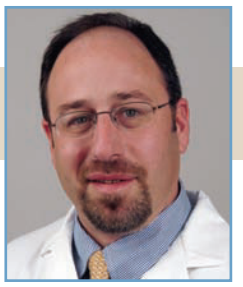
Medical Ethics



By Jonathan Evans, MD, MPH, CMD

Health Care Financing and Professionalism

Case

A 74-year-old man was admitted to a skilled nursing facility at 5:15 p.m. on a Friday afternoon, coming from a 17-day hospitalization for chest pain.

This was the third time in 3 months he had come to the skilled nursing facility from the hospital, so staff knew he had diabetes, chronic heart and lung disease, corticosteroid-dependent asthma, obesity, osteoarthritis, renal failure, and a previous stroke.

He had undergone coronary artery bypass surgery twice in the past, had 32 coronary catheterization procedures in his lifetime, including stenting, and became hemodialysis dependent following an episode of contrast-induced acute renal failure during his most recent hospitalization.

His hospitalization was further complicated by *Clostridium difficile* colitis causing fecal incontinence and then a sacral pressure ulcer. An indwelling bladder catheter was placed.

Nursing facility staff established that he had became colonized with methicillin-resistant *Staphylococcus aureus* and vancomycin-resistant *Enterococcus*. While hospitalized, he became delirious and was physically restrained for the remainder of his hospital stay.

His plan of care involved wound care, diabetes management, rehabilitation for deconditioning, and ongoing treatment of his comorbidities.

For the transfer to the skilled nursing facility, there was no discharge summary and no hand off of care from physician to physician.

A medication list with 25 drugs included quetiapine "as needed for sleep," sliding scale insulin, and amitriptyline.

On arrival at the facility, he appeared to be in acute respiratory distress on 10 L of oxygen per minute.

Later that evening, he was sent back to the hospital, where he remained for 10 additional days for treatment of pulmonary embolism complicated by heart failure.

Discussion

This case is emblematic of many of the problems related to inadequate health care quality and excessive expense under the current model. These are among the many problems that Medicare wants to fix: excessive testing that doesn't improve outcomes, premature hospital discharge, inappropriate drug prescribing, inadequate communication, the transfer of complicated patients to nursing facilities without adequate information, avoidable rehospitalization, and added expense.

The case also demonstrates the problems of simultaneous overtreatment and undertreatment, of not getting our collective money's worth, and of variable standards of quality across different care settings. While there are many contributors to the current state of health care in the United States, many analysts assert that the fee-for-service reimbursement system drives up costs without improving clinical outcomes.

What determines quality? Many people assume that when it comes to health care delivery, money matters most. On the other hand, as health care professionals, we generally believe that we do what we do for the good of the patient, based on our professional ethics, regardless of the money involved. There are two paradoxes here.

One stems from the contradiction between professional ethics and payment, complicated by the fact that the cost of practicing medicine or running a health care facility is too expensive to allow caregiving without regard to getting paid. The second paradox is that although we often believe that "you get what you pay for," the more we pay for medical care in America, the worse it seems to get.

In trying to improve health care quality, we have given much attention to the idea of pay for performance: rewarding providers of good care as opposed to bad. But what are the ethical implications of such a move? Are there pitfalls and unintended consequences? What difference does money really make in influencing professional conduct? What difference should it make? Moreover, what performance measures really ought to matter the most and who should decide?

Money is the single biggest determinant of access to health care across the continuum of care in the United States. Nursing facilities themselves have been transformed repeatedly by changes in health care reimbursement from places patients go to live (long-term "custodial care," paid for privately or by Medicaid) to places patients go to leave (short-term post acute "skilled care," paid for largely by Medicare).

The current fee-for-service model creates a financial incentive to do more, not necessarily to do better. High-quality care and good clinical outcomes are not directly rewarded, and neither is the efficient use of resources. The goal of pay for performance is to create financial rewards for better care or better clinical outcomes and financial penalties for worse care or worse outcomes. The first hope and belief is that quality will improve. As illogical as it may seem, however, the hope also is that the cost of care will go down.

Consistently good outcomes require good processes of care. Good processes must be rewarded. The efficient use of scarce or expensive resources must be rewarded as well.

Money and professional ethics. The idea of creating financial incentives to change providers' behavior is not new. Medicare created prospective payment for hospitals more than 20 years ago. The expectation was that these institutions would be motivated to adopt best practices in order to achieve good outcomes in less time. Almost no one anticipated that hospitals would instead discharge patients before they were well, shifting costs and fragmenting care rather than improving it.

We believed that health care professionals would not compromise their professional ethics by discharging patients when they were still sick, yet professionals seemed to change their values according to the marketplace.

Tying payment to performance is an effort to better align the interests of patients and providers. But how and why did those interests diverge in the first place? While the effort to improve care quality through financial incentives is laudable, as professionals, perhaps we should also see it as an indictment of our willingness and our ability to do good for its own sake. If financial incentives do indeed drive health care decision making more than anything else, then we are indeed a poor profession.

This time around, shifting the risk of poor performance onto providers may be different, but many questions remain unanswered. Commonly today, care for a single episode of serious illness is provided across multiple settings and by multiple providers. In a pay-for-performance world, will standards of quality finally be applied equally across care settings? Will hospitals be required to undergo the kind of annual survey process that nursing facilities do? How will the rewards or punishments for good or bad care be distributed if fees are bundled?

How will providers attempt to control their risk? Will it be shifted onto patients, such that patients considered to be at high risk for bad outcomes will be denied access to care? Will patients who cannot or will not do what their doctor says be spurned?

Rewarding what matters. If payment for health care services in the future is tied to performance, then what is rewarded indicates what society values. We need to be able to measure how well people feel and how well they are getting what they want. Likewise, the best care requires the effort of many people working together and communicating effectively with patients, families, and each other. We need to directly encourage that. Consistently good outcomes require good processes of care. Good processes must be rewarded. The efficient use of scarce or expensive resources must be rewarded as well.

Comfort, dignity, relief of suffering, maximizing and maintaining function, promoting and preserving autonomy, and helping people feel better through words and deeds – these are probably the truest measures of performance in health care but perhaps the most difficult to objectify and compare. They reflect the quality of caring, if not the quality of care itself.

Our current system of payment for health services isn't making care better and is simply unaffordable now. Trying to change provider behavior by changing payment will surely have a profound effect, just as it always has.

As professionals and as human beings, we must ensure that in a future of pay for performance, the metrics really matter and that they are a true reflection of the values we wish to promote and preserve: compassion, communication, respect for persons, and tender, loving care. The creation of incentives and the imposition or removal of barriers to change behavior must therefore promote, encourage, recognize, and reward beneficence, so that as individuals, as organizations, and as a society, we can only do well by doing good.

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