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Abstract

WHEN AND WHY PHYSICIANS DECEIVE: INTERACTIONS WITH THIRD-PARTY PAYERS.

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Background and Aims: Physicians may sometimes manipulate reimbursement rules, game the system and deceive third-party payers (TPPs). Our aims were to characterize the diversity of deceptive tactics physicians use, identify the goals that physicians seek to achieve through these actions, and to analyze the language and justifications that physicians employ when describing such deceptions.

Methods: This was a qualitative study based on purposeful sampling using open-ended interviews and the constant comparative method of qualitative data analysis. Interviews were conducted until the point of theoretical saturation with 24 physicians in greater New Haven, Connecticut who were selected to reflect breadth of specialty, professional setting, gender and years in practice.

Results: Deception of third-party payers was self-reported by almost all physicians interviewed, with a frequency of deceptions ranging from zero to 275 times over the past year. Physician reported deceptions were diverse and involved all aspects of the physician-patient encounter. Physicians employed deceptive tactics to achieve four primary goals: 1) relieve patient financial burden, 2) relieve other burdens of care, 3) protect patient privacy, and 4) increase physician reimbursement. Justifications for deceptive actions included 1) for patient benefit, 2) to preserve physician autonomy and 3) because the system was broken. Physicians often used euphemisms to describe their deceptive actions.

Conclusions: These findings are concerning for patient-physician trust and raise challenges to physician professionalism. Physician deceptions of third-party payers have implications for health care policy and medical research. The use of deception may be a barometer of those areas where the dissonance between care and rules have become so severe that physicians see violating their professional codes as the only way to do their jobs.

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Introduction and Statement of Purpose

Physicians who "manipulate"(1) reimbursement rules, "game the system"(2) or "deceive"(3) third-party payers (TPPs) have garnered much attention lately.(4-11) Such physicians are depicted both as noble advocates seeking to secure care for patients within an incomprehensible health care system(5) and as greedy professionals manipulating that system for their own gain(4, 6). Some argue that these behaviors can be justified by unfair or illegal rules and burdensome paperwork(7). Others insist that manipulative or deceptive tactics violate ethical physician conduct(12) potentially undermine the physician-patient relationship, and place the medical profession at risk(2).

Although this type of behavior goes by many names, each implying varying degrees of ethical misconduct and illegality, gaming, manipulation and deception of TPPs clearly happens(1, 3, 13, 14). In a random national sample of 720 practicing physicians, 39% reported that they had manipulated reimbursement rules to help patients secure coverage for needed treatments or services in the last year(1). Manipulations included exaggerating the severity of the patient's condition, reporting unfounded signs or symptoms, or changing the patient's diagnosis for billing purposes(1). In another study, 50% of primary care physicians reported that they had substituted another diagnostic code for major depression in the billing of services for at least one patient within the previous two weeks(14). Studies based on hypothetical vignettes(3, 13) also suggest high rates of TPP "deception" to obtain coverage for procedures such as coronary artery bypass graft surgery and arterial revascularization(3).

Relatively little is known about the goals of such physician actions. It has been reported that physicians deceive because of uncertainty about diagnoses, problems with

reimbursement when certain diagnoses are used,(14) and a desire to obtain additional coverage for patients.(3) It has also been hypothesized that physicians "game the system" when resource rules do not serve patient needs or when they perceive needless obstacles to care(2). How physicians justify their deceptive actions and the specific language they employ when talking about deceptions has also not been reported.

We undertook a qualitative study with the aims of 1) characterizing the range of deceptive tactics physicians use in their interaction with TPPs, 2) identifying the goals that physicians seek to achieve through the use of such tactics, and 3) understanding the justifications physicians give for deceiving the language they employing when discussing the topic of deception. In this study we asked physicians to describe instances when they believed themselves or others in their profession to have been "deceptive" with TPPs. We allowed physicians characterize the meaning of deception with their stories. How and why physicians deceive third-party payers are important questions relevant to the physician-patient relationship, physician professionalism, health care policy, patient rights, and medical research. A fuller understanding of deceptive behavior might enable policy makers and individual physicians to modify their positions and practices to better serve the needs of their patients and the profession.

Methods

Study Design and Sample

This was a qualitative study based on open-ended interviews that I conducted with physicians in greater New Haven, Connecticut during July and August of 2000. The qualitative approach was chosen to enable the comprehensive description of the range of tactics used to deceive third-party payers, as is not available in the existing literature. Qualitative methods are well suited for exploratory, descriptive studies for which previous literature is limited(15). In addition, we anticipated that such deceptive tactics would be multifarious and difficult to measure; qualitative research can useful for describing diverse facets and dimensions of such behaviors(15, 16). Such studies are also useful for generating hypotheses that can later be tested with quantitative data(15, 17).

The study employed purposeful sampling as is standard in qualitative research(15, 17). Physicians were selected to reflect breadth of specialty (primary eare physicians, specialists), professional setting (academic, private, solo practice, group practice) gender, and years in practice. Additional physicians were interviewed until no new concepts were identified, i.e., until the point of theoretical saturation(17). This occurred after 24 interviews.

Data Collection

In-depth, open-ended interviews were conducted in person with physicians, typically at their offices. I conducted the interviews after having been trained in qualitative interviewing skills using a standard interview guide with probes for clarification and additional detail. Interviews were audiotaped and professionally

transcribed. The interview guide (Appendix 1) began with the broad question, "In your field, what practices are you aware of that could be perceived as being deceptive of third-party payers?" If physicians did not describe personal examples they were then asked if "anything you have done could be perceived as being deceptive." TPPs were defined as governmental insurers (e.g., Medicare, Medicaid), managed care organizations, and indemnity insurers, i.e., any organization that pays health care costs that would otherwise fall to the individual patient. For each deceptive tactic described, physicians were asked to illustrate their experiences with specific stories or vignettes and were asked to describe their reason for using the tactic.

Data Analysis

The interview audiotapes were professionally transcribed. These transcribed data were analyzed using common coding techniques for qualitative data and the constant comparative method of data analysis(17). Dr. Bogardus and I independently coded each transcript and then met to review transcripts in joint sessions. Each successive interview was analyzed shortly after completion to refine coding categories and modify the interview guide for succeeding interviews. When coding of transcripts differed, consensus was achieved through discussion. New codes were added when new concepts were identified. Old codes were sometimes modified to accommodate new data. An initial code list was empirically derived from the first three interviews. This code list was reviewed by the full research team (myself, Dr. Bogardus and Prof. Bradley) and then updated and refined by Dr. Bogardus and myself as each additional interview was analyzed. I then entered coded data were in NUD-IST 4 (Sage Publications Software,

Thousand Oaks, California) to assist in reporting recurrent themes, links among themes, and supporting quotations. During its development, the code list was reviewed two more times by the full research team for logic and breadth. A total of 506 specific codes organized within 34 themes were developed and served as the basis for the final text review and organization of the transcript data.

Several techniques were used to ensure that data collection and analysis was systematic, as commonly recommended by experts in qualitative research(16). These included use of a consistent interview guide, audiotaping interviews, independent transcription of the audiotapes, and standardized coding and analysis of data. In order to document analytic decisions, hand-written notes on printed transcripts showing each researcher's coding, as well as changes to reach consensus, and records of each version of the coding scheme were maintained. Some quotations reported here have been edited for clarity and readability.

Results

Participant Characteristics

Participants were 24 physicians from the New Haven area (Table 1). Nine were women, and seven were academic physicians. Participants practiced in primary care fields (internal medicine, pediatrics, obstetrics and gynecology) and specialty fields (general surgery, psychiatry, medical oncology, dermatology, cardiology, gastroenterology, geriatrics and otolaryngology). Participants had been in practice for between two to 25 years and saw between three to 160 patients per week. The size of the

practices in which participant physicians were employed ranged from solo practices to those as large as 16 physicians.

Existence of Deception

Deception of third-party payers was self-reported by almost all physicians interviewed. Physicians of both genders, across all specialties, both in academia and private practice, and of a varying lengths of practice reported using deceptive tactics some of the time. Frequency of deceptive tactics varied widely; when asked to estimate the number of times they had deceived third-party payers in the past year, physicians reported a range from zero to 300 times. One gastroenterologist who reported using no deceptive tactics explained himself as follows:

> *I think it is a slippery slope, and although unethical means may justify ethical ends, it can become increasingly a challenge to make those distinctions. It's much cleaner, more comfortable and more professional to get what you want truthfully.*

Although a few physicians reported using deceptive tactics with third-party payers at least once per week, most reported their use as a relatively infrequent event.

Diversity of Deceptive Tactics

The diverse array of deceptive tactics reported by physicians can be described by three fundamental characteristics (Table 2). The first pertains to the location within the patient assessment where the tactic was used. The second pertains to the type of service that physicians were attempting to augment. The third characteristic pertains to the method of documentation used to enact the tactic. These characteristics can be used in concert to describe each deceptive tactic.

Patient Assessment

Each step in patient assessment -- history, symptoms and diagnosis -- was subject to use in a deceptive tactic. For instance, an internist describes misrepresenting a date in a patient's history:

> *He came to see me because he had tested HIV positive a month ago. I wrote that down, and then he said," to be honest, I really found out last summer, but I don't want you to put that down, because I applied for insurance in September"... In that situation I did not document the earlier test.*

In another example, a psychiatrist indicates that he would describe non-existent symptoms to prolong treatment:

> *I'm thinking of one lady where her being better is a function of continuing treatment. If she didn't have treatment, all of her symptoms would come back. So I describe the symptoms that I think would come back. But they're not asking, "What do you think would come back if treatment stopped?" They're saying, "What are you treating?" So I answer it differently.*

Type of Service

Physicians used deceptive tactics primarily around three types service: health maintenance visits, screening tests and treatments. In this example an internist describes obtaining coverage for a health maintenance visit by using a different diagnosis:

> *I've probably seen a patient in follow-up for depression and marked down a more extensive exam, say for health maintenance and billed for depression. And I'll say to the patient, "You're going to see on your bill today, 'depression.' Even though that's not the focus of the visit, that's what I'm billing for."*

In another example, a gynecologist describes misrepresenting a patient's sexual history to obtain coverage for a screening test:

> *There are places where you can check off that someone is at high risk for cervical cancer because they have had multiple sexual partners. And that's an easy one to*

do because they are never going check and ask the woman, "how many sexual partners?" They will assume that that's between me and the patient. And, of course, I ask the women, "whether or not this is true, we're not going to pry into your personal life, but this will get you coverage. Is that all right?"

Mode of Documentation

Physicians reported deceptive tactics involving misdocumentation of forms and misdocumentation of the medical record. This oncologist describes misdocumenting a form to obtain a necessary treatment:

I give chemotherapy to a patient with non-Hodgkin's lymphoma, and I know 10 days later their white blood cell count is going to get low. And, I know that they need to be treated on GCSF to stop that from happening. Medicare won't let me do that until the second time I treat them, but I know it's going to happen the first time. So, you have to say they are neutropenic so that you can treat them even if they are not.

In another example of form misdocumentation, an internist describes securing coverage for a particular medication:

It may be that (the medication) is only indicated for peptic ulcer disease and if I'm giving it to somebody for GERD I'll write on the script "for peptic ulcer disease" instead of GERD because I feel that this medication is indicated in their situation.

Goals of Deception

Analysis of interviews suggested that physicians employ deceptive tactics with third-party payers to achieve at least one of four primary goals: relieving patient financial burden (including expanding patient coverage), decreasing other burdens of care, protecting patient privacy, and increasing physician reimbursement (Table 3). For a given deceptive tactic, physicians may have multiple goals.

Reduction of Patient Financial Burden

Reducing patient financial burden related to well-visits, diagnostic screening tests, treatment of chronic conditions, and medications appeared to be a common goal of physicians' deceptive tactics.

Often, patients must pay out of pocket for well-visits. A physician describes his own experience as a patient in this situation:

> *I went to see my physician for a routine physical. At the end the bill said, "diagnosis of chest pain" and so I said "I didn't come for chest pain." They said, well that is the only way we can get the EKG and all the other things paid for. So I think (this kind of thing) is rapid and routine... but I was aware even as a patient that this made me uncomfortable.*

Physicians also frequently employed deceptive tactics in order to get diagnostic screening tests covered by TPPs. Screening tests mentioned included PSA antigen test, thyroid stimulating hormone, colonoscopy, bone density scan, Pap smear and electrocardiogram. Physicians deceived when patients did not meet third-party payer criteria for coverage of the desired diagnostic test, but the physician felt the test was necessary. A gastroenterologist describes the commonly reported strategy of making up a symptom that the physician knows will trigger coverage, in this case for a colonoscopy:

> *There are patients who don't meet those strict criteria by the letter of the policy, but come awfully close, in whom you really want to perform a screening colonoscopy as opposed to a flexible sigmoidoscopy or barium enema, both of which are inferior. As a result, you often want to do this procedure, but are aware that there is great risk the insurer will not cover it. Rectal bleeding is an indication for a colonoscopy. It would not be a "screening colonoscopy in an asymptomatic individual," it would be to "evaluate rectal bleeding."*

A third way that physicians reported reducing patient financial burden was by expanding coverage of chronic conditions (e.g., obtaining additional hospital days, access to restricted medications, additional physician visits). Physicians described choosing the

diagnosis associated with the most coverage from among those diagnoses, which conceivably fit the patient's condition. A medical oncologist describes how he will sometimes contravene his best guess, and instead report the diagnosis that provides the broadest coverage for the patient:

> *They will not pay unless there are clear indications that this medicine works. If it is not on the FDA list, they will not pay for it. And, you sort of can't get around that short of giving them the wrong diagnosis, which I have done sometimes when it is not clear what the diagnosis is. Such as someone who has a carcinoma of unknown primary—it could be coming from their lungs because they are a smoker and I want to use a medicine that I know they will pay for so I'll call it a lung cancer. It might be, but it might not be.*

Another area where physicians reported reducing patient financial burden by employing deceptive tactics with TPPs was medication prescriptions. Physicians sometimes try to obtain coverage for medications that may be more effective, but more expensive. They also may try to avoid burdensome medication changes or may try to satisfy patient preference for a brand-name medication. An internist is describes one such situation:

> *A patient called and said I want my inhalers renewed, but I don't like this one, I like another one, and they only will pay for this one, so would you please write and say that I didn't do well with other ones. I didn't know which other ones she has tried, I've never met this patient, so I just said you have to tell me. Now that's sort of a little bit gray, because I haven't tried her on those myself, I didn't have office visit notes that documented that.*

Relief of Non-Financial Burdens of Care

A second, less frequently reported goal of physicians' deceptive tactics is relief of non-financial burdens of care for patients. In serving this goal, there may not be a direct financial benefit to either the physician or the patient, but TPPs are deceived in order to

ease travel or time burdens that patients endure as part of care. A medical oncologist describes one example of increasing the convenience of care:

> *So on a weekend we will sometimes give people these drugs to give themselves...which is technically illegal. We don't bill for giving them the drug, but we will bill for the drug itself. And then I just write an ambiguous note—patient received 480 mcg of Neupogen. Supposedly you cannot bill for it unless you are there in the office getting it and we have done that because it is a real pain in the ass for a patient if they live 30 miles from here, to drive in here on a weekend to get a shot that they can certainly do themselves, like giving themselves insulin.*

An internist provides another example, also meant to save the patient a trip to the office:

> *But, sometimes people will call for referrals, and I think if you're really upstanding you would say come on in, let me see you, I'll see if you need the referral. Sometimes I just make the referral, and just based upon what the patient tells me over the phone, so I suppose that's a little deceptive.*

Protection of Patient Privacy

A third common goal was to protect patient privacy from third-party payers. Deceptive tactics with this goal typically took the form of withholding information from a patient chart to keep embarrassing or personal information strictly between the physician and the patient or to avoid denial of access to unrelated opportunities (employment, life insurance, etc.). In this first general example, a psychiatrist explains the rationale for understating a diagnosis:

> *I think a physician might choose the lesser, I mean if there were some gray area, I might choose the less severe diagnosis in order to protect patient confidentiality and not have something potentially stigmatizing on their record.*

A more specific example was given by this pediatrician:

> *There is another issue around asthma which again involves a ton of cheating. What is asthma? You do not know and I do not know because there are not any clear boundaries to it, but there are tremendously powerful issues that are associated with the naming, the naming of things. If I say that you are an eight-year-old kid and I say that you have asthma, you may never get into the Armed Forces. You may have terrible trouble 30 years from now getting a life insurance policy and so in a way, I cheat because I never put down asthma as a diagnosis until the kid has been to the Intensive Care Unit.*

Increasing Physician Reimbursement

A fourth goal of deceptive tactics was to increase physician reimbursement for services provided. These practices include submitting a code for a more remunerative service than the one actually provided ("upcoding"), performing unnecessary services so that more remunerative codes can be accurately submitted, editing past documentation so that audit penalties will be avoided, and failing to correct past reporting errors in the physician's favor. Physicians interviewed for this study spoke less frequently about this specific goal of deception than they did about expanding patient coverage. An otolaryngologist reported the following:

> *One possibility would be doing more than you need to do. For example, there are two types of ethmoidectomies that you can do—an anterior ethmoidectomy or a total ethmoidectomy. And you can often tell by the scan—the pre-operative CT scan--which are involved—just the anteriors or is it all of the ethnoids? If just the anteriors are involved, do you just do an anterior ethmoidectomy or do you go ahead and do a posterior ethmoidectomy because you get paid more for that? And I'm sure that goes on.*

Here a physician described replying to a medical record audit of breast cancer cases and providing missing information about location of the primary tumor so that his practice would not be fined:

> *So a lot of them we found. And if I didn't find it, I figured, statistically, upper outer (quadrant) is most common. Did I lie? I guess I might have. I don't know. They did the same thing with lung cancer and colon cancer. And I'm convinced*

that all they're trying to do is avoid paying. It has nothing to do with the care of the patient.

In the following instance, a physician describes an historical reporting mistake that benefited his office financially. Even after it was discovered, it was not corrected:

I realized at one point my staff were not correctly coding and were not correctly billing some things and that effect was that probably in some instances things were billed out at a higher code than they probably should have been billed out. Once I discovered that, and we talked it over in the office, and we set clear guidelines, we certainly didn't go back and correct it.

Justifications for Deception

Physicians explained the actions they undertook in pursuit of these goals with three common justifications. First, many physicians justified their deceptions based on the perceived medical, social or financial benefits to patients. Second, physicians justified deception as the only way to maintain their autonomy to make medical decisions. These two themes often overlapped and many physicians reported that they deceived because they felt they needed to freely exercise their medical judgment in order to assure high quality patient care. And third, physicians stated that deceptions could be justified when the health care system was perceived as broken or irrational.

Benefits the Patient

Many physicians attempted to morally ground their deceptions based upon the argument that anything that benefits that patient is acceptable. A representative example of this general theme was given by a pediatrician:

I think it's because they actually think that the patient needs care and that the insurance company or Medicare is not going to give it to them. And I think that's the managed care, again, tying our hands behind our backs and not letting us be

doctors, not letting us do what we're trained to do and do what's best for the patient.

An obstetrician justifies deception in this example by explaining how it socially benefits the patient:

Yes, either I think the patient is unstable to go home or because of illness in her child and because of post-partum patient, we try to justify an extra day in hospital so that somebody that lives far away can easily be right here with a critically ill newborn.

Physicians also justify their deceptions by arguing that patients benefit medically. In this representative example a surgeon feels he can only provide appropriate medical care by misrepresenting the size of a tumor:

There are certain health care plans that will not allow you to take it out in the operating room unless it is over 3 cm. And so if it is 2.5 cm, I feel it is too big for the office, so there I may say it is 3 cm, when in my mind, it is probably 2.5 cm. Because otherwise then I have to take care of it in the office and I think it is too much for the office and I think it is unsafe in the office.

Sometimes physicians justified their actions by citing their role as patient advocates. An obstetrician/gynecologist describes why she deceives to gain coverage of routine visits for a subgroup of her patients:

I kind of feel like I am the elderly advocate. Because they are the ones with the most problems, and often times...they can't read their policy, their hearing is impaired, they don't have the energy to fight Medicare... They need the most help.

An internist describes her commitment to patient advocacy:

I think that doctors feel rightly or wrongly that by doing the deception, they're really advocating for their patients. I don't think I would stick my neck out to the tune of a potential audit and the money that I may end up losing ... and even go to jail if, in my heart, I didn't think my patients were the ultimate benefactors of that.

Preserves Physician Autonomy

Physicians frequently justified their deceptive actions by stating that their autonomy is threatened by restrictive third-party payer rules. Here a surgeon justifies deceiving to obviate a prescribed length of stay:

> *If I am uncomfortable, if I am not ready to discharge a patient, I don't like being told by a third-party payer that that its time for him to go, because they don't know the situation well enough.*

An internist justified getting around a restriction on medication prescription by asserting her right to prescribe the right medication for the right situation:

> *It is the exact same medication, but for a different indication and I just don't think that the third party payer has a right to tell me for what reason I can prescribe a medication; it drives me crazy, it makes me really mad, so I just order it.*

This internist justified her deception by asserting her right to make her own value judgment in a complex situation:

> *There were competing values; the competing value of honesty, the competing value of serving this person, who had complexity in his life. There was a need to override the cost consideration with the ease consideration and what was I dealing with here.*

Broken System

Similarly, physicians cited a faulty system and irrational rules as a third justification for their deceptions of third-party payers. A medical oncologist described this situation as follows:

> *There are these arbitrary categories of things that they will and will not pay for and decisions are made on payments, not on any kind of real medical basis that I can figure out. Again, so I don't feel that bad if I do something like that because I don't think I am defrauding the government because I'm giving people treatment that they need with drugs that are indicated for that problem.*

An internist also explained such a justification quite bluntly:

> *I thought that the rule was stupid, because why should he not get insurance, I will be damned if I was going to take part in that. To what end? So that he wouldn't get insurance to pay for his HIV care, so that I could follow a rule. The values were way off here.*

Euphemisms: the language of deception

Physicians often described actions that they perceive to be deceptive of third-party payers using euphemisms. One physician described his deceptive action this way:

> *Yes, I have written notes in the charts that have been, I guess in politics they call it "spinning the patient's condition" to justify her spending more time than I thought she needed in the hospital. There is no personal gain for me. It is the way I think is in the patient's interest.*

Other examples of euphemisms used to describe deceptive tactics include "inflating up the truth," "sort of how you spin it," "go the extra mile and stretch the truth a bit to get that done," "if I think I can stretch it a bit I will," "I am sure I have embellished," "stressing more whatever the side of it that really needed to be stressed," "there is another way of sort of finessing things that hovers on the edge of troublesome," and "create more of a diagnosis than there was."

Discussion

Overview

The results of this study are consistent with previous work demonstrating that physicians use deceptive tactics with TPPs and expand on that work to elucidate the goals, justifications and language of deception. Physicians of diverse background, specialty and practice setting reported the use a wide range of deceptive tactics in their dealings with TPPs. These tactics can be located in three separate aspects of the

physician-patient encounter (Table 2): patient assessment, type of service, and mode of documentation. Additionally, this study finds that deceptive tactics are not limited to a few select scenarios but are employed to gain coverage for services, particularly well-visits, screening tests and access to medications. Although the variety of deceptive tactics varied widely, four goals (Table 3) emerged as the fundamental reasons that physicians use such tactics with TPPs: expanding coverage and/or decreasing patient financial burden, decreasing other burdens of care, protecting patient privacy, and increasing physician reimbursement. Though the majority of deceptions were undertaken for the betterment of patient care, some were purely for financial gain.

When explaining the need to use deceptive tactics, physicians gave three common justifications: doing what is best for the patient, maintaining their autonomy, and working within a broken system. Analysis of the language used by physicians to describe their own deceptions revealed frequent use of euphemisms. Overall, physician self-reporting of deception of third-party payers raises concerns about the physician-patient relationship and physician professionalism and has important implications for health care policy and medical research.

Potential Response to Deception

One response to these deceptive tactics might be increased oversight of physician behavior. Current anti-fraud initiatives have been successful at reducing the Medicare error rate(18) through both fear of penalty and through the sentinel effect(19). However, the current focus of prosecution is on providers who systematically commit fraud(20). Oversight sufficient to detect the subtle deceptions described in this study may be so

financially costly and so burdensome to the profession (e.g., further loss of physician autonomy, decreased physician satisfaction due to increased scrutiny(20)) as to be unworkable. It may be more fruitful to consider the impact and root causes of physician deceptions in order to arrive at a more trenchant proposal for reform.

Physician-Patient Relationship

These findings are concerning for the patient-physician relationship. Although some patients may receive additional, necessary care as a result of deceiving physicians, the distribution of this care is necessarily haphazard. Patients without deceptive physicians may suffer as deficient areas of care are managed subversively on a case-by-case basis rather than challenged openly in hopes of changing the system for all. For this reason, some patients may find themselves drawn to physicians who will use deceptive tactics for patient benefit.

The impact of deceptive tactics with TPPs on patient trust needs to be determined. Patients may find comfort in joining with their physician against an unsatisfactory TPP. Or, patient trust in their physician may suffer when the patient is aware of physician deception. Patients who do not trust their physicians may withhold information crucial to their own care and take costly steps to guard against poor care, such as obtaining multiple opinions(21) and pursuing complaints against physicians. Along with the risk to individual relationships between physicians and patients, we must also be concerned for the general perception by the public of deceiving physicians, even in those cases where the motivation is clearly to improve patient care.

Physician Professionalism

These results also reflect severe challenges to the medical profession under the current health care environment. The notion of professionalism can be defined as 1) a specialized body of knowledge, 2) control over training and labor markets and 3) devotion to a public good or "higher calling."(22) Added to that, Freidson describes the "soul of professionalism" as the "freedom to judge and choose the ends of work.."(22) For many physicians, the demands of the managed care combined with the emergence of consumerism as a driving force in health care has weakened their role as professionals. In justifying their deceptions, these physicians direct us to two specific challenges. In citing a desire to do what is best for the patient, physicians justified their actions by claiming they were otherwise unable to maintain their devotion to a higher calling or patient advocacy. In citing their need to maintain autonomy regarding medical decision making, physicians exhibit frustration with a loss of control over the ends of their work.

But physicians who deceive TPPs, while struggling nobly to maintain their professionalism, are sacrificing other values central to the profession: truth and integrity.(23) Stephen Carter defines integrity as (1) discerning right from wrong, (2) acting on the right (even at a personal cost) and (3) stating openly that you are acting on your understanding of the right.(24) While the physicians in this study may succeed at discerning right from wrong and acting on their decision, they fail to be open about their actions. Whether this is for fear of prosecution or for fear of being judged by those inside or outside the profession, we do not know. They deceive quietly and their integrity suffers.

Deception as Euphemism

Not only are these deceptions reflective of challenges to the profession as a whole, but they also reflect an internal struggle within each individual professional. By examining the language that physicians use to talk about deception, we gain some insight on this struggle. We found that physicians frequently used euphemisms when discussing deception. Euphemisms substitute "an agreeable or inoffensive word or expression for one that is harsh, indelicate or otherwise unpleasant or taboo."(25) "Stretching the truth" sounds much more palatable than "lying," especially to a professional whose core value is truthfulness. As Allan and Burridge explain, speakers often use euphemisms as a protective shield against the anger or disapproval of others.(26) These physicians feel under siege and the euphemism is a defense. The euphemism mitigates the internal struggle and protects the physician from external judgment -- but at what cost?

Stein comments further on the use of euphemism as a defense in a health care setting in *Euphemism, Spin and the Crisis of Organizational Life,* writing that euphemisms are "slippery language that humans devise to justify themselves to others."(27) Stein goes onto argue that the cost-control and efficiency championed by managed care are really an grand euphemism -- that is a sociologic structure created to obscure true purpose -- for our willingness as a society to leave the needy and sick outside the bounds of quality health care while keeping the rich and wealthy alive.(27) Thus, in his view "caring" and "managed care" are effectively incompatible. While this may be an extreme position, it is a useful framework to consider. One could argue that some physicians bridge this incompatibility (between their perception of appropriate

health care and the confines of TPP rules) with deceptions and then employ their own personal euphemisms to protect themselves from criticism.

Many physicians in this study sense that something is grossly amiss with the health care system, but their deceptions are themselves a euphemism -- a poorer, self-protective stand-in -- for battling the system openly. Thus, by committing secretive deceptions and compromising their integrity, they protect not only themselves from criticism, but the system as well. The result is not just unhappy professionals. Patient care may suffer from disgruntled physicians, the profession may lose current physicians to more satisfying careers, and future physicians may be dissuaded from entering the medical field altogether (or particular segments of the field such as the primary care specialties) when they learn of the loss of professional satisfaction.

Other Concerns

These physicians were well-intentioned and genuinely concerned with the care of their patients. Nonetheless, it is important to understand potentially indirect motivations to deceive. Patients are less satisfied and more likely to leave managed care plans, for example, when denied access to specialists(28). This reaction may extend to physicians generally, so that, as mentioned previously, those unwilling to manipulate the system lose patients to those who will. Deception may result in an indirect financial benefit to the physician, both from increased services and from increased practice size through returning patients and referrals. We studied both academic and community physicians, and both groups admitted to deceptions. Because this is a qualitative study, we could not distinguish tendencies between the two groups. However, it would be interesting to

investigate whether community physicians, whose salaries are tied to patient volume, are more likely to deceive than academic physicians, whose salaries are typically fixed by their institution.

These results should raise concerns about medical research as well. Much powerful epidemiologic research has resulted from analysis of large scale retrospective chart and document reviews. It is clear that these deceptions, which permeate all aspects of health care delivery, could affect such results in unpredictable ways. Based on our study, it is unlikely that these deceptions are pervasive enough to undermine results at this time, but we were not able to assess the frequency of deceptive actions in this qualitative study. The results of previous quantitative studies of deception, however, are concerning for research outcomes.(3, 13, 14)

Strengths and Limitations

By allowing physicians to define for themselves those practices they felt were deceptive, and thus recording actual experiences, it was possible to capture the full range of deceptive tactics and the goals and justifications underlying them. Because the study was qualitative with a nonrandom sample, the prevalence of deception could not be measured. Participants were physicians in one geographic area and may not be representative of the experiences of physicians around the country given the variety of TPPs in different regions. Physicians may not have revealed their worst deceptions (especially those that involved personal financial gain or embarrassment) and may have selectively reported certain types of deceptions.

Conclusion

The extent of deception reported in this study highlights serious challenges to the medical profession and probably reflects serious problems with health care delivery and financing in the United States. These physicians themselves were well-intentioned, often placing themselves at some risk for a perceived benefit to their patients. They made judgments that distinguished right from wrong and acted on them, though fell short in acting covertly against a system many feel is irrational and unjust. Their discomfort with their deceptive actions is clear and undermines their professional satisfaction.

While deception of third-party payers violates core physician values (and laws) it may be more fruitful to view these actions as a symptom rather than the disease. Under this model, deception may be a barometer of those areas where the dissonance between care and rules has become so severe that physicians see violating their professional codes as the only way to do their jobs. Both physicians and TPPs may benefit from addressing areas such as health-maintenance visits, screening tests and access to medication directly and openly. Physicians may benefit by improved patient relationships and professional satisfaction. TPPs may benefit through improved reputations and patient satisfaction. The cost of acknowledging this dissonance is unknown. TPPs may pay an economic cost. Physicians may find themselves beholden to additional rules.

Though individual physicians can certainly make a difference, physician professional organizations must play a central role. Recent activism directed at controlling malpractice insurance costs is promising.(29, 30) But the root causes of physician deception of third-party payers are more complicated and entrenched. A solution may not be reached until the health care system is rationalized and brought up to

date with both the needs of the uninsured and the consumer desires of middle class and wealthy Americans.

Physician organizations might consider backing an initiative to eliminate the employer-as-middle-man in the delivery of health care options and costs. Currently, third-party payers and employers negotiate rates and policies with their own bottom lines a top priority and with little input from end consumers. Allowing consumers a varied menu of health care plans to chose from should help rationalize rules and costs. It will also give physicians and society a fresh perspective on the choices Americans make regarding health care. Part of the problem that the physicins in this study face is that neither they nor their patients really know what a health care plan really buys, or often does not buy. Again, deceptions provide unintentional cover for both parties' ignorance.

Hopefully the profession of medicine has not yet reached a point of no return where gaming the system and using deceptive tactics are viewed as a permanent and necessary evil. Unlike in law, where the adversarial system serves to preserve rights and freedoms, in medicine adversarial behavior and deceptive tactics are at best an inefficient way to control costs and at worst a true detriment to patient care.

Table 1. Participant Characteristics

Characteristic	
Specialty	
Cardiology, n (%)	
Dermatology, n (%)	1 (4)
Gastroenterology, n (%)	2 (8)
General Surgery, n (%)	1 (4)
Geriatrics, n (%)	2 (8)
Internal Medicine, n (%)	1 (4)
Medical Oncology, n (%)	7 (29)
Obstetrics and Gynecology, n (%)	2 (8)
Otolaryngology, n (%)	2 (8)
Pediatrics, n (%)	1 (4)
Psychiatry, n (%)	2 (8)
	3 (13)
Female Gender, n (%)	9 (38)
Academic, n (%)	7 (29)
Years in practice, median (range)	14 (2 - 25)
Patients seen per week, median (range)	70 (4 - 150)
Number of deceptions per year, median (range)	6 (0 - 275)

Table 2. Characteristics of Deceptive Tactics

Characteristic	Examples
Patient Assessment	History
	Symptoms
	Diagnosis
Type of Service	Health Maintenance Visit
	Diagnostic/Screening Test
	Treatment
Mode of Documentation	Misdocumentation of Forms
	Misdocumentation of Medical record

Table 3 Goals of Deceptive Tactics

Goal	Examples
Expand coverage and/or decrease patient financial burden	Inflate diagnoses
	Find polyp to justify colonoscopy
	Create symptom to justify diagnostic test
	Keep child in hospital to observe parental behavior
	Code for routine visit with other diagnosis
	Undercode to save patient money
Decrease other burdens of care	Allow patient to take oncology drug at home
	Make referral over the phone rather than in person
Protect patient privacy	Don't document pre-existing condition
	Withhold requested records
	Report lesser diagnosis
Increase physician reimbursement	Upcode
	Perform unnecessary service
	Note irrelevant examination elements
	Fabricate number and length of visits

Appendix 1

Physician Deception Study Interview Guide

Do you consent to participate in this study? Y / N

Characteristics

I am going to begin by asking you some basic information about your practice.

Interviewer code: *Male / Female*

Race _____

How many years have you been in practice? _____yrs

Approximately how many patients do you see in an average week? _____pts

Do you perform any research? How many hours per week do you spend on research? _____hrs

How many physicians work in your practice? _____MDs

What percentage of your patients would you say are covered by managed care? _____%

Do you have any administrative duties? How many hours per week do you spend on administrative duties? _____hrs

Do you provide any *pro bono* medical care? Approximately how may hours per week?

Discussion Prompts

Now I am going to ask you to talk about physician deception of third-party payers.

Deception

- In your field, what practices are you aware of that could be perceived as being deceptive of third-party payers? How widespread do you think this kind of deception is? Can you give me some real-life examples that you have observed?

- Why do physicians use deceptive practices? Why else? Any other reasons?
    - Do you think that patient characteristics matter? Any examples?
- Some physicians will claim that they never employ deceptive practices. What to you think stops them from doing so? Anything else?
- Can you tell me about any times that something you did could have been perceived as deceptive of third-party payers?
    - If YES: Can you give me one or more examples of what you did and what the circumstances were?
    - If NO: For example, in the past year, have you a) up coded; b) used a different diagnosis; c) described symptoms that were not actually present? When? Why?
    - How do you decide if the use of deception is called for?
- Why do you practice deception? Why wouldn't you practice deception?
- Can you tell me about a time when you strongly considered employing a deceptive practice, but in the end chose not to? Why? How did you think about that?

Additional Probes

- What is your greatest fear when you use deception? What are some other fears?
- Do you feel pressure to deceive? Where does that pressure come from?
- Does it bother you when you, or others, employ deceptive practices?
- Are some deceptive practices more acceptable than others? If so, what sets them apart?
- Do you think that there are emotional or psychological factors that influence your decision to use deception? If so, what are they?

<u>Physician/Patient Relationship</u>

- When you use deception, how do you feel it affects your relationship with your patient?

  {If deception never used: How do you think physician deception of third-party

payers affects the relationship between physician and patient?} Can you give me some examples?

- Do you tell your patients when you are practicing deception on their behalf?
- How do your patients respond when they are told or find out that you are employing deceptive practices on their behalf

Quantitative Questions

We are almost done. I've just got five short questions to ask before we finish.

- How many instances of deception would you estimate that you have employed in the past year? _____
- What do you believe is your percentage risk of being audited in the next 12 months? _____%
- If you are audited in the next twelve months, what do you believe is the risk that the audit would identify deceptive practices that you may have employed? _____%
- Do you know any physicians who have been audited? What % of them were found in violation? Were any of them penalized? If so, how? _____%

  _____

  _____

  _____

- Do you ever discuss these types of deceptive practices with your colleagues?

- Is there anything else you would like to add before we finish the interview?

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