during experiments to avoid bias [5]. This is justified for the good of advancing clinical knowledge. In this case, too, concealing the identity of the secret shoppers is critical to an accurate assessment. Surely the goal of improving quality justifies the methods of the secret shoppers.

The third ethical critique, that the secret shopper method violates privacy and is no better than snooping [6], ignores the fact that there must be checks on the patient-physician relationship. That encounter is intimate; physicians are ethically bound to protect their patients' confidentiality [3]. Patients, however, are free to disclose information from that encounter to anyone they choose. They can fill out surveys, rate doctors on the Internet, or launch a public malpractice suit. The truth is that the encounter between a doctor and patient is only as private as the patient wants it to be. There is nothing new—or ethically questionable—about doctors being scrutinized and evaluated. The question of what happens to those secret shopper evaluations is discussed below, but the method does not violate the privacy of the exam room.

Do Secret Shopper Patients Gather Valid Data?

The use of secret shoppers to monitor quality is a relatively new development in the medical field, though they are used extensively in other industries [5]. Some argue that observations gathered by secret shoppers are merely a subjective snapshot that cannot be generalized to represent a physician or a practice [7]. That may be true, but the fact is that many aspects of a patient's medical experience are difficult to assess. Patient surveys suffer from recall bias, and physicians tend not to respond to surveys at all [5]. Secret shoppers are trained to be systematic and dispassionate. Thus their evaluations may offer valid observations about the patient experience that are otherwise difficult to capture.

Delta Health states that their secret shoppers would comment on the availability of timely appointments, the helpfulness of clinic staff, the physician's attentiveness, and her recommended treatment. The first three goals pertain to patient perceptions, and several published accounts of secret shopper evaluations suggest that they are well

qualified to comment on this aspect of the medical experience [8-10]. The fourth goal is problematic. Clinical decision making is a complex process that cannot be fully evaluated with a checklist. Physicians should be expected to approach each patient in a professional manner—and can thus be evaluated at this level—but assessment of the treatment plan is beyond the scope of a one-size-fits-all exercise.

Would the Data Be Useful to Both Mid-West Internal Medicine Clinic and Delta Health?

Critics of the secret shopper model focus on the potential misuses of the data gathered. They claim that the evaluations might be used against the medical practice, in malpractice lawsuits or as a form of economic profiling [11]. Delta Health presents the plan as a nonpunitive, private quality improvement assessment. If this were truly the case, it could be useful to the clinic. Delta Health's motivations, however, are open to question.

Many primary care practices have found secret shopper evaluations to be a helpful tool in improving the quality of their patients' experience. One academic outpatient center recently published data on its experience with secret shoppers. Using their feedback, the center increased customer service scores, decreased wait times, and increased the size of the patient panel [8]. Another published study on the use of secret shoppers found that they offered valid observations on telephone triage that led to improvements in the system [9]. While some accounts raise concerns—for example, use of the data gathered by secret shoppers to fire employees—these reports are anecdotal [4, 7]. At present, it seems the best use of this new evaluation methodology is for a good-faith, nonpunitive quality assessment. With that stipulation, a secret shopper evaluation focusing on patient experience—and not the treatment plan—could be potentially useful to the Mid-West Internal Medicine Clinic.

Why this evaluation would be useful to Delta Health is unclear, particularly if, as stated, the company intends to share the results only with the evaluated physician or clinic. True, it is in Delta Health's best interest to have excellent clinics in its preferred provider network. But a well-conducted secret shopper study is expensive, and Delta Health has no way of assuring that the clinics will make this investment worthwhile by acting on the secret shoppers' feedback. Such information might, however, provide the company with data that could be used for economic profiling. Delta Health's stated motivations for supporting such an evaluation are suspect because the study, as planned, would not certainly benefit the company.

Is the Proposed Evaluation Fair?

In certain situations, the secret shopper method offers an ethical, valid, and potentially useful way to evaluate patients' perceptions of a medical clinic. It is impossible to achieve quality improvement without the consent and cooperation of the clinic staff, and Delta Health announced this evaluation by fiat. The plan also lacks transparency. Delta Health states that the data would be "objectively acquired,"

but this is in some sense impossible since the secret shoppers will be company employees.
The planned evaluation is unfair. There is no guarantee that inappropriate evaluation factors would not be used, that the evaluations would be truly private, and that the data gathered would not be used in punitive ways. Finally, the clinic has been given no choice in the matter.

A Counter-Proposal
I suggest that the Mid-West Internal Medicine clinic write a letter to Delta Health stating that the clinic shares the goal of quality improvement but opposes this planned evaluation. The clinic would be willing, however, to experiment with the secret shoppers if Delta Health hires a third party to conduct that evaluation. The clinic would have an active role in determining which features the secret shoppers would evaluate. Given the relative newness of this method of quality evaluation, the clinic would use the data gathered in a nonpunitive way—it might make changes in how it does business, but would not fire any employees on the basis of this evaluation. Finally, to guarantee that that this evaluation is truly for quality improvement and not for economic profiling, the results would not be shared with Delta Health. The letter would raise the question of the company's motivations in launching the study, since the plan has no mechanism to guarantee that the clinic acts on the quality evaluation, Delta Health should not need to see the data. The clinic's willingness to work with a third-party evaluation company shows its dedication to quality improvement.

In this complex medical world, doctors must focus on the primacy of patient welfare. They must strive to help and to avoid harm. Central to the ancient art of healing is the act of listening. Though quality audits, such as the secret shoppers, may complement those conversations, nothing can replace a meaningful exchange between a patient and physician. Dr. Amy Friedman describes her own experience as a pseudo-secret shopper when she becomes a patient herself [12]. During the procedure, she feels "dispassionately processed rather than embraced." From this experience she concludes, "Finding a moment to hold your patient's hand, to look directly into her eyes, to ask about a grandchild or to even remember his name must retain importance, amidst the endless policies, financially coercive forces, and regulatory pressures." Friedman reminds us that quality improvement begins with acts of compassion.

References

1. American Medical Association. AMA principles of medical ethics. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page?. Accessed January 5, 2012.
2. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics*. 6th edition. New York: McGraw-Hill; 2006: 11.
3. ABIM Foundation, ACP-ASIM Foundation, American College of Physicians, American Society of Internal Medicine, European Federation of Internal

4. Loden JC, Frederick RC. Clinical case: do secret shoppers have a place in medicine? *Virtual Mentor*. 2008;10(5):288-294. http://virtualmentor.ama-assn.org/2008/05/ccas5-0805.html. Accessed January 16, 2013.
5. Rhodes K. Taking the mystery out of "mystery shopper" studies. *N Eng J Med*. 2011;356(6):484-486.
6. Pear R. U.S. plans stealth survey on access to doctors. *New York Times*. June 26, 2011. http://www.nytimes.com/2011/06/27/health/policy/27docs.html?pagewanted=all. Accessed January 7, 2012.
7. Borfitz D. Is a "mystery shopper" lurking in your waiting room? *Medical Economics*. May 21, 2001. http://medicaleconomics.modernmedicine.com/news/mystery-shopper-lurking-your-waiting-room. Accessed January 7, 2012.
8. O'Neill S, Calderon S, Casella J, et al. Improving outpatient access and patient experiences in academic ambulatory care. *Acad Med*. 2012;87(2):194-199.
9. Moriarty H, McLeod D, Dowell A. Mystery shopping in health service evaluation. *Br J Gen Pract*. 2003;53(497):942-946.
10. Cardello DM. Improve patient satisfaction with a bit of mystery. *Nurs Manage*. 2001;32(6):36-38.
11. Japsen B. MDs: Secret shoppers aren't cure. *Chicago Tribune*. June 16, 2008. http://articles.chicagotribune.com/2008-06-16/business/0806150176_1_secret-shoppers-doctor-patient-relationship-ama. Accessed January 7, 2012.
12. Friedman A. A piece of my mind. Secret shopper. *JAMA*. 2010;304(19):2103-2104.

Laura Blinkhorn will receive her MD from the University of Chicago Pritzker School of Medicine in 2013. She plans to pursue a residency in family medicine.

Related in VM

Secret Shopper Evaluations: Quality Improvement or Economic Profiling? February 2013

The American Medical Association *Code of Medical Ethics*' Opinions on the Physician as Businessperson, February 2013

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 125-130.

BANDER ESSAY CONTEST
2011 Runner-Up Essay
Secret Shopper Evaluations: Quality Improvement or Economic Profiling?
Marguerite Huff

Scenario
Delta Health was one of three large health insurers that shared a Midwest multistate market. Recently all individual and group practices and clinics that were among Delta's preferred provider organizations (PPOs) received letters from the company informing them that Delta was about to perform a quality audit on some providers, in the hope that the objectively acquired and reported information would help the physicians maintain or improve the quality of care. Delta employees would be calling to schedule appointments and reporting on the ease of getting a timely appointment, the helpfulness of the telephone and office staff, the physician's attentiveness and response to their reasons for the visit, and the treatment recommendations. The results concerning a physician or clinic would be shared with that physician or clinic only.

Reaction to the Delta Health letter at one PPO, Mid-West Internal Medicine Clinic, was typical. At a specially called meeting, 12 of the clinic's 15 physicians met to discuss what steps they should take to prepare for Delta audits if, indeed, they were among the "providers" visited.

"This is a secret shopper attack," said the first speaker, "and we're not Wal-Mart, and our patients aren't customers. We have difficulty seeing everyone who really needs care in a timely manner. Now that patient is going to have to wait while we see a secret shopper who's not even sick. It makes no sense."

"I'm not worried in the least," said a second physician. "It's a one-time thing. They're not going to send these fake patients in week after week. And we could get some observations that would really help. I don't have a clue what patients expect when they first walk into the waiting room."

But others feared that what Delta Health called "information to help maintain or improve quality care" was really going to be economic profiling. A physician whose husband had been getting treated at the faculty practice organization associated with an academic health center in a neighboring state said that Delta had recently dropped that organization as one of its PPOs.

Commentary

In the mid-80s, legislation allowing insurers to contract selectively with different providers at different reimbursement rates provided a starting ground for the development of preferred provider organizations (PPOs) [1]. Generally, the term PPO refers to a third-party payer system that contracts certain providers for patient services on a discounted fee-for-service basis. Patients are encouraged to select these "preferred providers" with economic incentives including broader coverage, and in-network providers gain a larger patient base in return for their discounted services [1]. Unlike health maintenance organization (HMO) coverage, PPO patients retain the ability to go out-of-network for care. Although patients are responsible for most of the costs in such situations, there is usually a yearly limit on out-of-pocket payments that allows patients who experience severe chronic conditions to access long-term out-of-network specialty care without prohibitive costs. PPOs have made a huge leap in the past two decades as a model for health insurance [2]: In 1988, PPOs represented 11 percent of employer-provided health care; by 2005, 85 percent of large employers offered at least one PPO option [3].

Surveys have revealed that a primary motivation for patients' selection PPOs is the choice of doctors, which is exchanged for a small reduction in the comprehensiveness of coverage [2, 3]. PPOs not only offer the flexible option of out-of-network care, they typically have larger provider networks than HMOs [2]. Having numerous in-network and a vast number of out-of-network physicians to select from promotes patient choice and a competitive environment, and this competitive environment can be a major incentive for providers to maintain quality care. A 2010 study performed to determine the effects of hospital competition on patient-perceived quality of care revealed that the addition of competition to a health care market can lead to an unusual pair of effects, reduced fees and improved patient-perceived quality of care, both results of efforts to attract more patients. If price is not regulated and hospitals reduce fees, quality of care can drop because the hospital reduces care to match the lower payment. However, when the patient pays a fixed price regardless of provider, as with a PPO, providers are forced to distinguish themselves in non-price domains and quality of care rises [4].

This finding is relevant to the situation at hand, because it demonstrates a clear incentive for PPO providers to maintain high-quality care. If a clinic is competing with several others in the area, all of which are considered "preferred" and cost the patient the same, customer service, patient satisfaction, and quality of care are all expected to increase as the clinics attempt to distinguish themselves from their competitors. Furthermore, although out-of-network providers exact greater cost-sharing from patients, economic models have shown they are increasingly preferred by patients whose diseases become more chronic or severe and who have to spend more time at health care facilities [2]. Therefore, in-network providers must also compete in the general provider market and can hardly become lax about the quality of care if they expect to maintain patient inflow.

This competition inherent in PPO networks means that internal and external competition should help maintain basic quality standards, and Delta Health has no

need for "secret shopper" visits to maintain quality among their providers. However, some would claim a mystery patient would add to this endeavor, making already good providers great and aiding them in attracting patients. Are these claims substantiated? As early as 2006 such services were highlighted in the *Wall Street Journal*, in 2010 AARP ran an article explaining their benefits, and in 2011 the Obama administration proposed utilizing secret shoppers to study providers' responses to Medicare patients [5-7]. Secret shoppers are already popular in evaluating customer service at stores and restaurants across the nation, and, to some, making the leap to the medical field seems only natural.

Anecdotally, such services receive positive reviews. Improvements in quality care have been reported by OhioHealth, a nonprofit organization of 15 hospitals and other health care services in Ohio, Medical City Dallas Hospital, and individuals in private practice utilizing a secret shopper service [6]. AARP reports:

> At Beth Israel Deaconess Medical Center, a Harvard University teaching hospital in Boston that recorded nearly 700,000 outpatient visits last year, eight secret shoppers regularly assess staff performance by posing as patients on the telephone and in visits to its 51 waiting rooms.... Appointment waiting time has been cut from an average of 12 days to five, and telephone customer service ratings have improved. Waiting room ratings increased from 78 percent in 2007 to 90 percent in 2009 [6].

However, due to concerns about privacy, allocation of resources, and difficulty establishing guidelines, there have not been any significant large-scale studies of the benefits of such services. Furthermore, there are significant obstacles to evaluating care, the consideration of which should make providers wary when considering secret shopper visits.

First, the quality of health care is very difficult to define. It can be generally divided into two categories. Technical quality refers to the knowledge and judgment exercised by a physician in reaching a diagnosis and the skill with which the patient is treated. It is often assessed via broad, objective measures such as mortality, rates of complication, and adherence to established guidelines [4]. Interpersonal quality comprises the second category and can be assessed by evaluating parameters such as staff and physician attitude, respect, timeliness, and communication [4, 8]. Increases in interpersonal quality do not always correlate to increases in technical quality, and papers published in 2004 and 2008 in the *Journal of Public Economics* even established a negative correlation between clinical quality as measured by mortality rate, and interpersonal quality as measured by short waiting time, suggesting it may be worse for patients in the long run if interpersonal quality is unduly emphasized [9].

Furthermore there are inherent biases in the patient-physician interaction, particularly if the patient is not actually ill but rather pretending, all the while

scrutinizing minute details of the clinician's service. Far from the retail mantra of "the customer is always right," a physician is often called to make recommendations the patient may not like or agree with. Recommendations for an invasive or painful diagnostic test may easily seem excessive to an evaluator who knows he or she is perfectly healthy, but may be welcome news to a patient anxiously waiting in pain to discover what is troubling her. Similarly, a physician may seem harsh or inconsiderate concerning a person's weight, but this may stem from a genuine concern for the patient's health. Inasmuch as only 20 percent of patients seeking medical care are ready to change unhealthy behavior, physicians often have to be more forceful in their recommendations than an evaluator might expect [10]. Avedis Donabedian, considered by many to be the father of quality assurance in health care, argues that when an evaluation lacks highly precise guidelines and is based on the assessor's own judgment, "very expert and careful judges must be used" [11]. This can hardly be applied to a standardized patient who is not suffering from the ailment he or she imitates and does not have the extensive medical and clinical knowledge of a practicing physician.

Another difficulty lies in predicting physician and staff responses. An excerpt from the Department of Health and Human Services standardized patient script for calling to schedule an appointment demonstrates this issue, one of the reasons the department decided in June not to proceed with the study:

> I've had a cough for the last two weeks, and now I'm running a fever. I've been coughing up thick, greenish mucus that has some blood in it, and I'm a little short of breath [7].

This script could provoke a variety of reactions based on such qualities of the patient calling as age, gender, and overall heath, and the experience and discretion of the doctor or office staff. Although the script was written as part of an appointment-scheduling evaluation, Glen Stream, MD, president-elect of the American Academy of Family Physicians, surmised that office staff, far from scheduling the patient an appointment, would most likely refer this person to urgent care [7].

Another problem is that of wasted patient resources. Although some doctors in the scenario speculate the visits will be a "one time thing," it is unlikely that one visit would provide an adequate statistical assessment of care quality. The proposed HHS survey consisted of three rounds of mystery shopper visits, and OhioHealth, which reported positive experiences with mystery shoppers, utilized 240 visits over the course of a year to its 15 clinics [5]. Furthermore, previous research shows that, in larger practices, quality of care varies widely by department and procedure type [12]. Therefore, it is probable that far more than one visit would be needed for the shopper service to be of any worth, and the repeated visits have a great potential to tie up resources needed by sick patients. The justice of repeatedly expending time and money on healthy people when there are many patients who actually need care is dubious and a legitimate concern for those physicians opposing the visits.

Finally, there remains the question of economic profiling. A main weakness of PPOs, noted even in the earliest stages of development, is their lack of incentive to network participants to deliver efficient care and control health care costs [1]. An increase in the number and complexity of procedures may even negate the savings insurers realize through PPO contracts [1]. Therefore, it is likely that Delta Health has a motive for screening providers who cost them too much. Although cost control is a necessity, it is not always in the best interest of the patient. A group of health care economists analyzed hospital secondary data to compare strategies for selecting "preferred" providers [12]. The 2007 survey looked at four claims-based measures of inpatient quality and patient safety, two structural quality measures, and hospital costs in five markets. It found that there was little overlap between lists of the top 25 percent of hospitals selected by quality alone and the top 25 percent selected by low cost alone (a 0 to 33 percent overlap) [12]. This sets quality and low cost at odds with each other, and, although in an ideal world an insurer would seek to optimize both, it is clear that one often comes at the expense of the other when selecting preferred providers. Therefore, doctors have reason to worry that such economic profiling could occur and that it could lower the quality of patient care supplied by in-network PPO providers.

Based on all of the information reviewed above, it would be in the best interest of the physicians to oppose Delta Health-established secret shopper visits, at least for the time being. Competition both within and outside the network already provides an incentive for providers to deliver quality care. At worst, the third-party payer is seeking to "economically profile" providers, and at best, the clinic may be placed in a position where what is good for business is suboptimal for clinicians and patients. Given the numerous unresolved problems of secret medical shopper programs and the potential for economic profiling, practices should be wary of the Delta Health visits. Should the clinic wish to improve its quality, it retains the option of hiring such services on its own behalf and tailoring visits and feedback to their needs.

References

1. Gabel J, Ermann D. Preferred provider organizations: performance, problems, and promise. *Health Aff (Millwood)*. 1985; 4(1):24-40.
2. Sengupta B, Kreier RE. A dynamic model of health plan choice from a real options perspective. *Atlantic Econ J*. 2011;39(4):401-419.
3. Hirth RA, Grazier KL, Chernew ME, Okeke EN. Insurers' competitive strategy and enrollment in newly offered preferred provider organizations (PPOs). *Inquiry*. 2007;44(4):400-411.
4. Chen CC, Cheng SH. Hospital competition and patient-perceived quality of care: evidence from a single-payer system in Taiwan. *Health Pol*. 2010;98(1):65-73.
5. Wang SS. Health care taps "mystery shoppers." *Wall Street Journal.* August 8, 2006. http://online.wsj.com/article/SB115499684792929340-search.html. Accessed January 16, 2013.
6. Boodman SG. New emphasis on customer service in medicine. *AARP Bulletin*. http://www.aarp.org/health/doctors-hospitals/info-08-

7. Fiegl C. Why HHS abandoned "mystery shopper" study. *American Medical News*. July 11, 2011. http://www.ama-assn.org/amednews/2011/07/11/gvl10711.htm. Accessed January 16, 2013.
8. Donabedian A. Special article: the quality of care: how can it be assessed? *Arch Pathol Lab Med*. 1997;121(11):1145.
9. Bevan G, Skellern M. Does competition between hospitals improve clinical quality? A review of evidence from two eras of competition in the English NHS. *Br Med J*. 2011;343;d6470.
10. Levinson W, Cohen M, Brady D, Duffy FD. To change or not to change: "Sounds like you have a dilemma." *Ann Intern Med*. 2001;135(5):386-391.
11. Donabedian A. Evaluating the quality of medical care. 1966. *Milbank Q*. 2005;83(4):691-729.
12. Rosenthal MB, Landrum MB, Meara E, Huskamp HA, Conti RM, Keating NL. Using performance data to identify preferred hospitals. *Health Serv Res*. 2007;42(6 Pt1):2109-2119.

Marguerite Huff is a second-year medical student in the honors program in medical education at the Northwestern University Feinberg School of Medicine in Chicago, where she is involved in a variety of activities, including community health volunteering and clinical research. She graduated from Northwestern University in 2011 with a degree in statistics, which piqued her interest in biostatistics, quality control, and health economics.

Related in VM

Secret Shoppers and Conflicts of Interest, February 2013

The American Medical Association *Code of Medical Ethics*' Opinions on the Physician as Businessperson, February 2013

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 131-135.

MEDICAL EDUCATION

Can Physician Training and Fiscal Responsibility Coexist?

Hyeyoung Oh, MA, and Stefan Timmermans, PhD

United States health care costs rose from $253 billion in 1980 to $714 billion in 1990 and $2.5 trillion, or 17.6 percent of the nation's gross domestic product (GDP), in 2009 [1, 2]. Projections for 2020 indicate that national health care spending will reach $4.6 trillion and account for 19.8 percent of the nation's GDP [3]. One target for cost-curbing measures is inpatient care. In 2008, Medicare payments for hospital inpatient care totaled $129.1 billion [4]. Accordingly, one of the initiatives of the Patient Protection and Affordable Care Act that President Obama signed in March 2010, was to reduce the number of rehospitalizations of Medicare patients. (Until recently Medicare covered all costs associated with rehospitalizations if they occurred within 24 hours of the patient's discharge from a hospital. Studies highlighting the prevalence and costliness of rehospitalizations of Medicare patients [5] argued for the implementation of new Medicare policy. Variation in rates of rehospitalization by hospital and geographic area further supported this policy [4].) If most medical education takes place in hospitals, what impact will a concentrated effort to reduce the cost of inpatient hospital care have on the training of the next generations of clinicians?

Since the mid-twentieth century, scholars have argued that the ever-growing mountain of biomedical knowledge [6] would prevent finances from jeopardizing the quality of medical training and education. However, exogenous interference may be inevitable because academic medical centers have three organizational purposes; they are (1) centers of care giving, (2) businesses that must make a profit or at least break even, and (3) the bedrocks of medical education.

Cost-cutting initiatives are likely to create further tension between the academic center hospital's function as a place for education and as a business. Current health care policies already encourage hospitals to prevent high costs due to excessive resource utilization (such as unnecessary consults and testing) [7]. But education inevitably requires greater use of resources because trainees must practice the skills of their specialty (e.g., differential diagnosis). The learning curve frequently results in additional medical workups, extra use of equipment and materials, and, occasionally, delays in care and discharge. At the same time, policies, such as Medicare's refusal to reimburse care in some cases of rehospitalization, also encourage additional medical work [4]. To avoid unreimbursed Medicare readmissions, physicians may run extra tests, call additional consultants, and extend patients' stays in the hospital—driving up health care costs.

Tensions between teaching and making money may also be exacerbated from the academic side. All academic medical institutions must adhere to the rules established by the Accreditation Council for Graduate Medical Education (ACGME) [8]. In recent years, the ACGME has modified the requirements for residency training, including setting limits on the number of hours residents are allowed to work. The latest restriction, instated in July 2011, declared that interns (first-year residents) could work a maximum of 16 hours a day. Hospitals have struggled to adopt the changes to residency training without compromising care quality and efficiency [9]. ACGME requirements, however, must be adhered to at least on paper [9], or the center will risk losing its accreditation or dropping in ranking and prestige. Accordingly, these requirements must be met even when they directly interfere with what is financially most lucrative for the hospital. Work-hour limitations inevitably result in numerous problems, ranging from overworked senior residents to delays of treatment due to frequent patient hand-offs (when an intern or resident must take a mandated break from work) and extended lengths of stay in the hospital.

How have academic hospitals reacted to resident labor limits? One solution adopted by academic medical institutions to decrease health care costs without compromising medical care or training has been the shift toward the use of hospitalists. Hospitalists, a term coined by Dr. Robert Wachter and Dr. Lee Goldman in 1996, emerged as a specialty group and have taken an integral role in medical training in the United States. The Society of Hospital Medicine (SHM) defines hospital medicine as "a medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients" [10]. The hope was that, by working in a single setting, hospitalists would become more accustomed to managing the conditions of hospitalized patients and, in the process, improve the quality of care. They would also be more attuned to the complexities of hospital care delivery than those who spent less time in the hospital, resulting in more efficient care and decreased health care costs [11].

Academic medical centers embraced this hospitalist model of care. The nature of hospitalist work allows physicians not only to spend more time with hospitalized patients but also to dedicate more time to teaching interns and residents. Studies show that interns and residents rate hospitalists highly, indicating the positive impact they have had on teaching services. Furthermore, many hospitals credit the hospitalist model with reduced health care costs and lengths of stay, increased efficiency, and similar or improved quality of care outcomes [12-14].

Another approach to reducing the tension between training and finances has been to focus a portion of residency training on learning how to manage patient discharge. Long stays in the hospital, which have been associated with rising health care costs, have been targeted as a preventable problem. Hospitals have responded by hiring discharge planners, who try not only to expedite discharge but to prevent readmission by working to ensure that rehabilitation and outpatient care are well

established [15]. Discharge planners are a valuable resource for trainees because they educate young physicians in how to reduce extended lengths of stay in the hospital.

Rapidly rising health care costs have generated nationwide concern; legislative changes and transformations in both health care delivery and training have been adopted in hopes of curbing these costs. Some observers remain concerned about the unintended consequences of the shift towards hospitalist medicine in academic medical centers, especially now that the nation is facing a shortage of primary care physicians. For exmaple, because medical residency takes place primarily in inpatient care settings, young physicians are less well equipped to understand the barriers to care and financial issues that emerge in outpatient settings. The divide between inpatient and outpatient care becomes more entrenched, and transferring patients from one care setting to the next may become increasingly difficult. Such inefficiencies cause patients to receive care in the hospital that could easily be performed in the outpatient setting, resulting in extended lengths of stay, increased resource utilization, and rising health care costs. One solution may be to follow the ACGME's recommendations for more outpatient training sites. With greater emphasis placed on outpatient care during training, residents may be better equipped to recognize when care should be delivered in the outpatient setting and to expedite transitions of care.

References

1. Kimbuende E, Ranji U, Lundy J, Salganicoff A. U.S. health care costs: background. http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx#Background. Accessed January 16, 2013.
2. Centers for Medicare and Medicaid Services. NHE fact sheet (2011). http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html. Accessed January 16, 2013.
3. Centers for Medicare and Medicaid Services. National health expenditure projections 2010-2020. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2010.pdf. Accessed January 16, 2013.
4. Stone J, Hoffman GJ. Medicare hospital readmissions: issues, policy options and PPACA. Washington, DC: Congressional Research Service; 2010. http://www.pascenter.org/publications/publication_home.php?id=1230. Accessed January 16, 2013.
5. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the medicare fee-for-service program. *N Engl J Med*. 2009;360(14):1418-1428.
6. Becker HS, Geer B, Hughes EC, Strauss A. *Boys in White: Student Culture in Medical School*. New Brunswick, NJ: Transaction Publications; 1976.
7. Wennberg JE, Fisher ES, Goodman DC, Skinner JS. *Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care*

2008. Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2008. http://www.dartmouthatlas.org/downloads/atlases/2008_Chronic_Care_Atlas.pdf. Accessed January 16, 2013.
8. This council oversees residency training across accredited hospitals in the United States and Canada, establishing a set of national requirements that all training programs must adhere to. This standardization of medical training can be traced back to the publication of the 1910 Flexner Report, which sought to eradicate variation in U.S. medical education. It was a bulletin that called for the closure of underperforming medical schools and the establishment of an accreditation system that would signify "good" schools. Starr P. *The Social Transformation of American Medicine*. New York: Basic Books; 1982.
9. Kellogg KC. *Challenging Operations: Medical Reform and Resistance in Surgery*. Chicago: University of Chicago Press; 2011.
10. Society of Hospital Medicine. General information About SHM. http://www.hospitalmedicine.org/Content/NavigationMenu/AboutSHM/GeneralInformation/General_Information.htm. Accessed January 16, 2013.
11. Wachter R. An introduction to the hospitalist model. *Ann Intern Med*. 1999;130(4 Pt 2):338-342.
12. Palmer Jr. HC, Armistead NS, Elnicki M, et al. The effect of a hospitalist service with nurse discharge planner on patient care in an academic teaching hospital. *Am J Med*. 2001;111(8):627-632.
13. Bellet PS, Whitaker RC. Evaluation of a pediatric hospital service: impact on length of stay and hospital charges. *Pediatrics*. 2000;105(3 Pt 1):478-484.
14. Wachter RM, Goldman L. The hospitalist movement 5 years later. *JAMA*. 2002;287(4):487-494.
15. Holliman DC, Dziegielewsk SF, Datta P. Discharge planning and social work practice. *Soc Work Health Care*. 2001;32(3):1-19.

Hyeyoung Oh, MA, is a doctoral student in the Department of Sociology at UCLA. Her research interests include the sociology of health and illness, race and ethnicity, and organizational studies.

Stefan Timmermans, PhD, is a professor and chair of the Department of Sociology at UCLA. He is author of the book *Saving Babies? The Consequences of Newborn Genetic Screening*.

Related in VM

Medical Education and Decision-Support Systems, March 2011

The Hospital Medicine Movement, December 2008

The Ethical Dilemma of Duty-Hour Reporting, November 2009

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 136-140.

THE CODE SAYS
The American Medical Association *Code of Medical Ethics*' Opinions on the Physician as Businessperson

Opinion 6.11 - Competition
Competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of services, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc, is not only ethical but is encouraged. Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely between and among competing physicians and alternate systems of medical care.
Issued July 1983.

Opinion 8.054 - Financial Incentives and the Practice of Medicine
In order to achieve the necessary goals of patient care and to protect the role of physicians as advocates for individual patients, the following statement is offered for the guidance of physicians:

(1) Although physicians have an obligation to consider the needs of broader patient populations within the context of the patient-physician relationship, their first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice.

(2) Physicians, individually or through their representatives, should evaluate the financial incentives associated with participation in a health plan before contracting with that plan. The purpose of the evaluation is to ensure that the quality of patient care is not compromised by unrealistic expectations for utilization or by placing that physician's payments for care at excessive risk. In the process of making judgments about the ethical propriety of such reimbursement systems, physicians should refer to the following general guidelines:

> (a) Monetary incentives may be judged in part on the basis of their size. Large incentives may create conflicts of interest that can in turn compromise clinical objectivity. While an obligation has been established to resolve financial conflicts of interest to the benefit of patients, it is important to recognize that sufficiently large incentives can create an untenable position for physicians,
>
> (b) The proximity of large financial incentives to individual treatment decisions should be limited in order to prevent physicians' personal financial concerns

from creating a conflict with their role as individual patient advocates. When the proximity of incentives cannot be mitigated, as in the case of fee-for-service payments, physicians must behave in accordance with prior Council recommendations limiting the potential for abuse. This includes the Council's prohibitions on fee-splitting arrangements, the provision of unnecessary services, unreasonable fees, and self-referral. For incentives that can be distanced from clinical decisions, physicians should consider the following factors in order to evaluate the correlation between individual act and monetary reward or penalty:

(i) In general, physicians should favor incentives that are applied across broad physician groups. This dilutes the effect any one physician can have on his or her financial situation through clinical recommendations, thus allowing physicians to provide those services they feel are necessary in each case. Simultaneously, however, physicians are encouraged by the incentive to practice efficiently.

(ii) The size of the patient pool considered in calculations of incentive payments will affect the proximity of financial motivations to individual treatment decisions. The laws of probability dictate that in large populations of patients, the overall level of utilization remains relatively stable and predictable. Physicians practicing in plans with large numbers of patients in a risk pool therefore have greater freedom to provide the care they feel is necessary based on the likelihood that the needs of other plan patients will balance out decisions to provide extensive care.

(iii) Physicians should advocate for the time period over which incentives are determined to be long enough to accommodate fluctuations in utilization resulting from the random distribution of patients and illnesses. For example, basing incentive payments on an annual analysis of resource utilization is preferable to basing them on monthly review.

(iv) Financial rewards or penalties that are triggered by specific points of utilization may create enormous incentives as a physician's practice approaches the established level. Therefore, physicians should advocate that incentives be calculated on a continuum of utilization rather than a bracketed system with tiers of widely varied bonuses or penalties.

(v) Physicians should ascertain that a stop-loss plan is in place to prevent the costs associated with unusual outliers from significantly impacting the reward or penalty offered to a physician.

(3) Physicians also should advocate for incentives that promote efficient practice, but are not be designed to realize cost savings beyond those attainable through efficiency. As a counterbalance to the focus on utilization reduction, physicians also should advocate for incentives based on quality of care and patient satisfaction.

(4) Patients must be informed of financial incentives that could impact the level or type of care they receive. Although this responsibility should be assumed by the health plan, physicians, individually or through their representatives, must be prepared to discuss with patients any financial arrangements that could impact patient care. Physicians should avoid reimbursement systems that, if disclosed to patients, could negatively affect the patient-physician relationship.

Issued June 1998, based on the report "Financial Incentives and the Practice of Medicine," adopted December 1997; updated June 2002.

Opinion 4.04 - Economic Incentives and Levels of Care
The primary obligation of the hospital medical staff is to safeguard the quality of care provided within the institution. The medical staff has the responsibility to perform essential functions on behalf of the hospital in accordance with licensing laws and accreditation requirements. Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. The organized medical staff has an obligation to avoid wasteful practices and unnecessary treatment that may cause the hospital needless expense. In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority. Issued June 1986.

Opinion 8.0321 Physicians' Self-Referral
Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(1) Ensure that referrals are based on objective, medically relevant criteria.

(2) Ensure that the arrangement:

(a) is structured to enhance access to appropriate, high quality health care services or products; and

(b) within the constraints of applicable law:

(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;

(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and

(iii) adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.

(3) Take steps to mitigate conflicts of interest, including:

(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;

(b) establishing mechanisms for utilization review to monitor referral practices; and

(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.

(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

Issued June 2009 based on the report "Physicians' Self-Referral," adopted November 2008.

Opinion 6.03 - Fee Splitting: Referrals to Health Care Facilities
Clinics, laboratories, hospitals, or other health care facilities that compensate physicians for referral of patients are engaged in fee splitting, which is unethical. Health care facilities should not compensate a physician who refers patients there for the physician's cognitive services in prescribing, monitoring, or revising the patient's course of treatment. Payment for these cognitive services is acceptable when it comes from patients, who are the beneficiaries of the physician's services, or from the patient's designated third party payer.

Offering or accepting payment for referring patients to research studies (finder's fees) is also unethical.

Issued prior to April 1977; updated June 1994 and June 1996, based on the report "Finder's Fees: Payment for the Referral of Patients to Clinical Research Studies," adopted December 1994.

Opinion 8.132 - Referral of Patients: Disclosure of Limitations
Physicians should always make referral decisions based on the best interests of their patients, regardless of the financing and delivery mechanisms or contractual agreements between patients, health care practitioners and institutions, and third party payers. When physicians agree to provide treatment, they assume an ethical obligation to treat their patients to the best of their ability. If a physician knows that a patient's health care plan or other agreement does not cover referral to a non-contracting medical specialist or to a facility that the physician believes to be in the patient's best interest, the physician should so inform the patient to permit the patient to decide whether to accept the outside referral.
Physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties. Because patients must have the necessary information to make informed decisions about their care, physicians have an obligation to disclose medically appropriate treatment alternatives. Physicians should also promote an effective program to monitor and improve the quality of the patient care services within their practice settings.

Physicians must ensure disclosure of any financial incentives that may limit appropriate diagnostic and therapeutic alternatives that are offered to patients or that may limit patients' overall access to care. This obligation may be satisfied if the health care plan or other agreement makes adequate disclosure to enrolled patients.

Issued June 1986; updated June 1994, based on the report "Financial Incentives to Limit Care: Ethical Implications for HMOs and IPAs," adopted June 1990; updated June 2002; updated November 2007, based on the report "Opinion E-8143. 'Referral of Patients: Disclosure of Limitations,' Amendment," adopted November 2007.

Related in VM
Physician-Owned Hospitals and Self-Referral, February 2013

The Physician as Hospital Employee, February 2013

Profiling Patients to Identify Prospective Donors, February 2013

Secret Shoppers and Conflicts of Interest, February 2013

Secret Shopper Evaluations: Quality Improvement or Economic Profiling? February 2013

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 141-144.

JOURNAL DISCUSSION
The Physician-Employee/Hospital Partnership
Faith L. Lagay, PhD

Belde DM. Physician employment in an era of health reform: using shared ideals to achieve social interests. *Health Prog*. 2012;93(2):62-71.

Changes over the last 30 years in how medical care is delivered and paid for in the U.S. have put financial and administrative pressures on solo and small-group-practice physicians. As a result, more and more are becoming employees of hospitals or health care organizations. While becoming an employee reduces the financial uncertainties of managing one's own practice and relieves administrative headaches, it introduces an equally troubling set of concerns that range from clinical autonomy to ethical decision making.

In "Physician Employment in an Era of Health Reform: Using Shared Ideals to Achieve Social Interests," David M. Belde, vice president for mission and ethics at Bon Secours Richmond Hospital System, presents a vision for how physicians can become hospital employees while retaining their clinical autonomy and professional integrity [1]. I call it his "vision" because Belde describes a true partnership between physicians and health care organizations based upon shared ideals but points to no existing exemplars.

Belde believes such a mutually beneficial partnership is possible if both parties put the "socially directed ideals of the profession and health care organizations" first and only then "get on to the business of making it work operationally" [2]. (Belde's writerly decision to avoid "operationalize" in this sentence tells me he is thinking as a humanist educator first and a hospital administrator second.)

Belde begins by explaining why physicians choose to become employees. The first and most obvious reason is financial security that employment brings [3]. Other "pushes" toward employee status include "administrative burdens associated with participation in private and government-sponsored insurance programs" [3]; financial burdens associated with capital investment in medical technology, clinic facility overhead, rising cost of medical malpractice insurance, and paying off medical education debt; and, finally, the changing priorities of physicians, many of whom now seek more work-life balance [3].

Provisions of the Patient Protection and Affordable Care Act (ACA) that emphasize illness prevention, managing chronic conditions more efficiently, reducing hospital admissions, and providing greater continuity of care compound the inducements for

physician employment that existed before its passage in 2010. Most of these care initiatives rely on close collaboration among numbers of specialties and greater attention to patients' lives inside and outside the doctor's office.

During the 1970s and '80s, "hospital systems employed physicians at a feverish pace," Belde says [4]. He thinks these arrangements failed chiefly because the hospital and health care organization employers tried to manage the practices of their physician workforce on the acute care model appropriate to hospitals. Such organizations' operational strategies, one can infer from this statement, did not transfer to care of patients and families with needs that range from extended management for chronic conditions to patient education, to well-man, -woman, and -child visits to care for mental health problems. Observers of the HMO and managed care era can certainly agree.

The radical reforms in delivery of and accountability for medical care represented in the ACA give physicians and health care organizations a chance to get it right, opines the optimistic Belde, and they can do so if and only if both groups allow the "social ideals foundational to the health professions" to "constrain the self-interests that often tend to dominate their public actions" [5]. Belde defines these foundational ideals as amelioration of pain and suffering in patients, individually and in the aggregate; disease prevention; and clinical research into the causes of and cures for pain and suffering [2].

But in the United States, delivery of health care is a business. Is it possible to strive toward these foundational social ideals and turn the profit needed to sustain the health care enterprise? Here are Belde's suggestions for doing so.

1. Understand health care as a *unique* business activity (emphasis added), one that is meant to serve humanity [2]. With this imperative Belde intends to expose as unethical any practice that ignores preservation of health or prevention of illness on the grounds that treating sickness is profitable and creates jobs for lots of people. The boost to the economic cycle that comes from providing care for sick people would be welcome in another industry, but it cannot serve as a rationale for neglecting conditions that foster illness just so the economy can benefit from treating that illness. (This reasoning re-emerges in principle #3.)
2. Treat health care as a social good. The point here is that "a social good is not, in the financial sense 'owned' by any one individual" [6], but, like education, owned collectively by those it serves. Belde interprets society's collective ownership of health care services on behalf of all its members to mean that business and corporate interests should not have the final say in health care reform [6].
3. Direct health care towards amelioration of social inequities because those inequities, by and large, are the social determinates of health status [6].

The final section of "Physician Employment in an Era of Health Reform" outlines strategies for incorporating these organizational principles into physician-health care organization relationships. Belde believes that creation of the relationship he describes—"envisions" is still the better word—is in the enlightened self-interest of all, and can be achieved if all parties recognize that long-term professional rewards redound from this socially sensitive orientation. He also urges employer organizations to endorse "critical loyalty," a felicitous term that allows for disagreement and constructive criticism within a relationship to which both parties remain committed [7].

All in all, Belde's optimism stems from his view that the ACA aligns economic incentives with good medical practices in a way that the U.S. health care system has not seen before [8]. The attentive reader's question has to be whether Belde's optimism is naive or experienced. The idea of enlightened self-interest is not a new economic theory, but one of those enduring concepts that, as has often been said about democracy, is the best alternative after all others have failed. We are about at that "all-others-have-failed" place with health care in the United States. We tried the open-market, fee-for-service model until the cost of it became unsustainable and many people were overtreated along the way. We experimented with "managed" (not entirely open-market) care models. These left professionals frustrated, their clinical judgment second-guessed and their autonomy abrogated.

Now comes a model that says, in effect, to physicians and health care organizations "work it out among yourselves." It preserves professional judgment while holding those professionals accountable for the outcomes and rewarding them when the outcomes prove best for patients and economically sustainable.

Yes, Belde is an optimist, but he did not propose a single-payer system. *That* would have been naive in 2012. Rather he exhorted health care organizations to remember the origins of their enterprise, acknowledge the ideals they share with the profession of medicine, and begin to build their business operations on those mutual foundations.

References

1. Belde DM. Physician employment in an era of health reform: using shared ideals to achieve social interests. *Health Prog*. 2012;93(2):62-71.
2. Belde, 66.
3. Belde, 64.
4. Belde, 63.
5. Belde, 65.
6. Belde, 67.
7. Belde, 68.
8. Belde, 70.

Faith L. Lagay, PhD, has been managing editor of *Virtual Mentor,* the American Medical Association's monthly online ethics journal, for 12 years. Her doctorate in the medical humanities is from the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston.

Related in VM

The Physician as Hospital Employee, February 2013

Ethics in Accountable Care Organizations, February 2013

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 145-149.

STATE OF THE ART AND SCIENCE

Transitions of Care: Putting the Pieces Together

Devan Kansagara, MD, MCR, Brian Chan, MD, MPH, David Harmon, MD, MPH, and Honora Englander, MD

Transitions of care have become an important target for the Triple Aim of improving care quality and the patient care experience, improving the health of our population, and reducing cost [1]. Most research to date has focused on hospital-to-home care transitions, and numerous studies have shown major gaps in care during these transitions. For instance, communication across sites happens infrequently, follow-up needs are not consistently identified, and relatively few patients have timely outpatient follow-up care after hospital discharge [2, 3]. Moreover, patients and their caregivers feel unprepared to manage their conditions after discharge, are uncertain about their medications, and are often unclear about whom to contact with questions [4]. For socioeconomically disadvantaged patients, these issues are compounded by insufficient access to outpatient care, lack of social support, and transportation needs [5, 6]. Health care professionals, likewise, identify poor care transitions as an important target for improvement [7].

In addition to patients' and clinicians' frustration with these gaps in care, some evidence suggests they could threaten patient safety. For example, one study found 19 percent of patients had an adverse event after discharge; 30 percent of these, most of which were medication errors, were preventable [8].

The cost to our health care system of poorly executed care transitions has been the major driver of interest in this field. Hospital readmissions are common and costly. A 2009 analysis of Medicare fee-for-service beneficiaries found that about one-quarter were readmitted to the hospital within 30 days of discharge at an estimated total cost of $17.4 billion [9]. Though it is unclear how many, some readmissions are preventable, and there has been a great deal of effort in recent years to develop strategies to prevent some them [10].

In many ways, transitional care deficiencies are a reflection of a fragmented health care system, perpetuated by fee-for-service payments that reward individual interventions by individual clinicians rather than systems integration. Over the last decade, there have been increasing efforts to improve transitions of care at the national, regional (i.e., a metro region comprising several health systems), and local (i.e., a single hospital or health system) levels.

Nationally, the Center for Medicare and Medicaid Services (CMS) has recently introduced several innovations designed to realign financial incentives and promote

improved care coordination across sites. The Center for Medicare and Medicaid Innovation (CMMI)—established by the Affordable Care Act—includes a bundled payment pilot program that is examining ways to bundle all payments for an entire episode of care rather than paying separately for discrete elements of care [11]. Currently, CMS pays separately for each service delivered to a patient during the hospital stay, for each service delivered in the outpatient setting, andr any readmission. One example of a bundled payment would be a lump sum paid for all services during an inpatient stay as well as any care—including readmissions—during the 30 days after discharge. Advocates hope that the promise of sharing the dollars saved by this approach will provide incentive for health systems to invest in care coordination efforts between in- and outpatient services.

CMS has also started a program that will reduce payments to hospitals with high readmission rates for several conditions (after adjustments have been made for illness severity and risk level of patients); these penalties are set to increase over each of the next few years. Finally, CMS has been publicly reporting hospital readmission rates on hospitalcompare.gov as an additional impetus emcouragement to hospitals to engage in readmission risk-reduction efforts.

At the regional level, the Affordable Care Act has led to the development of accountable care organizations (ACOs) as a vehicle for integrating health systems [12]. An ACO brings together a collection of health providers—including hospitals and clinics that may have been competitors previously—into a risk-sharing agreement. Again, the promise of shared savings through better care coordination is the "carrot" with which regulators hope to drive interest in ACOs.

There is a growing body of literature examining transitional care interventions deployed at the local level. Several "bridging" interventions have reduced readmission rates among older patients with complex medical needs [13], older patients with congestive heart failure [14], and socioeconomically disadvantaged patients [15]. In these interventions, a member of the health care team—often a nurse—meets with the patient and family prior to hospital discharge, helps prepare them to manage care at home, and then makes home visits for several weeks after discharge. However, not all transitional care interventions have successfully reduced readmissions [16], and interventions have not been rigorously tested in broader patient populations.

A number of outstanding questions concerning transitions of care remain. National efforts to realign financial incentives are commendable, but, as with any intervention, there is the possibility of unintended harmful consequences. For instance, financial penalization of hospitals with high readmission rates may disproportionately impact resource-poor hospitals that serve socioeconomically disadvantaged patients, potentially exacerbating existing health care disparities [17].

The establishment of primary care medical homes was an effort at care coordination that preceded ACOs. Their role in improving transitions of care and reducing

readmissions has not been well examined. Patient experiences and gaps in care prior to emergency room and hospital visits are not well understood. In other words, we do not know much about care as patients are becoming ill or whether attention to care "proximate" to hospitalizations could be an important adjunct to improving transitional care quality. Finally, we are only beginning to understand how transitional care personnel, outpatient clinics, and community resources could interact with one another to provide seamless care across settings. More study is needed before we understand how to define roles and train diverse personnel to optimize care transitions.

Medical students and postgraduate trainees can be an integral part of improvement efforts. While, in many cases, they continue to train in the fragmented system of old, they are increasingly being exposed to discussions about health care delivery rehabilitation while their attitudes and ideas are still forming.

In both in- and outpatient settings, trainees experience firsthand the shortcomings of a fragmented system. For example, they may receive critically ill patients transferred from a hospital with disorganized, incomplete records; they may care for readmitted patients whose seemingly comprehensive care plan was derailed by unforeseen transportation or access barriers, or see patients in posthospitalization follow-up who are ill-prepared to manage their illnesses or implement numerous medication changes. Amid these realities, residents are uniquely positioned to address care transition challenges systematically and to seek advanced postgraduate training in this arena.

Although the new guard of physicians may have more training in interdisciplinary teamwork and care coordination, care transitions education has been neither widely adopted nor standardized, and mentorship in this area may be lacking. There is a need to develop transitions of care curricula to better prepare trainees for today's health care environment, in which patient handoffs across and within settings occur frequently.

Finally, little is understood about what patients need to make the transition successfully from the structured hospital environment to being responsible for their own care. Health systems are rapidly hiring health coaches, care coordinators, and community health workers, but we don't yet have a clear sense of how and for which patients these health care personnel will be most helpful. Some may benefit from a multidisciplinary team approach, whereas others may want a single point-person across settings. And while enhanced education and coaching may benefit many patients, others may prioritize material needs such as food, shelter, transportation, and social supports during times of transition.

Many innovations to improve transitions of care across settings are being implemented at national, regional, and local levels and help address key gaps in our fragmented health system. However, as with the introduction of any new intervention, continued research on the effectiveness and potential harms of these

innovations will be important. Many questions remain about which innovations will best achieve the aims of affordable, high-quality, patient-centered care.

References

1. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769.
2. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831-841.
3. Hernandez AF, Greiner MA, Fonarow GC, et al. Relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. *JAMA*. 2010;303(17):1716-1722.
4. Coleman EA, Smith JD, Frank JC, Eilersten TB, Thiare JN, Kramer AM. Development and testing of a measure designed to assess the quality of care transitions. *Int J Integr Care*. 2002;2:1-8.
5. Kansagara D, Ramsay RS, Labby D, Saha S. Post-discharge intervention in vulnerable, chronically ill patients. *J Hosp Med*. 2012;7(2):124-130.
6. Englander H, Kansagara D. Planning and designing the Care Transitions Innovation (C-Train) for uninsured and Medicaid patients. *J Hosp Med*. 2012;7(7):524-529.
7. Davis MM, Devoe M, Kansagara D, Nicolaidis C, Englander H. "Did I do as best as the system would let me?" Healthcare professional views on hospital to home care transitions. *J Gen Int Med*. 2012;27(12):1649-1656.
8. Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med*. 2003;138(3):161-167.
9. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med*. 2009;360(14):1418-1428.
10. van Walraven C, Bennett C, Jennings A, Austin PC, Forster AJ. Proportion of hospital readmissions deemed avoidable: a systematic review. *CMAJ*. 2011;183(7):E391-E402.
11. Centers for Medicare and Medicaid Services. Bundled payments for care improvement. www.innovations.cms.gov/initiatives/Bundled-Payments. Accessed November 5, 2012.
12. Emanuel EJ. Why accountable care organizations are not 1990s managed care redux. *JAMA*. 2012;307(21):2263-2264.
13. Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med*. 2006;166(17):1822-1828.
14. Naylor MD, Brooten DA, Campell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *J Am Geriatr Soc*. 2004;52(5):675-684.
15. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. *Ann Intern Med*. 2009;150(3):178-187.

16. Hansen LO, Young RS, Hinami K, Leung A, Williams MV. Interventions to reduce 30-day rehospitalization: a systematic review. *Ann Intern Med*. 2011;155(8) 520-528.
17. Joynt KE, Jha AK. Who has higher readmission rates for heart failure and why?: Implications for efforts to improve care using financial incentives. *Circ Cardiovasc Qual Outcomes*. 2011;4(1):53-59.

Devan Kansagara, MD, MCR, is an assistant professor of medicine in the Division of General Internal Medicine at Oregon Health and Science University and a staff physician at the Portland Veterans Administration. He is interested in health systems improvement research, specifically in the area of transitions of care, and in evidence-based medicine.

Brian Chan, MD, MPH, is a senior resident at Oregon Health and Science University in Portland. He is interested in health services research in the areas of health care quality, policy, and systems improvement.

David Harmon, MD, MPH, is a resident in internal medicine at Oregon Health and Science University in Portland. He graduated with a BA from the University of Notre Dame, did a stint with Americorps in Philadelphia, and completed a master of public health degree during medical school at the University of Kansas. Following graduation he will remain at OHSU as a teaching hospitalist with interests in transitions of care and resident education.

Honora Englander, MD, is an assistant professor of medicine at Oregon Health and Science University and an internist in OHSU's division of Hospital Medicine and the Old Town Clinic, a federally qualified health center in Portland. She is the medical director for the Care Transitions Innovation (C-TraIn), a transitional care improvement program for uninsured and low-income publicly insured adults served by the Portland-area coordinated care organization.

Related in VM

Can Physician Training and Fiscal Responsibility Coexist? February 2013

Ethics in Accountable Care Organizations, February 2013

Are Physicians Ready for Accountable Care? February 2013

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 150-155.

HEALTH LAW

Physician-Owned Hospitals and Self-Referral

Cristie M. Cole, JD

By 2010, approximately 265 hospitals in the United States were owned, in whole or in part, by physicians [1]. Commonly known as physician-owned hospitals (POH), many have an outstanding reputation for providing quality care, maintaining high patient satisfaction ratings, and allowing physician-investors to gain more control over their clinical practice [2]. Proponents of POHs argue that they not only enhance patient care but function as a necessary competitive force in the medical marketplace, promoting patient choice [3]. Critics of POHs, however, caution that conflicts of interest inherent in the model have the potential to compromise patient care at both the POH and surrounding hospitals [3]. Strict legal restrictions are in place to prohibit physician self-referrals, but POHs have been exempt from these laws, which has allowed them to thrive [4]. Now, the Patient Protection and Affordable Care Act (ACA) seeks to limit exemptions for POHs substantially, raising questions about their future status and viability [5].

Physician Self-Referrals and Physician-Owned Hospitals

Financial gain from self-referrals—referrals for health care services or to facilities in which a physician has a financial interest—can improperly influence a physician's medical judgment [2]. Risks of unregulated self-referrals include overutilization of the services in which physicians have investments, increased health care costs, and decreased quality of care [2].

POHs raise similar concerns—for example, a physician who shares ownership in a POH may have a financial incentive to refer patients for unnecessary services if he or she receives a percentage of the revenue generated [2]. While medicine as a profession has historically been unwelcoming to commercial practices that place the financial interests of physicians above the best interest of a patient, in the twentieth century physician entrepreneurship (including self-referral to POHs) was generally embraced [2].

Concerned by the growing number of self-referrals in the late 1980s, Congress ordered the Office of the Inspector General (OIG) in the Department of Health and Human Services (HHS) to investigate them [3]. The OIG's 1989 report substantiated many of Congress's concerns regarding the sizable presence of self-referrals in the medical market, despite existing anti-kickback laws [3]. There was substantial debate, however, over the systemic effect self-referrals had on patient care and the medical marketplace and the need for government regulation [3]. Proponents of government regulation believed that self-referrals decreased competition, increased

health care costs, and compromised quality of care [3]. Critics of regulation, however, believed that self-referrals strengthened the marketplace by giving patients more choices for health care services and, thus, providing an incentive to physicians to maintain high quality of care [3].

Stark Law, the "Whole Hospital Exception," and the Rise of Physician-Owned Hospitals

The 1989 OIG report prompted Congress to push forward legislation, commonly known as the Stark law, which prohibits physician self-referrals for eleven designated health services paid for by Medicare or Medicaid [2]. Physicians who violate the law face denial of Medicare payment for services rendered or mandated refunds of payments and civil monetary penalties [6-9]. The Stark law allowed certain safe harbors (or exemptions from the law) for activities that, as is commonly said, accommodate a legitimate business relationship [10].

Included among the safe harbor provisions was the "whole hospital exception." Under this exception, a physician could refer Medicare or Medicaid patients to a hospital in which he or she had a financial interest if (1) the referring physician was authorized to perform services at that hospital and (2) the physician's financial interest was in the *whole* hospital as opposed to a specific department or subdivision [4]. Savvy physician entrepreneurs used this provision to invest in and refer patients to POHs, which satisfied the "whole hospital exception" because POHs are freestanding facilities [2, 11]. However, many POHs closely resemble divisions within general hospitals. Most specialize in specific services, such as cardiac or orthopedic surgery, and many of their patients are referred from general hospitals by the POH's physician-investors [11]. As such, the "whole hospital exception" allowed the growth of an industry that profited from the very type of self-referral scheme it was clearly intended to prevent [1].

Government Investigation of the Impact of POHs

In 2003, Congress ordered an 18-month moratorium on further development of POHs while the Department of Health and Human Services (HHS) and the Medicare Payment Advisory Commission (MedPac) investigated their impact on care, patient safety, and the medical marketplace [12]. Overall, the reports painted POHs as less of a threat than originally believed. While they confirmed that POHs increased overutilization of services, treated patients whose care was less costly, and provided less uncompensated care that nonphysician-owned hospitals, the feared decreased in competition was found to be negligible [13, 14]. Moreover, the data showed that physician-investor referral patterns to POHs and other facilities were similar to those of physicians without an investment interest [13, 14]. The HHS report did, however, substantiate concerns about patient safety arising from inadequate emergency services [15].

Ultimately, neither MedPac nor HHS recommended the elimination of the "whole hospital exception" [13-15]. In fact, MedPac stated that POHs "may be an important competitive force" and "an appropriate response to physician frustration with

community hospitals' lack of responsiveness and physicians' desire for control" [13]. Instead, they recommended modification of the Medicare payment system [13] and "that hospitals...require a registered nurse to be on duty 24 hours a day, 7 days a week, and a physician to be on duty or on call if one is not onsite" [15].

Despite the relatively benign picture painted by these reports, Congress proposed several measures in 2007 and 2008 that would have, in varying degrees, eliminated the "whole hospital exception" for new and expanded POHs [16-18]. While none of these measures was enacted, they demonstrated a continuing effort by some to continue to limit or eliminate POHs [16-18].

Section 6001 of the Patient Protection and Affordable Care Act (ACA)

The movement against POHs gained substantial ground in May 2010 when President Obama signed the ACA into law, substantially restricting POHs [5]. Section 6001 of the ACA modified the "whole hospital exception" of the Stark law in three key ways, adding (a) limits on the growth of POHs in the medical marketplace, (b) requirements to disclose investment terms and investor identities, and (c) requirements to provide emergency services [5]. Notably, the ACA measures are somewhat narrow in their impact and scope—they apply only to facilities seeking reimbursement for Medicare services that were Medicare certified after December 31, 2010. They do not affect POHs' ability to seek reimbursement from self-pay patients or private insurance [19-21]. To the extent that POHs rely on Medicare reimbursements, however, their growth and development are substantially curtailed.

(a) Prohibitions expanding existing or establishing new POHs. Section 6001 prohibits expanding the capacity of existing Medicare-certified POHs as of March 23, 2010, unless they meet one of two exceptions. The law also placed a moratorium on the establishment of new Medicare-certified POHs after March 23, 2010. For the 60-65 POHs that were already being developed in March 2010, the ACA set a deadline of December 31, 2010 to obtain Medicare certification [22, 23].

(b) Disclosure requirements. The ACA imposes reporting requirements and restrictions on physician investments. POHs must report to HHS and disclose to their patients the identity of their investors and investment terms and post their POH status on websites and in public advertising. Moreover, the percentage of the aggregate value of investments owned by physicians (as opposed to nonphysicians) in a given POH was capped at its March 23, 2010, level. The act also limits the terms of physician investment to prevent inappropriate behavior, prohibiting, for example, lending money to finance physician investment in POHs or requiring physician-investors to meet referral quotas [24].

(c) Emergency services. Also included in the ACA are regulations addressing patient safety concerns regarding insufficient emergency services in POHs. POHs that lack 24-hour physician availability are required not only to disclose this fact to their patients but also to obtain written acknowledgment that the patient understands. Moreover, POHs must "provide assessment and initial treatment for medical

emergencies and have the capacity to refer and transfer patients to full-service hospitals, if necessary to treat a patient's emergent condition" [20].

Physician Hospitals of America v. Sebelius

The new measures of the ACA that restrict POH growth and development have recently come under legal challenge. Physician Hospitals of America (PHA), an advocacy group for POHs, and one specialty POH, Texas Spine and Joint Hospital (TSJH), filed suit against the secretary of HHS in the U.S. District Court for the Eastern District of Texas challenging the constitutionality of section 6001 [20]. TSJH was in the process of expanding but was unable to complete its efforts before the ACA restricted it [20]. PHA and TSJH argued that the restrictions (1) violated due process and equal protection rights, (2) constituted an unjustified governmental taking because it deprived the owners of their real property and capital investment, "including their anticipated revenue source of Medicare," and (3) were unconstitutionally vague [20].

The district court dismissed the suit, upholding the constitutionality of the restrictions and finding in favor of the secretary (and the Obama administration), a victory for the ACA [20]. At the same time, it recognized that PHA and TSJH may have identified a "wiser legislative approach" to achieving the underlying purposes of the statute—primarily limiting financial incentives for unnecessary referrals [20]. The district court's opinion implied that sufficient evidence was presented to support the position that POHs are a valuable element of the medical marketplace and less restrictive means would be "wiser" [20].

PHA and TSJH appealed to the Fifth Circuit Court of Appeals, which also dismissed the suit [20]. Unlike the district court, the appellate court did not address the constitutional arguments [20]. Instead, it determined that the court lacked subject matter jurisdiction because PHA and TSJH needed to pursue their claims directly through HHS before bringing a lawsuit [20]. In order to bring a claim directly to HHS, though, TSJH would have to complete its $30 million expansion, treat patients, and file a claim with Medicare for reimbursement [20]. Only after its claims for Medicare reimbursement were denied could TSJH then pursue its claim through HHS directly [20]. This is a substantial financial risk for any institution.

Conclusion

In sum, the long-term impact of section 6001 of the ACA on the POH industry and patient care is unknown. The dismissal of *Physician Hospitals of America v. Sebelius*, the only challenge to section 6001 thus far, does not preclude future suits in other federal jurisdictions or challenges to HHS—in fact, because the appellate court did not address the constitutionality of the law, more claims are likely, either through HHS or in other federal courts. Neither does the Supreme Court's June 2012 decision upholding the constitutionality of the ACA preclude challenges to section 6001 [25]. Even with legal challenges looming, though, section 6001 is a regulatory reality for POHs. While critics of section 6001 warn that it will debilitate an important competitive force in the marketplace, it does not categorically eliminate further

development of the POH industry. It only eliminates Medicare as a source of income for affected POHs. Even though most POHs' financial stability has relied on Medicare, new or expanding POHs could alter their business models. Moreover, it is questionable whether section 6001 will fulfill its stated intent, particularly given the fact that the 2003 MedPac and HHS reports showed the POHs were not, or at least not yet, the grave threat to patient care that many feared.

References

1. The reconciliation act of 2010: report of the Committee on the Budget, House of Representatives, to accompany HR 4872. HR Rep No 111-443, at 4 (2010). http://housedocs.house.gov/rules/hr4872/111_hr4872_rpt2.pdf. Accessed January 22, 2013.
2. Perry JE. Physician-owned specialty hospitals and the Patient Protection and Affordable Care Act: health care reform at the intersection of law and ethics. *Am Business Law J*. 2012;49:369-416.
3. US Department of Health and Human Services, Office of Inspector General. *Financial Arrangements Between Physicians and Health Care Businesses: Perspectives of Health Care Professionals*. HHS; 1989.
4. Limitation on certain physician referrals, 42 USC sec 1395nn(d)(3)(c) (2006).
5. Limitation on certain physician referrals, 42 USC sec 1395nn (2011).
6. Limitation on certain physician referrals, 42 USC sec 1395nn(g) (2006).
7. Prohibition on certain referrals by physicians and limitations on billing, 42 CFR sec 411.353(d) (2012).
8. Basis for civil money penalties and assessments, 42 CFR sec 1003.102(a)(5) (2012).
9. Exclusion from participation in Medicare, Medicaid and all Federal health care programs, 42 CFR sec 1003.105(a)(1)(i) (2012).
10. Limitation on certain physician referrals, 42 USC sec 1395nn(b)-(e) (2006).
11. United States General Accounting Office. Specialty hospitals: information on national market share, physician ownership, and patients served; 2003. http://www.gao.gov/new.items/d03683r.pdf. Accessed November 26, 2012.
12. Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Pub L no 108473 sec 507(a), 117 stat 2066.
13. Medicare Payment Advisory Committee. *Report to the Congress: Physician-Owned Specialty Hospitals*; 2005. http://www.medpac.gov/documents/Mar05_SpecHospitals.pdf. Accessed November 26, 2012.
14. Medicare Payment Advisory Committee. *Report to the Congress: Physician-Owned Specialty Hospitals Revisited*; 2006. http://www.medpac.gov/documents/Aug06_specialtyhospital_mandated_report.pdf. Published August 2006. Accessed November 26, 2012.
15. US Department of Health and Human Services, Office of Inspector General. Physician Owned Specialty Hospitals' Ability to Manage Medical Emergencies. Washington, DC: US Department of Health and Human Services; 2008.

16. Children's Health and Medicare Protection Act of 2007, HR 3162, 110th Cong (2007).
17. Rural Hospital Assistance Act of 2008, HR 6912, 110th Cong (2008).
18. S 4803, 110th Cong (2008).
19. Limitation on certain physician referrals, 42 USC sec 1395nn(i)(1) (2011).
20. *Physician Hospitals of America and Texas Spine & Joint Hospital, Ltd. v Sebelius*, 781 F Supp 2d 431 (ED Tex 2011).
21. Limitation on certain physician referrals, 42 USC sec 1395nn(i)(3) (2011).
22. Limitation on certain physician referrals, 42 USC 1395nn(1)(C).
23. Limitation on certain physician referrals, 42 USC 1395nn(i)(1)(C) and (D)(i)-(ii) (2011).
24. Limitation on certain physician referrals, 42 USC 1395nn(1)(E) (2011).
25. *National Federation of Independent Business v Dept of Health and Human Services*, 132 S Ct 2566 (2012).

Cristie M. Cole, JD, is a 2012-2014 fellow in the Cleveland Fellowship in Advanced Bioethics affiliated with Cleveland Clinic, Case Western Reserve University, MetroHealth Medical Center, University Hospitals Case Medical Center, and the Louis Stokes Cleveland VA Medical Hospital in Ohio. She received her JD from the University of Arizona's James E. Rogers College of Law. Her current research focuses on the legal and ethical limits of procreative liberty in clinical practice, particularly in the context of vulnerable patient populations, emerging reproductive technologies, and disease management, as well as the legal and ethical issues in treating adolescent patients and direct-to-consumer genetic testing.

Related in VM

The American Medical Association *Code of Medical Ethics*' Opinions on the Physician as Businessperson, February 2013

The Physician as Hospital Employee, February 2013

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 156-161.

POLICY FORUM
Ethics in Accountable Care Organizations
Matthew DeCamp, MD, PhD

Accountable care organizations (ACOs) are receiving significant attention as a policy initiative for achieving the "Triple Aim" [1] improved patient care experiences, better health for populations, and reduced per capita cost. This attention appears warranted. Although other initiatives exist (including pay for performance, the patient-centered medical home, value-based design, and global payment, among others), ACOs are forming rapidly in both the public and private sector.

Most of the attention paid to ACOs focuses on their structural features; less attention is paid to the ethical issues ACOs might raise or exacerbate. How health care is delivered and paid for, however, helps determine those issues. Traditional fee-for-service systems, for example, create an incentive for clinicians to perform more or unnecessary procedures, and capitated payment systems reward clinicians for doing less. Identifying and managing ethical problems will therefore be critical to the long-term success of ACOs. This essay examines some of the concerns ACOs—particularly hospital-based ACOs—confront.

Accountable Care Organizations: A Primer
The term "accountable care organization" was introduced relatively recently and is said to have originated with Elliot Fisher during a 2006 Medicare Payment Advisory Committee meeting and a subsequent publication [2]. The general concept is simple: by linking groups of providers and hospitals into a formal organizational structure and providing incentives based on specified health outcome measures and spending benchmarks, one is able to create shared accountability and coordination among all group members for achieving the Triple Aim. Shared accountability among all providers—as compared to traditional individual incentives (e.g., pay-for-performance)—is considered a novel feature of ACOs. By the time "ACO" entered the medical lexicon, pilot projects, such as Medicare's Physician Group Practice Demonstration (PGPD) pilot project (2005-2010), involving its key features were already in operation [3].

The 2010 Patient Protection and Affordable Care Act [4] was a watershed moment for ACOs. Section 3022 directed the Secretary of the Department of Health and Human Services to create a "shared savings program," i.e., ACOs, for Medicare. This legal framework was subsequently detailed by the Center for Medicare and Medicaid Services (CMS) as a final rule in November 2011 [5, 6]. Although a number of privately organized and successful accountable organizations exist [7], describing ACOs under Medicare outlines their basic structural features.

The Medicare Shared Savings Program allows any physician, hospital, physician network, and other health care provider group that cares for more than 5,000 Medicare fee-for-service beneficiaries to form an ACO and apply to participate. Agreements last at least 3 years. The incentive to participate is the "shared savings" that the organization can earn if Medicare expenditures for its beneficiaries are less than the CMS benchmark calculated for that ACO. This incentive should stimulate ACOs to provide better coordinated, higher-quality care while reducing expenses. Under a one-sided risk model, the ACO shares savings but suffers no loss if its expenditures are higher than the benchmark; under a two-sided risk model, the ACO can share a greater portion of the savings at the risk of having to pay back a portion of Medicare's losses if its expenditures are higher than the benchmark. Both models require an ACO to report and meet 33 national quality measures. ACOs have significant freedom to adopt and create their own quality, efficiency, and patient care coordination interventions.

Data from the PGDP pilot suggest that ACOs may be effective at improving quality and reducing expenditures [8]. Participation is expanding rapidly. As of January 2013, more than 250 Medicare-related ACOs exist, covering nearly 4 million Medicare beneficiaries [9]. Two parallel initiatives are the advance payment model (which has provided upfront funds for infrastructure investment to small or rural ACOs), and the pioneer ACO model (which allows for higher levels of shared savings and risk for organizations with significant coordination experience). Of note, although the initial ACO concept centered on the acute-care hospital and its patient/physician area, having a hospital is not required in Medicare's final rule, and some physician-only ACOs do exist [10].

Ethical Issues in ACOs

Hospitals and hospital-based systems, however, will undoubtedly head some if not most ACOs, and they will also contract with physician-only ACOs. This section introduces a few of the ethical concerns hospitals and their leadership might face.

Patient autonomy and cost savings. To protect patient autonomy, hospitals that lead ACOs assume responsibility for informing patients of their membership in the ACO, what an ACO is, and how it might affect their care. Within Medicare's Shared Savings Program, for example, ACOs must inform patients either in writing or in person about their clinicians' participation. Unlike health maintenance organizations, ACOs claim to allow patient choice of doctors (especially under Medicare's rules), but evidence suggests that cost savings might depend on the ACO's control over referral patterns [11]. How should hospitals balance control over referral patterns with physician and patient preferences, or might a constraint on autonomy be ethically justified [12]?

Unintended financial effects. ACOs face a certain financial tension. Excellent outpatient care, for example, might reduce admissions for "ambulatory-sensitive conditions," such as chronic obstructive pulmonary disease; can hospitals put the overall ACO savings and patient well-being above the fees they would receive from

more admissions? Hospitals and other ACO leaders have an ethical obligation not to engage in behaviors that are inconsistent with the intent of the signed agreement, namely, to reduce or limit overall health expenditures. But there is the possibility that hospitals will engage in unethical fiscal behaviors, including cost shifting and escalation. For example, hospitals might shift patients from costly therapeutics paid for under Medicare part A to outpatient therapeutics paid for under Medicare part D, because the latter is not part of the benchmark calculation [13]. Others worry that powerful hospitals might use substantial market power obtained through participation in a large, well-integrated ACO to raise prices [14]. A hospital or health system, for example, could use its large size to negotiate higher payments from private insurers, thereby gaining additional revenue or offsetting any reduction in revenue, were it to occur as a result of reduced Medicare payments. For patients with private insurance, this could result in higher premiums that effectively supplement or subsidize the shared savings. Payers (such as CMS) will undoubtedly watch for such scenarios, and legal rules (such as antitrust law) might place certain constraints on them.

Benefit sharing. Successful ACOs will share in the savings accrued with the payer, which means that hospitals will need to determine how to use these savings. In the case of the Medicare Shared Savings Programs, the savings must be shared with ACO participants or used for purposes consistent with those of the program. How can a hospital use and distribute these savings fairly? Should savings be shared equally among ACO members, or awarded to departments or clinicians according to a formula based on performance? If ACO savings result mainly from reduced hospital readmissions, for example, should those savings go to the hospital unit responsible for the discharge—or the outpatient clinicians' efforts to follow up and keep patients at home? Finally, should patients in an ACO share some portion of the savings?

Focus. ACOs will need to determine which of many quality metrics to focus on. In the CMS program, for example, among the 33 quality measures, specific attention is given to "at-risk" patient populations (e.g., patients with diabetes, hypertension, coronary artery disease, and heart failure). Time and resources are limited, so ACOs must decide how to spend limited quality-improvement resources fairly. Acute-care hospital leaders might have experience with certain measures (e.g., medicine reconciliation at discharge), lack of experience with others (e.g., preventive health, such as mammography), and lack of control over still others (e.g., ambulatory care). Deciding how to prioritize goals will require careful balancing of ethical values. Should an ACO focus, for example, on improving quality measures that are furthest from the target, those nearest, or those most easily achieved? Because quality measures will likely be associated with specific patient populations, this choice will be analogous to choosing between those "most in need" and those "most likely to benefit"—a classic issue of distributive justice.

Relationships with physicians. From ACOs' beginnings, the historically strained relationships between hospitals and providers was seen as a potential "cultural"

barrier [2], and this tension continues [15]. The appropriate relationship between hospitals and providers is an ethical concern, not just cultural or financial. Ethical values of concern to the profession, such as professional autonomy, might be affected when hospitals decide upon and implement initiatives for achieving ACOs' aims [16]. If physicians or other providers resist or sense a loss of professional autonomy, this could impact their willingness to adopt new initiatives and thereby affect their patients' care. Hospitals within ACOs will need to recognize this historical context and develop strategies for appropriately managing relationships with physicians.

Board governance. Finally, ACO leadership will play a key role in determining how an ACO behaves. Determining an appropriate governance structure is therefore important. The Medicare Shared Savings program rules require governing boards to include a Medicare beneficiary but otherwise allow significant latitude in composition and procedures. Including a beneficiary should add critical accountability, legitimacy, and patient-centered input, but questions will remain regarding the beneficiary's role and ability to remain an independent and powerful voice.

Conclusion

As ACOs proliferate, their long-term success depends in part upon identifying and addressing the ethical issues that, while not entirely new to hospitals, are relatively unique to this structure. Some behavioral economists caution that undue focus on financial incentives erodes intrinsic motivation and altruism [17]. Whether this will change or compromise a hospital's mission and organizational behaviors over time requires ongoing study. To the extent that certain issues (e.g., cost shifting) require empirical identification, verification, or testing, future empirical research will be necessary. To the extent that other issues, such as fair sharing of ACO savings with patients, require conceptual clarity, further thought will be necessary.

References

1. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood).* 2008;27(3):759-769.
2. Fisher ES, Staiger DO, Bynum JP, Gottlieb DJ. Creating accountable care organizations: The extended hospital medical staff. *Health Aff (Millwood).* 2007;26(1):w44-w57.
3. Kautter J, Pope GC, Trisolini M, Grund S. Medicare physician group practice demonstration design: Quality and efficiency pay-for-performance. *Health Care Financ Rev*. 2007;29(1):15-29.
4. Patient Protection and Affordable Care Act. 2010. Pub L 111-148, section 2702, 124 stat 119. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm. Accessed January 18, 2013.
5. Berwick DM. Making good on ACOs' promise - the final rule for the Medicare shared savings program. *New Engl J Med*. 2011;365(19):1753-1756.

6. Centers for Medicare & Medicaid Services (CMS), HHS. Medicare program; Medicare shared savings program: Accountable care organizations. Final rule. *Fed Regist*. 2011;76(212):67802-67990.
7. Higgins A, Stewart K, Dawson K, Bocchino C. Early lessons from accountable care models in the private sector: Partnerships between health plans and providers. *Health Aff (Millwood)*. 2011;30(9):1718-1727.
8. Colla CH, Wennberg DE, Meara E, et al. Spending differences associated with the Medicare physician group practice demonstration. *JAMA*. 2012;308(10):1015-1023.
9. More doctors, hospitals partner to coordinate care for people with Medicare [news release]. Baltimore, MD: Centers for Medicare and Medicaid Services Media Relations; January 30, 2013. http://www.cms.gov/apps/media/press/release.asp?Counter=4501&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date. Accessed January 18, 2013.
10. Evans M. Doctors on deck. ACOs led by doctors seek to manage costs, quality and hospital relationships. *Mod Healthc*. 2012;42(16):6-7, 16, 1.
11. Mechanic RE, Santos P, Landon BE, Chernew ME. Medical group responses to global payment: Early lessons from the 'alternative quality contract' in Massachusetts. *Health Aff (Millwood)*. 2011;30(9):1734-1742.
12. McCullough LB. An ethical framework for the responsible leadership of accountable care organizations. *Am J Med Qual*. 2012;27(3):189-194.
13. Barlas S. Final rule on ACOs raises concerns about medication cost-shifting: pharmacists to play a secondary role in new physician-hospital organizations. *P T*. 2011;36(12):780.
14. Scheffler RM, Shortell SM, Wilensky GR. Accountable care organizations and antitrust: Restructuring the health care market. *JAMA*. 2012;307(14):1493-1494.
15. Kocher R, Sahni NR. Physicians versus hospitals as leaders of accountable care organizations. *New Engl J Med*. 2010;363(27):2579-2582.
16. Emanuel EJ, Pearson SD. Physician autonomy and health care reform. *JAMA*. 2012;307(4):367-368.
17. Woolhandler S, Ariely D, Himmelstein DU. Why pay for performance may be incompatible with quality improvement. *BMJ*. 2012;345(7870):e5015.

Matthew DeCamp, MD, PhD, is a postdoctoral fellow in the Division of General Internal Medicine and the Berman Institute of Bioethics, both at Johns Hopkins University in Baltimore. His research interests include global health, social media and medical professionalism, and ethical issues in health reform, including accountable care organizations.

Related in VM

Are Physicians Ready for Accountable Care? February 2013

Assignment, Attribution, and Accountability: New Responsibilities and Relationships in Accountable Care Organizations, May 2012

The Physician Group Practice Demonstration—A Valuable Model for ACOs? November 2011

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 162-166.

MEDICINE AND SOCIETY

Physicians' Role in Protecting Patients' Financial Well-Being

Neel Shah, MD, MPP

During medical training we learn as much from our patients as we learn from our professors. With rising health care costs and bursting household budgets, patients are teaching us that now, more than ever, physicians have a moral obligation to protect not just patients' physical health but their financial health as well.

Our job routinely requires us to manage expensive resources—one day in a hospital bed can cost the same as a week in the Ritz Carlton. Yet we have minimal training in how to manage resources responsibly. In fact, we may have anti-training.

We are taught to approach patient care with an "everything possible" ethos that seems at odds with cost effectiveness. We are rewarded for discovering the rare zebras among the more common medical condition "horses" and for working up exhaustive differential diagnoses indiscriminately [1]. Although we realize health care is expensive, we often mistakenly assume that our patients' best interests and conserving resources are mutually exclusive goals.

Our patients teach us differently.

Medical bills are the leading cause of personal bankruptcy in the United States, even among the insured [2]. As physicians we decide which tests or treatments go on the bill but have little idea how our decisions impact what patients pay [3]. At the same time, up to a third of the tests and treatments we order do not seem to make anyone healthier [4]. This includes daily lab tests on inpatients that never get followed up, imaging tests in patients with nonspecific low back pain, and countless other practices (45 of which are currently listed on the ABIM Foundation's Choosing Wisely web site as practices that patients and physicians should question [5]).

The consequences affect everyone. In 2008 in Massachusetts, where 98 percent of citizens have insurance coverage, more insured non-elderly adults reported difficulty paying medical bills than ever before [6]. More Americans are on high-deductible plans than ever before, meaning many of us are paying the first couple thousand dollars of medical expenses out of pocket [7]. And the emerging case reports are as powerful as the statistics; the Costs of Care Essay Contest has collected hundreds of stories from all over the country of unnecessary financial harm due to cost-insensitive medical decisions that do not help patients get better [8]. In medical school we are taught that any preventable harm is unacceptable, and these examples are no exception.

Patient demand for physicians to consider costs has never been stronger. In 2013, consumers can make informed purchasing decisions about products, services, and entertainment based on the pricing and quality information on web sites such as Yelp and Travelocity. Government and private industry are both betting that patients have developed similar expectations for information about health care. More than 30 states either have or are pursuing price transparency legislation for patients [9]. I know that more than a dozen companies dedicated to health care price transparency have incorporated to date, with some capturing hundreds of millions of dollars in venture capital funding.

Payers and policy makers are also exerting pressure to stop the waste of health care funds. Reimbursement systems are shifting from fee-for-service models, in which doing more means making more (because each intervention is paid for separately), to capitated models, in which doing too much can mean making less money (because payment is per episode of care). Medicare has begun contracting with accountable care organizations (ACOs)—contractual networks of physicians, clinics, and hospitals committed to delivering quality and cost-effective care by coordinating patient treatment. ACOs that meet benchmarks for quality and cost efficiency share savings with Medicare. In the private sector, shared financial risk contracts between payers and physicians and clinics are becoming increasingly common [10].

With patients, the government, and the private sector lining up against wastefulness, the medical profession has been encouraged to promote resource stewardship as a matter of professional ethics. The ABIM Foundation's widely endorsed Physician Charter on Medical Professionalism states that we are obligated to scrupulously avoid "superfluous tests and procedures" in an effort to provide care that is "based on the wise and cost-effective management of limited clinical resources" [11]. In the last year, professional initiatives such as the ABIM Foundation's Choosing Wisely Campaign added greater visibility to the need for physicians to decrease waste.

As many as 80 percent of practicing physicians currently believe it is their responsibility to help bring health costs under control, and even those who do not share this view believe that costs are increasingly influencing their clinical decisions [12]. At the same time, the IOM recently estimated that $750 billion may be wasted each year in the United States on care that does not make anyone healthier, a figure on a par with the Department of Defense cost estimate for the entire Iraq War.

Nonetheless, professional and ethical standards on overutilization have not yet been widely put into practice. While our responsibility to contain costs is clear, lack of training on how to consider costs while caring for patients muddies the way forward.

A central problem is that most of the conversation about health care costs is abstracted to the population level. We discuss percentages of GDP and other macroeconomic statistics rather than patient-level financial harms. We physicians are trained primarily to take care of the patient in front of us, not to assume responsibility for entire populations. As a result, it is seldom clear how resources

diverted from one patient will help better serve the needs of another. For a physician at the bedside, savings realized from ordering a less expensive test or avoiding a marginally valuable therapy seem to accrue to the profit margins of insurance companies, not necessarily to the sick patient down the hall. Moreover, while we have frameworks for thinking about patient safety and therapeutic efficacy, we have no similar framework for thinking about cost and value. In the absence of such a framework, the only alternative is the understandably disturbing image of individual clinicians making rogue rationing decisions.

A first step to developing a framework for cost-conscious care may be to abandon the mythology that we are able to do everything for every patient without harmful consequences [13]. This will require distinguishing between macroeconomic resource stewardship and the financial well-being of the patient in front of us. By doing this, we may see instances in which the best interests of our patients and the need to conserve societal resources are well aligned. For example, both the patient and society win when we use generic medications, yet we routinely miss these opportunities to pick low-hanging fruit.

The cases in which our patients' interests and societal resource stewardship are less well aligned are more challenging to navigate. Occasionally, patients themselves demand low-value services and we must be prepared to advise them appropriately and recommend cost-conscious alternatives. In the same way we are expected to explain to patients why a narcotic or antibiotic may not be indicated, we should feel comfortable explaining why an unnecessary MRI should not be performed.

In other cases, a patient may truly need an expensive therapy but may struggle to afford it. In these cases, we should devise and teach strategies to decrease patients' out-of-pocket expenses by using alternative diagnostic and therapeutic formulations. If less expensive alternatives do not produce the best or standard care, patients should still have the opportunity to choose them as long as they know full well what the anticipated tradeoff is. Dismissal of these type of therapies (even well-intended dismissal) can lead to greater harms, particularly if more expensive options cause financial burdens or if they cause patients to forgo care altogether [2].

For these types of cost-conscious frameworks to be successful, physicians must have some sense of the financial consequences of their decisions. While precise costs are difficult to obtain at the point of care, physicians should be able to identify the largest resources under their direct discretion (for example hospital beds and MRI scans) and be able to estimate the average costs of their decisions within an order of magnitude (does a CT scan cost $10, $100, or $1,000?). Learning how to evaluate costs and interpret cost-effectiveness studies should also be standard parts of medical school curricula.

The task of considering costs while taking care of patients adds an additional dimension of complexity to an already difficult job. Still, there are many sources of complexity in our profession, ranging from the genomic revolution to the integration

of informatics. Our obligation to consider costs is not exceptional. That is why a group of medical educators formed Costs of Care, a nonprofit organization that helps physicians, nurses, and other caregivers master the complex world of health care costs to protect patients from financial harm. Through our Teaching Value Project [12], an initiative of Costs of Care that was funded by the ABIM Foundation, a group of medical educators and economists have come together to create a series of short, web-based video modules that teach medical students practical strategies such as, for example, decreasing patient medication expenses and avoiding test overutilization. The modules are designed to be widely accessible and allow users to efficiently demonstrate their learning with interactive exercises.

It is apparent that the physicians of tomorrow will be increasingly compelled to consider costs and recognize their role in protecting patients' wallets. It is time we give them the skills, training, and support they need to do so.

References

1. Rosenbaum L, Lamas D. Cents and sensitivity--teaching physicians to think about costs. *N Engl J Med*. 2012;367(2):99-101.
2. Himmelstein DU, Thorne D, Warren E, Woolhandler S. Medical bankruptcy in the United States, 2007: results of a national study. *Am J Med*. 2009;122(8):741-746.
3. Graham JD, Potyk D, Raimi E. Hospitalists' awareness of patient charges associated with inpatient care. *J Hosp Med*. 2010;5(5):295-297.
4. Institute of Medicine. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*. Washington, DC: National Academies Press; 2012.
5. ABIM Foundation. Choosing wisely. http://www.choosingwisely.org. Accessed January 11, 2013.
6. Long SK, Triplett D, Dutwin D. *The Massachusetts Health Reform Survey*. Washington, DC: Urban Institute; 2008. http://www.urban.org/UploadedPDF/411649_mass_reform_survey.pdf. Accessed January 11, 2013.
7. Employer Health Benefits Survey. Menlo Park, CA: Kaiser Family Foundation; 2012. http://ehbs.kff.org/. Accessed January 11, 2013.
8. Costs of Care. Stories. http://www.costsofcare.org/category/stories/. Accessed November 1, 2012.
9. Sinaiko AD, Rosenthal MB. Increased price transparency in healthcare--challenges and potential effects. *N Engl J Med*. 2011;364(10):891-894.
10. Mechanic RE, Santos P, Landon BE, Chernew ME. Medical group responses to global payment: early lessons from the 'Alternative Quality Contract' in Massachusetts. *Health Aff (Millwood)*. 2011;30(9):1734-1742.
11. ABIM Foundation. Physician Charter. http://www.abimfoundation.org/Professionalism/Physician-Charter.aspx. Accessed November 1, 2012.
12. Costs of Care. Teaching Value web site. www.teachingvalue.org. Accessed January 11, 2013.

13. Cooke M. Cost-consciousness in patient care--what is medical education's responsibility? *New Engl J Med*. 2010;362(14):1253-1255.
14. Farkas C, van Biesen T. *The New Cost-Conscious Doctor: Changing America's Healthcare Landscape*. Bain & Company; 2011. http://www.bain.com/Images/BAIN_BRIEF_Shifting_physician_behavior.pdf. Accessed January 11, 2013.

Neel Shah, MD, MPP, is chief resident in obstetrics and gynecology based at Harvard Medical School, Brigham & Women's Hospital, and Massachusetts General Hospital in Boston and the executive director of Costs of Care, Inc.

Related in VM

Is the Standard of Care Always Worth the Cost? February 2013

To Scan or Not to Scan? March 2006

Can Physician Training and Fiscal Responsibility Coexist? February 2013

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 167-169.

OP-ED

Are Physicians Ready for Accountable Care?

Matthew McNabney, MD

As health care in this country shifts toward delivery models that emphasize cost effectiveness and measurable quality, physicians must adapt to evolving expectations. In particular, they will need to possess the knowledge and skills to lead and contribute to accountable care organizations (or ACOs) [1, 2]. Many of these needed skills and practices are not specifically addressed in traditional undergraduate and postgraduate medical education. In this article, I will discuss a few competencies that are important for practitioners to develop in anticipation of a changing medical landscape.

A few existing models with similarities to ACOs have years of operational experience and can serve as important examples of techniques and best practices. The Program of All-Inclusive Care for the Elderly (PACE) [3] was developed in the early 1980s to provide comprehensive and cost-effective care for high-risk, frail older adults in a community-based model. Since 1980, PACE has expanded to 82 sites in 29 states and serves 24,000 older adults. All enrollees are under the care of a highly organized interdisciplinary team (IDT) with responsibility for all health care services and costs. Programs like PACE are fully integrated (outpatient, inpatient and long-term care services) and are responsible for all health care costs. Payments are capitated—per patient, rather than per intervention—and funding is primarily through Medicare and Medicaid, but enrollees not eligible for Medicaid can also pay with private funds. In every sense of the term, PACE programs are accountable for the health care needs of their patients. Because I am a medical director of a PACE program, I have had the opportunity to learn what practices and skills are most important for success in an integrated, cost-conscious, performance-driven program.

Be a Team Player

Consistent with federal regulations, PACE programs must maintain interdisciplinary teams as the primary mode of care provision. It is likely that ACOs, too, will establish IDTs specific to patient needs (and will monitor them to ensure best results). The members of typical IDTs in programs like PACE or ACOs include nurses, social workers, and transportation personnel as well as rehabilitation therapists. Sharing responsibility for assessment and treatment plans with nonphysician team members can be hard for physicians [4]. Although physicians have historically assumed leadership roles and *directed* care, most care situations are better served with a balanced interdisciplinary approach, in which input is freely exchanged and efficiently incorporated into plans of care. This is not easy, nor is it seen as feasible within many existing practice models. For this type of shared

decision making to be successful, clinical teams need common goals for patient care and a culture of respect in which input is continually encouraged. Taking notice of input and providing feedback (especially positive) is particularly effective in maximizing team performance.

Pay Attention to Costs

The degree of financial risk within the ACO structure depends on the specific payment model. For example, "shared savings" programs entail the least risk; provider organizations work to reduce costs to obtain a percentage of the money saved. In capitated models, provider organizations assume more risk because they receive a lump sum for each patient; if that patient's care exceeds the amount of the capitated payment, the organization loses money [1]. Physicians should be able to provide "high-value, cost-conscious care"; being able to do so has been recognized as a critical "core competency" in medical training [5]. For every test, treatment or consultation, I ask myself and others within our IDT, "Why is this being done, what do we plan to do with the result or effect, and how will that affect the patient? Does it have measurable value? Does that value justify the cost?" I have found that asking these questions routinely is sufficient to ensure that quality of care is not compromised while minimizing waste. For example, clinicians should routinely discuss with patients the likely outcome of a test and what next steps might be prompted by a positive result. As a result of these discussions, some patients will choose to forgo testing.

Let Patients Decide

Many decisions in medicine are driven by evidence-based guidelines that standardize care according to established recommendations derived from experts, and, in many respects, this has improved the quality of care. However, physicians must also practice patient-centered care, which is the intentional effort to include patients in medical decisions. Not only does this empower patients, it allows for appropriate deviations from standard practice driven by the individual's specific clinical scenario and preferences. This approach results in high-quality care that adheres less rigidly to recommendations *if* it is driven by patient wishes and perceived potential for benefit.

Acknowledge and Plan for Death

Patients do not typically enjoy talking about death, and doctors are often uncomfortable with these discussions as well. However, it is a central part of good medical care planning. In my experience, these discussions become easier and more natural as they become routine in patient-doctor conversation. Rather than discussing death as a medical defeat, physicians should describe these conversations as "insurance policies" for maintaining control of personal health decisions when decision making might not be possible. These discussions allow patients to clarify how they would prefer things to go at the end of life. This is analogous to addressing preventive care with patients, and physicians can prospectively serve their patients best by having thoughtful and clear discussions. Physicians who are able to serve patients through the end of life reap rewards associated with doing it well.

Conclusion

We are entering a new phase of medicine in this country. Physicians will work within models of care that are quite different from those prevalent 10 years ago. We will be expected to provide high-quality care that meets measurable standards, and we will be held accountable for outcomes. We will be paid less and less for how *much* we do, and more and more for how *well* we do. By engaging the four practices discussed above, it is likely that physicians will feel more prepared to care for patients effectively and enjoy their careers.

References

1. Berkowitz SA, Miller ED. Accountable care at Academic medical centers--lessons from Johns Hopkins. *N Eng J Med*. 2011;364(7):e12.
2. McClellan M, McKethan AN, Lewis JL, Roski J, Fisher ES. A national strategy to put accountable care into practice. *Health Aff (Millwood)*. 2010;29(5):982-990.
3. Eng C, Pedulla J, Eleazer GP, et al. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. *J Am Geriatr Soc*. 1997;45(2):223-232.
4. Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? *JAMA*. 2004;291(10):1246-1251.
5. Weinberger SE. Providing high-value, cost-conscious care: a critical seventh general competency for physicians. *Ann Intern Med*. 2011;155(6):386-388.

Matthew McNabney, MD, is an associate professor of medicine at Johns Hopkins University in Baltimore, where he is medical director of the Program of All-Inclusive Care for the Elderly (PACE). He is also fellowship program director in the Division of Geriatric Medicine and Gerontology.

Related in VM

Ethics in Accountable Care Organizations, February 2013

The Physician as Hospital Employee, February 2013

Is the Standard of Care Always Worth the Cost? February 2013

Suggested Readings and Resources

ABIM Foundation. Choosing wisely. http://www.choosingwisely.org. Accessed January 11, 2013.

ABIM Foundation. Physician Charter. http://www.abimfoundation.org/Professionalism/Physician-Charter.aspx. Accessed November 1, 2012.

ABIM Foundation, ACP-ASIM Foundation, American College of Physicians, American Society of Internal Medicine, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136(3):243-246.

American Hospital Association. Fast facts on U.S. hospitals. http://www.aha.org/research/rc/stat-studies/fast-facts.shtml. Accessed January 10, 2013.

American Medical Association. AMA principles of medical ethics. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page?. Accessed January 5, 2012.

American Medical Association. Principle VI. Principles of Medical Ethics. https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page. Accessed January 10, 2013.

Asch DA. Basic lessons in resource allocation: sharing, setting limits, and being fair. *Pharos Alpha Omega Honor Med Soc*. 1995;58(2):33-34.

Asch DA, Ubel PA. Rationing by any other name. *N Engl J Med*. 1997;336(23):1668-1671.

Barlas S. Final rule on ACOs raises concerns about medication cost-shifting: pharmacists to play a secondary role in new physician-hospital organizations. *P T*. 2011;36(12):780.

Basis for civil money penalties and assessments, 42 CFR sec 1003.102(a)(5) (2012).

Becker HS, Geer B, Hughes EC, Strauss A. *Boys in White: Student Culture in Medical School*. New Brunswick, NJ: Transaction Publications; 1976.

Belde DM. Physician employment in an era of health reform: using shared ideals to achieve social interests. *Health Prog*. 2012;93(2):62-71.

Bellet PS, Whitaker RC. Evaluation of a pediatric hospital service: impact on length of stay and hospital charges. *Pediatrics*. 2000;105(3 Pt 1):478-484.

Berkowitz SA, Miller ED. Accountable care at Academic medical centers--lessons from Johns Hopkins. *N Eng J Med*. 2011;364(7):e12.

Berwick DM. Making good on ACOs' promise - the final rule for the Medicare shared savings program. *New Engl J Med*. 2011;365(19):1753-1756.

Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769.

Bevan G, Skellern M. Does competition between hospitals improve clinical quality? A review of evidence from two eras of competition in the English NHS. *Br Med J*. 2011;343;d6470.

Boodman SG. New emphasis on customer service in medicine. *AARP Bulletin*. http://www.aarp.org/health/doctors-hospitals/info-08-2010/new_emphasis_on_customer_service_in_medicine.html. Accessed January 16, 2013.

Borfitz D. Is a "mystery shopper" lurking in your waiting room? *Medical Economics*. May 21, 2001. http://medicaleconomics.modernmedicine.com/news/mystery-shopper-lurking-your-waiting-room. Accessed January 7, 2012.

Cardello DM. Improve patient satisfaction with a bit of mystery. *Nurs Manage*. 2001;32(6):36-38.

Centers for Medicare and Medicaid Services (CMS). Bundled payments for care improvement. www.innovations.cms.gov/initiatives/Bundled-Payments. Accessed November 5, 2012.

Centers for Medicare and Medicaid Services (CMS). Medicare program; Medicare shared savings program: Accountable care organizations. Final rule. *Fed Regist*. 2011;76(212):67802-67990.

Centers for Medicare and Medicaid Services (CMS). National health expenditure projections 2010-2020. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2010.pdf. Accessed January 16, 2013.

Centers for Medicare and Medicaid Services (CMS). NHE fact sheet (2011). http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html. Accessed January 16, 2013.

Chen CC, Cheng SH. Hospital competition and patient-perceived quality of care: evidence from a single-payer system in Taiwan. *Health Pol*. 2010;98(1):65-73.

Children's Health and Medicare Protection Act of 2007, HR 3162, 110th Cong (2007).

Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med*. 2006;166(17):1822-1828.

Coleman EA, Smith JD, Frank JC, Eilersten TB, Thiare JN, Kramer AM. Development and testing of a measure designed to assess the quality of care transitions. *Int J Integr Care*. 2002;2:1-8.

Colla CH, Wennberg DE, Meara E, et al. Spending differences associated with the Medicare physician group practice demonstration. *JAMA*. 2012;308(10):1015-1023.

Cooke M. Cost-consciousness in patient care--what is medical education's responsibility? *New Engl J Med*. 2010;362(14):1253-1255.

Costs of Care. Stories. http://www.costsofcare.org/category/stories/. Accessed November 1, 2012.

Costs of Care. Teaching Value web site. www.teachingvalue.org. Accessed January 11, 2013.

Davis MM, Devoe M, Kansagara D, Nicolaidis C, Englander H. "Did I do as best as the system would let me?" Healthcare professional views on hospital to home care transitions. *J Gen Int Med*. 2012;27(12):1649-1656.

Donabedian A. Evaluating the quality of medical care. 1966. *Milbank Q*. 2005;83(4):691-729.

Donabedian A. Special article: the quality of care: how can it be assessed? *Arch Pathol Lab Med*. 1997;121(11):1145.

DonorSearch. Healthcare fundraising: challenges and opportunities. http://www.donorsearch.net/NonProfit/healthcare.html. Accessed October 29, 2012.

Emanuel EJ. Why accountable care organizations are not 1990s managed care redux. *JAMA*. 2012;307(21):2263-2264.

Emanuel EJ, Pearson SD. Physician autonomy and health care reform. *JAMA*. 2012;307(4):367-368.

Employer Health Benefits Survey. Menlo Park, CA: Kaiser Family Foundation; 2012. http://ehbs.kff.org/. Accessed January 11, 2013.

Eng C, Pedulla J, Eleazer GP, et al. Program of All-inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. *J Am Geriatr Soc*. 1997;45(2):223-232.

Englander H, Kansagara D. Planning and designing the Care Transitions Innovation (C-Train) for uninsured and Medicaid patients. *J Hosp Med*. 2012;7(7):524-529.

Evans M. Doctors on deck. ACOs led by doctors seek to manage costs, quality and hospital relationships. *Mod Healthc*. 2012;42(16):6-7, 16, 1.

Exclusion from participation in Medicare, Medicaid and all Federal health care programs, 42 CFR sec 1003.105(a)(1)(i) (2012).

Farkas C, van Biesen T. *The New Cost-Conscious Doctor: Changing America's Healthcare Landscape*. Bain & Company; 2011. http://www.bain.com/Images/BAIN_BRIEF_Shifting_physician_behavior.pdf. Accessed January 11, 2013.

Fiegl C. Why HHS abandoned "mystery shopper" study." *American Medical News*. July 11, 2011. http://www.ama-assn.org/amednews/2011/07/11/gvl10711.htm. Accessed January 16, 2013.

Fisher ES, Staiger DO, Bynum JP, Gottlieb DJ. Creating accountable care organizations: The extended hospital medical staff. *Health Aff (Millwood)*. 2007;26(1):w44-w57.

Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med*. 2003;138(3):161-167.

Friedman A. A piece of my mind. Secret shopper. *JAMA*. 2010;304(19):2103-2104.

Gabel J, Ermann D. Preferred provider organizations: performance, problems, and promise. *Health Aff (Millwood)*. 1985; 4(1):24-40.

Graham JD, Potyk D, Raimi E. Hospitalists' awareness of patient charges associated with inpatient care. *J Hosp Med*. 2010;5(5):295-297.

Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? *JAMA*. 2004;291(10):1246-1251.

Hall RT. *An Introduction to Healthcare Organizational Ethics*. New York: Oxford University Press; 2000.

Hansen LO, Young RS, Hinami K, Leung A, Williams MV. Interventions to reduce 30-day rehospitalization: a systematic review. *Ann Intern Med*. 2011;155(8) 520-528.

Hernandez AF, Greiner MA, Fonarow GC, et al. Relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. *JAMA*. 2010;303(17):1716-1722.

Higgins A, Stewart K, Dawson K, Bocchino C. Early lessons from accountable care models in the private sector: Partnerships between health plans and providers. *Health Aff (Millwood)*. 2011;30(9):1718-1727.

Himmelstein DU, Thorne D, Warren E, Woolhandler S. Medical bankruptcy in the United States, 2007: results of a national study. *Am J Med*. 2009;122(8):741-746.

Hirth RA, Grazier KL, Chernew ME, Okeke EN. Insurers' competitive strategy and enrollment in newly offered preferred provider organizations (PPOs). *Inquiry*. 2007;44(4):400-411.

Holliman DC, Dziegielewsk SF, Datta P. Discharge planning and social work practice. *Soc Work Health Care*. 2001;32(3):1-19.

Institute of Medicine. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*. Washington, DC: National Academies Press; 2012.

Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. *Ann Intern Med*. 2009;150(3):178-187.

Japsen B. MDs: Secret shoppers aren't cure. *Chicago Tribune*. June 16, 2008. http://articles.chicagotribune.com/2008-06-16/business/0806150176_1_secret-shoppers-doctor-patient-relationship-ama. Accessed January 7, 2012.

Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med*. 2009;360(14):1418-1428.

Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics*. 6th edition. New York: McGraw-Hill; 2006: 11.

Joynt KE, Jha AK. Who has higher readmission rates for heart failure and why?: Implications for efforts to improve care using financial incentives. *Circ Cardiovasc Qual Outcomes*. 2011;4(1):53-59.

Kansagara D, Ramsay RS, Labby D, Saha S. Post-discharge intervention in vulnerable, chronically ill patients. *J Hosp Med*. 2012;7(2):124-130.

Kautter J, Pope GC, Trisolini M, Grund S. Medicare physician group practice demonstration design: Quality and efficiency pay-for-performance. *Health Care Financ Rev*. 2007;29(1):15-29.

Kellogg KC. *Challenging Operations: Medical Reform and Resistance in Surgery*. Chicago: University of Chicago Press; 2011.

Kimbuende E, Ranji U, Lundy J, Salganicoff A. U.S. health care costs: background. http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx#Background. Accessed January 16, 2013.

Kocher R, Sahni NR. Hospitals' race to employ physicians--the logic behind a money-losing proposition. *N Engl J Med*. 2011;364(19):1790-1793.

Kocher R, Sahni NR. Physicians versus hospitals as leaders of accountable care organizations. *New Engl J Med*. 2010;363(27):2579-2582.

Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831-841.

Levinson W, Cohen M, Brady D, Duffy FD. To change or not to change: "Sounds like you have a dilemma." *Ann Intern Med*. 2001;135(5):386-391.

Limitation on certain physician referrals, 42 USC sec 1395nn.

Loden JC, Frederick RC. Clinical case: do secret shoppers have a place in medicine? *Virtual Mentor*. 2008;10(5):288-294. http://virtualmentor.ama-assn.org/2008/05/ccas5-0805.html. Accessed January 16, 2013.

Long SK, Triplett D, Dutwin D. *The Massachusetts Health Reform Survey*. Washington, DC: Urban Institute; 2008. http://www.urban.org/UploadedPDF/411649_mass_reform_survey.pdf. Accessed January 11, 2013.

McClellan M, McKethan AN, Lewis JL, Roski J, Fisher ES. A national strategy to put accountable care into practice. *Health Aff (Millwood)*. 2010;29(5):982-990.

McCullough LB. An ethical framework for the responsible leadership of accountable care organizations. *Am J Med Qual*. 2012;27(3):189-194.

Mechanic RE, Santos P, Landon BE, Chernew ME. Medical group responses to global payment: Early lessons from the 'alternative quality contract' in Massachusetts. *Health Aff (Millwood)*. 2011;30(9):1734-1742.

Medicare Payment Advisory Committee. *Report to the Congress: Physician-Owned Specialty Hospitals*; 2005. http://www.medpac.gov/documents/Mar05_SpecHospitals.pdf. Accessed November 26, 2012.

Medicare Payment Advisory Committee. *Report to the Congress: Physician-Owned Specialty Hospitals Revisited*; 2006. http://www.medpac.gov/documents/Aug06_specialtyhospital_mandated_report.pdf. Accessed November 26, 2012.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Pub L no 108473 sec 507(a), 117 stat 2066.

Medicare. Hospital Compare web site. www.hospitalcompare.hhs.gov. Accessed January 10, 2013.

More doctors, hospitals partner to coordinate care for people with Medicare [news release]. Baltimore, MD: Centers for Medicare and Medicaid Services Media Relations; January 30, 2013. http://www.cms.gov/apps/media/press/release.asp?Counter=4501&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date. Accessed January 18, 2013.

Moriarty H, McLeod D, Dowell A. Mystery shopping in health service evaluation. *Br J Gen Pract*. 2003;53(497):942-946.

National Federation of Independent Business v Dept of Health and Human Services, 132 S Ct 2566 (2012).

Naylor MD, Brooten DA, Campell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *J Am Geriatr Soc*. 2004;52(5):675-684.

O'Neill S, Calderon S, Casella J, et al. Improving outpatient access and patient experiences in academic ambulatory care. *Acad Med*. 2012;87(2):194-199.

Palmer Jr. HC, Armistead NS, Elnicki M, et al. The effect of a hospitalist service with nurse discharge planner on patient care in an academic teaching hospital. *Am J Med*. 2001;111(8):627-632.

Patient Protection and Affordable Care Act. 2010. Pub L 111-148, section 2702, 124 stat 119. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm. Accessed January 18, 2013.

Peabody FW. The care of the patient. *JAMA*. 1927;88(12):877-882.
Pear R. U.S. plans stealth survey on access to doctors. *New York Times*. June 26, 2011.
http://www.nytimes.com/2011/06/27/health/policy/27docs.html?pagewanted=all. Accessed January 7, 2012.

Perry JE. Physician-owned specialty hospitals and the Patient Protection and Affordable Care Act: health care reform at the intersection of law and ethics. *Am Business Law J*. 2012;49:369-416.

Physician Hospitals of America and Texas Spine & Joint Hospital, Ltd. v Sebelius, 781 F Supp 2d 431 (ED Tex 2011).

Polsky D, Grande D. The burden of health care costs for working families—implications for reform. *N Engl J Med*. 2009;361(5):437-439.

Prohibition on certain referrals by physicians and limitations on billing, 42 CFR sec 411.353(d) (2012).

Rhodes K. Taking the mystery out of "mystery shopper" studies. *N Eng J Med*. 2011;356(6):484-486.

Rosenbaum L, Lamas D. Cents and sensitivity--teaching physicians to think about costs. *N Engl J Med*. 2012;367(2):99-101.

Rosenthal MB, Landrum MB, Meara E, Huskamp HA, Conti RM, Keating NL. Using performance data to identify preferred hospitals. *Health Serv Res*. 2007;42(6 Pt1):2109-2119.

Rural Hospital Assistance Act of 2008, HR 6912, 110th Cong (2008).

Scheffler RM, Shortell SM, Wilensky GR. Accountable care organizations and antitrust: Restructuring the health care market. *JAMA*. 2012;307(14):1493-1494.

Sengupta B, Kreier RE. A dynamic model of health plan choice from a real options perspective. *Atlantic Econ J*. 2011;39(4):401-419.

Sinaiko AD, Rosenthal MB. Increased price transparency in healthcare--challenges and potential effects. *N Engl J Med*. 2011;364(10):891-894.

Snyder L; American College of Physician Ethics, Professionalism, and Human Rights Committee. American College of Physicians Ethics Manual: sixth edition. *Ann Intern Med*. 2012;156(1 Pt 2):73-104.

Society of Hospital Medicine. General information About SHM. http://www.hospitalmedicine.org/Content/NavigationMenu/AboutSHM/GeneralInformation/General_Information.htm. Accessed January 16, 2013.

Starr P. *The Social Transformation of American Medicine*. New York: Basic Books; 1982.

Stone J, Hoffman GJ. Medicare hospital readmissions: issues, policy options and PPACA. Washington, DC: Congressional Research Service; 2010. http://www.pascenter.org/publications/publication_home.php?id=1230. Accessed January 16, 2013.

The reconciliation act of 2010: report of the Committee on the Budget, House of Representatives, to accompany HR 4872. HR Rep No 111-443, at 4 (2010). http://housedocs.house.gov/rules/hr4872/111_hr4872_rpt2.pdf. Accessed January 22, 2013.

Thompson RE. Assault on the professional ethic: will professionalism survive? *Physician Exec*. 2007;33(5):80-82.

Thompson RE. *Healthcare Reform as Social Change: Why Successful Physicians and Health Care Executives are Retooling the Health Care Industry*. Tampa, FL: American College of Physician Executives; 1993.

Thompson RE. I swear by Apollo, the Hippocratic Oath is obsolete. *Physician Exec*. 2004;30(2):60-63.

Thompson RE. The ethics of exclusivity: should doctors practice concierge medicine? *Physician Exec*. 2009;35(5):96-99.

Ubel PA, Jepson C, Baron J, Hershey J, Asch DA. The influence of cost-effectiveness information on physicians' cancer screening recommendations. *Soc Sci Med*. 2003;56(8):1727-1736.

US Department of Health and Human Services, Office of Inspector General. *Financial Arrangements Between Physicians and Health Care Businesses: Perspectives of Health Care Professionals*. US Department of Health and Human Services; 1989.

US Department of Health and Human Services, Office of Inspector General. *Physician Owned Specialty Hospitals' Ability to Manage Medical Emergencies.* Washington, DC: US Department of Health and Human Services; 2008.

US General Accounting Office. Specialty hospitals: information on national market share, physician ownership, and patients served; 2003. http://www.gao.gov/new.items/d03683r.pdf. Accessed November 26, 2012.

van Walraven C, Bennett C, Jennings A, Austin PC, Forster AJ. Proportion of hospital readmissions deemed avoidable: a systematic review. *CMAJ*. 2011;183(7):E391-E402.

Wachter R. An introduction to the hospitalist model. *Ann Intern Med*. 1999;130(4 Pt 2):338-342.

Wachter RM, Goldman L. The hospitalist movement 5 years later. *JAMA*. 2002;287(4):487-494.

Wang SS. Health care taps "mystery shoppers." *Wall Street Journal.* August 8, 2006. http://online.wsj.com/article/SB115499684792929340-search.html. Accessed January 16, 2013.

Weinberger SE. Providing high-value, cost-conscious care: a critical seventh general competency for physicians. *Ann Intern Med*. 2011;155(6):386-388.

Wennberg JE, Fisher ES, Goodman DC, Skinner JS. *Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008*. Lebanon, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2008. http://www.dartmouthatlas.org/downloads/atlases/2008_Chronic_Care_Atlas.pdf. Accessed January 16, 2013.

Werner R, Asch DA. The unintended consequences of publicly reporting quality information. *JAMA*. 2005;293:1239-1244.

Woolhandler S, Ariely D, Himmelstein DU. Why pay for performance may be incompatible with quality improvement. *BMJ*. 2012;345(7870):e5015.

Virtual Mentor
American Medical Association Journal of Ethics
February 2013, Volume 15, Number 2: 180-182.

About the Contributors

Theme Issue Editor
Alessandra Colaianni is a third-year medical student at the Johns Hopkins University School of Medicine in Baltimore. Her research interests include medical ethics, medical culture, and narrative medicine. Prior to medical school, she worked at the Advisory Board Company, a health care administration consulting firm in Washington, D.C.

Contributors
David A. Asch, MD, MBA, is a professor of medicine and health care management at the Perelman School of Medicine and the Wharton School of the University of Pennsylvania in Philadelphia, where he is executive director of the Penn Medicine Center for Innovation. He is also a physician at the VA Center for Health Equity Research and Promotion in Philadelphia.

Laura Blinkhorn will receive her MD from the University of Chicago Pritzker School of Medicine in 2013. She plans to pursue a residency in family medicine.

Brian Chan, MD, MPH, is a senior resident at Oregon Health and Science University in Portland. He is interested in health services research in the areas of health care quality, policy, and systems improvement.

Cristie M. Cole, JD, is a 2012-2014 fellow in the Cleveland Fellowship in Advanced Bioethics affiliated with Cleveland Clinic, Case Western Reserve University, MetroHealth Medical Center, University Hospitals Case Medical Center, and the Louis Stokes Cleveland VA Medical Hospital in Ohio. She received her JD from the University of Arizona's James E. Rogers College of Law. Her current research focuses on the legal and ethical limits of procreative liberty in clinical practice, particularly in the context of vulnerable patient populations, emerging reproductive technologies, and disease management, as well as the legal and ethical issues in treating adolescent patients and direct-to-consumer genetic testing.

Matthew DeCamp, MD, PhD, is a postdoctoral fellow in the Division of General Internal Medicine and the Berman Institute of Bioethics, both at Johns Hopkins University in Baltimore. His research interests include global health, social media and medical professionalism, and ethical issues in health reform, including accountable care organizations.

Honora Englander, MD, is an assistant professor of medicine at Oregon Health and Science University and an internist in OHSU's Division of Hospital Medicine and

the Old Town Clinic, a federally qualified health center in Portland. She is the medical director for the Care Transitions Innovation (C-TraIn), a transitional care improvement program for uninsured and low-income publicly insured adults served by the Portland-area coordinated care organization.

Susan Dorr Goold, MD, MHSA, MA, is a professor of internal medicine and health management and policy in the Center for Bioethics and Social Sciences in Medicine at the University of Michigan in Ann Arbor.

David Harmon, MD, MPH, is a resident in internal medicine at Oregon Health and Science University in Portland. He graduated with a BA from the University of Notre Dame, did a stint with Americorps in Philadelphia, and completed a master of public health degree during medical school at the University of Kansas. Following graduation he will remain at OHSU as a teaching hospitalist with interests in transitions of care and resident education.

Marguerite Huff is a second-year medical student in the honors program in medical education at the Northwestern University Feinberg School of Medicine in Chicago, where she is involved in a variety of activities, including community health volunteering and clinical research. She graduated from Northwestern University in 2011 with a degree in statistics, which piqued her interest in biostatistics, quality control, and health economics.

Devan Kansagara, MD, MCR, is an assistant professor of medicine in the Division of General Internal Medicine at Oregon Health and Science University and a staff physician at the Portland Veterans Administration. He is interested in health systems improvement research, specifically in the area of transitions of care, and in evidence-based medicine.

Faith L. Lagay, PhD, has been managing editor of *Virtual Mentor,* the American Medical Association's monthly online ethics journal, for 12 years. Her doctorate in the medical humanities is from the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston.

Matthew McNabney, MD, is an associate professor of medicine at Johns Hopkins University in Baltimore, where he is medical director of the Program of All-Inclusive Care for the Elderly (PACE). He is also fellowship program director in the Division of Geriatric Medicine and Gerontology.

Shivan Mehta, MD, MBA, is an instructor of medicine in gastroenterology at the Perelman School of Medicine at the University of Pennsylvania in Philadelphia. He is also director of operations at the Penn Medicine Center for Innovation and has an interest in health system improvement and behavioral economics.

Hyeyoung Oh, MA, is a doctoral student in the Department of Sociology at UCLA. Her research interests include the sociology of health and illness, race and ethnicity, and organizational studies.

Charles A. Peck, MD, is a board-certified internist and rheumatologist who is managing director of Navigant Consulting. His background includes being CEO of a surgical and physician services company and a large academic multispecialty physician group, regional president of a national managed care company, and partner in a global health care consulting firm.

Neel Shah, MD, MPP, is chief resident in obstetrics and gynecology based at Harvard Medical School, Brigham & Women's Hospital, and Massachusetts General Hospital in Boston and the executive director of Costs of Care, Inc.

Richard E. Thompson, MD, has dealt firsthand with ethical dilemmas as a private practitioner, pioneer neonatologist, staff member of the Joint Commission, vice president of the Illinois Hospital Association, and hospital credentials and quality assessment consultant. He is an adjunct online instructor in health care ethics at Drury University in Springfield, Missouri. His publications include *So, You're on the Ethics Committee, A Primer and Practical Guidebook* (American College of Physician Executives, 2012).

Stefan Timmermans, PhD, is a professor and chair of the Department of Sociology at UCLA. He is author of the book *Saving Babies? The Consequences of Newborn Genetic Screening*.