Show me the money: The ethics of physicians’ income

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If all economists were laid end to end, they would not reach a conclusion.

George Bernard Shaw

It has been 40 years since enactment of the first Medicare legislation and 22 years since the concept of diagnosis–related groups, which changed the financial complexion of medical practice forever. Since then, reductions and delays in reimbursement by third-party payers, ever–rising costs, and an unending proliferation of costly regulations and pressures by accrediting bodies and government agencies have been visited on us like the plagues upon Egypt. Are we right to object, and how should we ethically respond to the effect these measures have had on physicians’ incomes?

A. Society is trying to ratchet down the cost of medical care while expecting constant improvement in medical science, technology, procedures, and life expectancy. Tell your patients that this is unfair to physicians.

B. Political promises of low–cost medical care cannot be met. Influence the political system by opposing all candidates unsympathetic to physician interests.

C. Stop accepting Medicare and Medicaid patients, and do not enter preferred provider contracts with private insurers who will fix your rates at discounted prices.

D. Compensate for lost revenue by performing more billable procedures and scheduling more appointments for your patients to increase your total charges to Medicare and private insurers.

E. Continue to base your practice on the best available clinical evidence, and strictly limit your interventions to indicated treatment.

Frequent readers of these pages have encountered regular advocacy of the physician’s fiduciary relationship with patients as the most effective method of treatment and as the basis for medical ethics. That fiduciary relationship requires the physician to place the patient’s clinical needs before the physician’s self-interest in professional advancement, convenience, or personal compensation. The ethical requirement that the patient must come first does not, however, mean that the physician’s individual needs cannot come next or that the physician has no legitimate entitlement to the fruit of his or her labor. Only a relatively few in any culture can satisfy the requirements of superior intellect, hard work, technical skill, dedication, compassion, and ethical sensibility essential to the physician’s function. Few indeed have as long a period of preparation or contribute as much to their societies as physicians, and it is meet and proper that their compensation is calculated accordingly.

Medicine remains a relatively lucrative profession for most practitioners despite recent annoyances, and most of us earn everything we make.

For almost three decades after the conclusion of World War II, the United States experienced unprecedented annual economic growth rates, primarily because the industrial capacities of our potential European and Asian competitors had been destroyed by more than half a decade of total war. With the reconstitution of foreign industry and development of a global market economy after the end of the Cold War, the US growth rate slowed to a solid but less robust annual pace. Business became increasingly cost-conscious, and wage expansion slowed. American corporate and individual tax payers put increasing pressure on the government to contain and reduce taxes. First the Medicare system and then private health insurance plans put downward pressure on physician reimbursement. Physicians responded to the reductions with a variety of strategies to maintain a status quo that had traditionally been very friendly to them.

Predictably, medical economists began to interpret the medical profession’s defensive maneuvers as lapses in financial integrity.1 There certainly was, and perhaps remains, enough verifiable fraud in Medicare billing by physicians to
showed persistent variations in procedural incidence. A prevalence, sex, and economic status, that some regions investigators often found, after adjusting for age, disease from town to town introduced the methodology. Later Studies in New England over three decades ago that procedures of a particular type were performed than others. units of geographic distinction) markedly more medical of measure. Economists were shocked to find that in some counted easily numerated medical procedures as their units population, which, as a matter of convenience, usually skeptically upon geographic differences in units of care per showed that twice the number of hysterectomies were done from town to town introduced the methodology. Later investigators often found, after adjusting for age, disease prevalence, sex, and economic status, that some regions showed persistent variations in procedural incidence. A study of 44,000 myocardial infarction patients in 95 selected regions found statistically significant SAVs in the number of patients in each area who had received angiograms. One geographic region had a 10-fold incidence of tympanostomy tube insertion over other supposedly matched regions. Hundreds of other articles by medical economists over the years confirmed patterns of geographic variation in the incidence of medical procedures per population. The economists controlled for many demographic variables, but they missed the most important ones, and of course the resultant conclusion was deeply flawed.

The conclusion that the economists reached and passed on to governmental and private third-party payers was that the frequency of SAVs indicated prescription by doctors of excessive, expensive, and unindicated treatment in the high-frequency procedure areas. They further concluded that the data proved that procedural medicine, of which the surgical specialties were the most prominent practitioners, was fat and ripe for cutting. Their premises and conclusions were wrong because their adjusted variables made inadequate distinctions between areas such as rural counties with a single bare-bones hospital and major urban centers. In a study of 19,000 patients having knee replacements, counties with more medical school–affiliated beds had significantly higher rates. The economists’ main parameter was only the number of adjusted procedures per capita, without much allowance for the local ease of access to the procedures being considered or the likelihood of referral to another county with greater expertise. All these and the other complex cases were of course referred to the fully equipped private clinics or medical schools, and the increased procedural workload in their counties was then interpreted as irresponsible profligacy.

The second of the medical economists’ major areas of study was supplier (physician)-induced demand. Procedurally, much like the auto mechanic, whom we all suspect of black-hearted corruption, the physician advises a substantially naive and anxious clientele of what is wrong and then what the physician will do to fix it. Because the physician effectively controls both the demand and the supply side of the economic equation, the environment fairly invites an expansive interpretation of the problem.

Economists developed and studied the target-income model of physician-induced demand early in Medicare’s fee-regulation era. As fees were decreased by Medicare managers, physicians did in fact compensate by increasing their services to Medicare patients, enough to replace from 40% to 70% of lost income. Medical care consumption in the more lucrative private insurance sector was also increased during this period, perhaps to an even greater degree, as doctors scrambled to catch up. When physicians were not making additional interventions to compensate for the lowered profitability of some Medicare-targeted procedures, they made up the difference by applying their time to something else. A 10% decrease in Medicare’s physician payments for cataract removal caused a 5% increase in the incidence of noncataract procedures. In a community that fluoridated its water, dentists compensated for the reduction in corrective dental services by increasing their even more lucrative restorative work. Correctly reading the implications of continued reductions in Medicare fees in a physician-induced demand market, economists advised Medicare governors that if physicians’ fees fell too low, doctors would react by increasing the number of procedures and other billable encounters among all their patients and ultimately raise the overall national cost of medical care.

When increased utilization of angiography was examined according to guidelines proposed by the College of Cardiology, the increase was in the group in which angiography was useful and effective and not in the unindicated group. Certainly, the overall consumption of care is influenced significantly by many factors beyond physician manipulation of the market. As medicine becomes more successful in prolonging life, the general population increases, grows older, and requires continuing care. A significant rise in the number of patients treated does a lot more to increase the total cost of medical care than an increase in physicians’ fees would by itself. Improved screening methods such as mammography, advanced imaging, colonoscopy, and various batched screening laboratory tests all create new costs in and of themselves and by identifying disease processes which then require treatment. Public education programs encourage people to ask their doctors for these studies. Preventive care has been shown to be effective in reducing subsequent high-cost morbidities, ranging from dental care to vascular procedures. Early in the 21st century, preventive medical care is neither well scripted nor universalized. Medical care utilization obeys ancient economic laws of consumption: it falls as its cost to the patient rises, giving little incentive for patients in our present third-party payor system to limit their requests.
The sum of the available evidence is that physicians and surgeons committed to preserving their elevated financial status have responded creatively with questionabile ethics to reduced reimbursements from third-party payers. When physicians permit economic self-interest to eclipse fiduciary responsibility and professional integrity, they become more likely to offer, recommend, and perform diagnostic and therapeutic services for which clinical indications are marginal. Surgical overtreatment, in particular, is not benign. As costly and painful as it is to patients, it is deadly to professional integrity and public trust in our profession. As early as the mid-18th century, medical ethicist John Gregory foresaw that unscrupulous physicians could enrich themselves by exploiting the worried well, indulging their anxieties with frequent office visits and abundant medical procedures, and ultimately create an actual threat rather than a benefit to their patients' health, as well as to doctors' professionalism. Gregory urged physicians to understand that their best long-term personal and professional interest lay in honoring their fiduciary responsibility, observing an ethical standard of care in treating patients, and building community trust in the profession's knowledge, effectiveness, and integrity.14

Option A invites patients to respond sympathetically to their doctors' complaints of reduced economic circumstances and, perhaps, to gladly take a greater proportion of the physician's compensation upon themselves. There is a subtly coercive element in such an approach—an implication that the patient's stated agreement is required if he is to continue to receive the doctor's best effort in treating him. Patients are unlikely to spontaneously respond sympathetically to the personal financial worries of physicians who, they rightly believe, are in most cases far more affluent than themselves. Option A should be rejected as potentially unethical at worst and unseemly at best. As the data we have cited support, physicians do indeed bear considerable responsibility for the amount of medical care. Asking the political system alone to save physicians denies their own poor practice, ultimately shifts the burden of these costs to others in the society, evades responsibility for correcting problems internal to the medical profession, and does nothing to improve the quality or availability of care. Option B should be rejected.

Option C must be rejected as unethical because if widespread, it would deprive needy elderly and poor patients of access to technically superior care. As a business decision, it would surely be disastrous; vascular surgery is substantially a geriatric specialty supported by Medicare. The distal bypasses, carotid endarterectomies, and aneurysmectomies that are the bread and butter of a vascular surgical practice are seldom needed by any but elderly patients who rely on Medicare to cover their costs. Private insurers with whom you decline discounted contracts simply advise their patients that they should seek other providers to maximize their coverage.

Option D subjects patients to the serious risks of overtreatment, diminishes the physician's professionalism, and is in many cases grossly illegal. It is to be rejected as the most unethical of the choices offered.

Option E, continuing to practice surgery on the basis of scientific evidence, clinical indications, fiduciary responsibility, and empathic regard for the genuine needs of patients, remains the best response to the forces that have buffeted medicine. Your long and difficult years of training, the knowledge and skill you have acquired through hard and dedicated work, and the enormous good that you do within your community have indeed earned you the opportunity to make a comfortable and secure living. They have not earned any of us the right to game the system, mistreat patients, or take more than we have earned. The culture continues to hold us in high esteem and compensate us well substantially because it still trusts us to behave ethically and empathically and to serve our patients' interests before our own. When any members of our profession overtreat and sicken our patients to feather our own nests, we all risk losing the trust of our fellow humans.

REFERENCES