

Virtual Mentor

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CLINICAL CASE

Practice Incentives and Professional Responsibility

Commentary by David Satin, MD, and Justin Miles

Drs. Adler, Jones, and Pollman routinely met to discuss their internal medicine practice. One discussion in particular focused on recent measures from Medicare that reward practitioners financially if they adopt new screening and prevention guidelines that result in fewer rehospitalizations and other outcome improvements. Ideally, each of the three physicians could decide whether to adopt the Medicare plan on his own, but since they see each other's patients, one doctor's abstention from the new measures would make it impossible for the others to comply.

If adopted, the new guidelines would significantly expand the amount of screening and prevention performed at each patient visit for many prevalent diseases such as diabetes, congestive heart failure, coronary artery disease, and hypertension. A diabetic patient, for example, would be subjected to 10 different screening or prevention measures, including management of HbA1c, blood pressure, lipids and cholesterol levels, eye and foot exams, immunizations for influenza and pneumonia, and a test for urine protein. Without the guidelines, the clinic doctors would perform only a few of the aforementioned tests, focusing on those indicated for a specific patient.

Since the majority of the clinic's patients are insured by Medicare, Drs. Jones and Adler both supported the new guidelines, arguing that the "pay-for-performance" plan will ensure more effective care for patients and simultaneously bring financial rewards for this small, busy clinic in an underserved, low-income community.

Dr. Pollman, on the other hand, was not supportive of the new measures. While he recognized the potential benefits to his patients, he could not imagine forcing his patients to undergo the extensive list of tests and procedures outlined in the Medicare plan. Providing medical care to patients is one thing, he argued, but assuming rigid control over their health care and subjecting them to strict regimens without offering a choice in the matter is frank paternalism.

Adopting the Medicare plan would mean applying the new guidelines to virtually every patient who visited the clinic. When Dr. Pollman asked his colleagues what would be done if a patient declined a particular screening measure, they suggested that such patients be weeded out of their clinic and referred to other health care centers. "We can't afford to allow our patients to weasel out of these rules," Dr. Jones argued. "Besides, it's not as if we're forcing harm on anyone. It's been shown

that systematic screening and prevention can significantly improve care, especially for chronic conditions like diabetes.”

Pollman felt torn between supporting his colleagues in a new plan that could bring more effective care to patients, but he was hesitant to adopt the blanket guidelines and compromise his patients’ rights to decide on screening and prevention for themselves.

Commentary

One of our favorite references is the bestselling popular economics book *Freakonomics* [1]. Its authors explain that there are three types of incentives: financial, social, and moral. The case at hand illustrates how tensions can develop when pay for performance (P4P) raises the possibility that these incentives may conflict with one another.

Drs. Adler, Jones, and Pollman struggle with aligning the financial, social, and moral incentives of a new P4P program that offers financial compensation for reaching particular clinical outcomes in their patients. First, they consider the financial benefits and burdens of adopting the P4P program, including maximizing P4P profits by reluctantly “forcing patients to undergo the extensive list of tests” and not allowing patients “to weasel out of these rules.” Second, there are social incentives to consider. Although not explicit in this case description, the social impact of scoring poorly on publicly reported measures often weighs heavily on clinicians who consider P4P programs [2]. Third, the doctors wrestle with the moral incentives. Drs. Jones and Adler cite the moral benefits of P4P to their patients’ health and the financial health of their clinic that serves a low-income, underserved community. Dr. Pollman, however, expresses concerns about the moral cost of transforming their practice into one that is paternalistic, performs unnecessary tests, and fires non-compliant patients.

Which incentive is most important: financial, social, or moral? As a bioethicist, I (Satin) am partial to the third, but this does not mean we should turn a blind eye to the first two. Moral judgments must take all factors into account, including the financial and social impact of our decisions. For example, if you knew in advance that participating in a voluntary P4P program would result in your clinic’s financial ruin or in you becoming a social pariah to your patients, it would be immoral to implement it, especially if the clinic served a patient population in great need. Therefore, the issue at hand can ultimately be understood as a moral question. For Drs. Jones, Adler, and Pollman, is participating in this P4P program ethical?

Eliminating Bad Choices and Facilitating a Good Choice

Although bioethicists cannot typically recommend a single best choice in cases as complex as this, they can eliminate clearly bad options. Bioethicists can also refine questions and clarify ethical issues to facilitate a good choice. This commentary illustrates how two common conceptual tools—respect for patient autonomy and

medical professionalism—can help eliminate some potentially bad choices described in this case, and refine a very specific question to facilitate a good choice.

Respecting Patient Autonomy

In this case, Dr. Pollman’s concerns about forcing his patients to undergo screening tests can be understood as a concern about respect for patient autonomy. Autonomy is not my (Satin) favorite conceptual tool. It is often wielded as a trump card to resolve moral dilemmas by alluding to the primacy of a patient’s right to self determination. But of course there are limits to patient autonomy. A patient cannot compel you to prescribe antibiotics for his or her viral pharyngitis. So when respect for patient autonomy appears to be an issue, one must narrow the scope of the discussion to a specific exercise of patient autonomy such as informed consent.

Informed Consent: Full Disclosure

The principle of informed consent says that clinicians must provide patients with full disclosure; that is the degree of information about the risks and benefits of treatment, non-treatment, and alternative treatments that a reasonable person in that patient’s position would want to know [3, 4]. Following this principle, the three clinic doctors would have to explain the risks and benefits of each screening test, alternatives to each test, as well as the risks and benefits of omitting each test. P4P reimbursements should not factor into the recommendation for screening tests. If a test is clinically indicated, physicians should recommend it and explain why. If it is not, physicians should not recommend it. So, are Medicare’s “10 different screening” tests clinically indicated? Only clinicians can answer that by examining the evidence from the literature and determining if it applies to each individual patient in light of his or her age, sex, and clinical conditions [5, 6]. Which screening tests are reimbursed under P4P changes neither the evidence nor the patient. If Dr. Pollman felt that a particular guideline was either scientifically invalid or did not apply to his patient, he ought not to have recommended it then and he ought not to recommend it now.

One reason P4P exists is to bring clinicians up-to-date on the importance of following particular guidelines. Many expect that P4P will accomplish with financial incentives what continuing medical education has so far failed to do. For example, why didn’t Dr. Pollman offer all 10 screening tests? If his concern was that 10 tests are too many for his poor, underserved patients, perhaps he should be concerned about his current paternalistic practices. If he chooses to focus on the “most relevant” tests, perhaps he should take note that Medicare has done that job for him, by employing hundreds of national experts selected by the American Medical Association who painstakingly combed through the primary literature and fiercely debated the evidence to determine the best screening tests, which were submitted for public commentary, third-party review, revision, and final submission to Medicare, who then further paired down the recommendations to the 10 most relevant tests [7]. Our question to Dr. Pollman and his colleagues is, “Why weren’t you recommending these tests before?”

Informed Consent: Non-Coerced Choice

Once patients understand the information that has been fully disclosed, they must make a non-coerced choice [3, 4]. Coercion is typically described as undue or inappropriate influence. If a patient must decide on a screening test under the threat of being fired from the clinic, I think most experts and laymen would call that coercion. Here Dr. Pollman's moral intuition is accurate in that, "assuming rigid control over their health care and subjecting them to strict regimens without offering them a choice in the matter is frank paternalism." Moreover, proceeding with an invasive test without obtaining proper informed consent is malpractice. Not only must the three doctors know the latest clinical guidelines, they must also determine which guidelines apply to each patient and facilitate a non-coerced decision by the patient.

Dr. Pollman is appropriately concerned by this daunting task. How will he and his partners feel if they make a concerted effort to meet the P4P measures only to be thwarted by their patients' right to self-determination? How will the clinic fare if it hires nurse educators to help facilitate informed patient choices, only to discover it missed the P4P bonus and cannot afford to keep its doors open? How will they cope with public reports of their poor performance on preventative health measures, unaccompanied by an asterisk denoting the demographic and clinical factors that contributed to the missed intervention? Indeed, what would enable clinicians to enter a quality improvement game they could lose?

Professionalism

All reimbursement systems create conditions for financial conflicts of interest [8]. The fee-for-service approach to reimbursement tempts us to see as many patients in as short a period of time as possible, while salaried clinicians are motivated to see fewer patients. Capitation tempts us to spend as little as possible on testing and treating patients. What keeps physicians from giving in to these temptations and maximizing profits? The moral ideal of professionalism.

As professionals, we have a fiduciary responsibility to patients—an implicit contract that places their interests above our own. Professionalism also entails self-regulation, whereby we pledge, both as individual physicians and as a group, that we will police ourselves. Quite simply, we promise not to lie, cheat, or steal. If we do, we expect colleagues to report us to medical boards who will sanction us for the protection of the public [9, 10].

The fact that physicians are professionals keeps us from gaming the system in P4P, despite financial and perhaps even social incentives to do otherwise. Britain implemented P4P in 2004, and a recent study suggests that its clinicians have not taken advantage of ways to game the system [11]. The professionalism of American physicians will be tested with every elderly patient whose risk of falling from hypotension outweighs the benefit of lowering blood pressure below the P4P target. Our integrity is at stake every time we consider not accepting into our practice a diabetic patient whose blood sugar is hopelessly far from the P4P goal [12].

Professionalism also entails that we strive to keep up with the latest improvements in patient care. The basis of requiring continuing medical education is our medical boards' commitment and therefore our commitment to maintain medicine as a reputable profession. Although professionalism does not demand that we participate in P4P, it does demand continuous quality improvement [9, 10].

Conclusions, Bioethics Style

P4P is one small part of a quality revolution dedicated to improving patient care through clinical outcomes measurement. With that in mind, we have seen that professionalism implies a moral imperative of continuous quality improvement. Moreover, it is unethical to improve outcomes at the expense of informed consent—either by withholding information that a reasonable person in that patient's position would want to know or by coercing patients with the threat of dismissal from the clinic. These are the bad choices that ethical reasoning exposes.

Now to refine a question that will help facilitate a good choice. A professional who chooses to participate in a P4P program must participate honestly. Even if P4P were to become mandatory, physicians would still have a professional obligation not to game the system, just as they do within our current systems of reimbursement. Drs. Adler, Jones, and Pollman have a difficult decision to make and need to consider many pragmatic factors discussed elsewhere [13, 14]. But to make a wise choice, the overarching moral question each must ask himself is, "Will my participation in this P4P program render me unable to fulfill my professional responsibilities?"

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