

A Perspective from Within the White Coat

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I do solemnly swear by that which I hold most sacred that I will be loyal to the profession of medicine and just and generous to its members. I will lead my life and practice my art in uprightness and honor, . . . it shall be for the good of the sick, to the utmost of my power, I holding myself aloof from wrong, from corruption, from the tempting of others...¹

—Oath of Hippocrates

One can easily generate a noisy and angry discussion in any physicians' dining room in the United States by bringing up the subject of managed care systems and their use of financial incentives to control physicians' behavior. Generally, the reaction will range from a palpable frustration among the younger physicians to a feeling of resignation in the senior colleagues. The latter group will then reflect back on the era before managed care, when compensation was on a *per diem* basis. The more vocal younger generation will continue to vent their spleens about the illogical and unfair nature of their compensation systems, and then realize that they must quickly return to their respective offices, lest their productivity be undermined.

Having entered clinical practice during the adolescence of managed care, I can provide one clinician's perspective, but cannot pretend to speak for all physicians. There are many of my colleagues who have taken to arms, securing M.B.A. degrees and reviewing HMO contracts every evening before bed. It is easy to discern who these people are: They talk about covered lives, contractual withholds, and capitation systems. I am not among their number. Naïve as it is to say, I chose to enter medicine to take care of patients, and I assumed that I would be compensated fairly and live comfortably. If indeed, I had wanted to maximize my future income, I would have sought my fortune in the business world, or failing that, the legal profession.

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I am a general internist, a physician for adults, spending most of my time in the office setting seeing scheduled patients. Approximately 40% of the patients for whom I provide primary care are insured by managed care programs. An equal fraction are insured through Medicare, Medicaid, or commercial insurance. Finally, a significant, but small proportion have no insurance at all. The managed care patients belong to one of perhaps a dozen different plans with which I am enrolled, each with their own panels of specialists, drug formularies, laboratories for blood tests, and radiology facilities. The managed care administrators monitor my prescribing habits, compliance with recommended health maintenance measures (e.g., provision of influenza vaccines or screening mammography on appropriate patients), rates of hospitalization, and utilization of emergency room visits. They review data from pharmacies, office charts, and charges from hospitals and emergency departments. They prefer that I prescribe generic medications and keep patients out of hospitals and emergency rooms. They generate utilization reports on an annual basis, comparing my practice patterns to national averages.

I like to believe that I treat all patients the same, regardless of their insurance. However, there are very practical economic dilemmas that I face on a daily basis. For patients who do not have a prescription plan, generic medications are almost mandatory. A common example is the new class of arthritis drugs, which have the same effectiveness as the older ones, but do not have the potential side effect of causing stomach ulcers. However, the newer drugs cost \$3.00 a pill, whereas the older generic arthritis medications, such as ibuprofen, cost pennies a pill. HMOs allow me to prescribe the newer medications, but only after obtaining formal approval from their medical directors. Needless to say, this is a tedious and time-consuming process. Similarly, authorization must be obtained for subspecialty consultations outside of the primary HMO referral base. In general, the HMO medical directors are loath to approve such requests, claiming that similar care can be rendered within their plans. One example might be acute leukemia, a cancer that is optimally treated at special centers such as Johns Hopkins Hospital. However, the HMO may wish to restrict care to their local hospital, which can certainly treat the leukemia, but perhaps without the experience that Hopkins would provide. However, the HMO may have a pre-arranged contractual arrangement such that the local hospital takes care of all the HMO enrollees for a flat fee.

The unflagging responsibility of a primary care physician is that of the patient's advocate. Indeed, that is part of Hippocrates' Oath. My goal is to provide quality care within whatever practical constraints exist for each

CASE STUDY—CHOW

individual patient. Such constraints might be lack of a prescription plan, dependence on public transportation, or presence of a language barrier. For each of these respective scenarios, I might offer sample medications provided by pharmaceutical companies, complete applications for bus passes for seniors, and provide language translation lines. Patients often need our assistance in extracting from their insurer what is rightfully theirs, such as medical equipment, access to home visiting nurses, or ambulance transportation. On the other hand, limiting referrals, laboratory testing, or consultations are important ways for HMOs to control costs. If the patient's HMO becomes an obstacle to provision of what I perceive to be optimal care, then I must try to petition the medical director to allow an exception. If the HMO administrator chooses to deny payment for the more effective but higher cost radiology study or medication, then the HMO should be liable for any adverse outcome related to that decision. For example, if the HMO declines to pay for the aforementioned new arthritis medication, and the patient develops a gastric ulcer on the traditional arthritis medication, then the fault lies with the HMO. However, if I neglected to request authorization for the new arthritis medication, then the fault lies with me. In general, the HMO fully realizes this position, and will allow higher cost expenses when necessary. However, the effort spent on the application, and the time delay of days to weeks in securing approval, can be frustrating. Offices with at least three general internists usually have at least one administrative staff member dedicated entirely to managing referrals.

What limits the expense and breadth of my treatment for each patient? In general, there is an accepted standard of care for most clinical situations. This prevents physicians from ordering MRI scans of the head for every patient with a headache, or CAT scans of the abdomen for each patient with "stomach" pain. Physicians also have a responsibility to society to limit utilization of medical resources and practice in a cost-effective fashion. However, that responsibility is distinct from any responsibility physicians may have to the HMO to reduce costs. The HMO may well have a fiduciary responsibility to its shareholders to maintain profit and reduce costs, but in the optimal situation, its health care providers should feel beholden only to the well-being of the patients in the plan.

Any incentive that compromises the physician's role as the patient's advocate creates an untenable position. Contractual arrangements with HMOs are complex and varied, but many have incentives that attempt to influence physician behavior. According to a survey of California physicians in 1996, 38% reported having financial incentives in the form of a bonus, yielding a median of 7% (or approximately \$10,500) of net

practice income.² It is entirely reasonable to provide financial incentives to reward those physicians who work harder for the betterment of their patients. Examples of acceptable incentive programs are those tied to patient satisfaction results or productivity parameters. Measurement of quality of care is a controversial and inexact science, and all medical systems find inherent difficulties in developing an ideal incentive system.

Clearly, incentive programs that seek to improve the financial status of the HMO may, at times, directly conflict with patients' well-being. For example, consider a physician who has 10% of his salary withheld each year, but is eligible to receive the lump sum at the end of the year if he meets certain targets in terms of hospital and emergency room costs. This physician may feel conflicted at the end of the year if he is on the verge of qualifying for his "withhold," and is evaluating ill patients who might otherwise benefit from hospitalization or emergency room visits. If the physician errs on the side of not hospitalizing ill patients, and an adverse event occurs, then who is at fault?

The *Pegram* decision holds that the physician alone is liable. Most clinicians do not agree with this decision, but that may be related to their dissatisfaction with managed care in general. I hope the focus and attention that *Pegram* brings to this issue will make physicians reconsider their contractual relationships with their respective managed care systems. I believe clinicians will want to avoid such adverse financial incentives based on ethical standards alone, and seek alternatives that reward hard work and quality of care. If physicians decline to participate with those managed care programs that utilize financial disincentives, such programs will have fewer providers from which patients may choose. Programs with limited panels of physicians will be less desirable to potential patients. If such incentive programs continue to exist, the *Pegram* decision will reinforce the responsibility of physicians to provide high quality care, irrespective of the impact of the cost of that care on the physicians' reimbursement.

Although ill-received by physicians, the *Pegram* decision should not significantly alter the practice of medicine. If the *Pegram* decision ruled that the HMO was liable, this would become a cloak behind which poor medical decisions are substantiated. I hope that little will change in the day-to-day practice of medicine as a result of this decision; that clinicians will continue to treat in their patients' best interests rather than in their own. As long as there are concerns about the cost of health care, efforts will continue to control costs. Physicians must individually and in unison guard against these efforts if patient care is jeopardized as a result.

CASE STUDY—CHOW

References

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2. Kevin Grumbach et al., *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516 (1998).