Physicians' Conflicts Between Their Patients and Society

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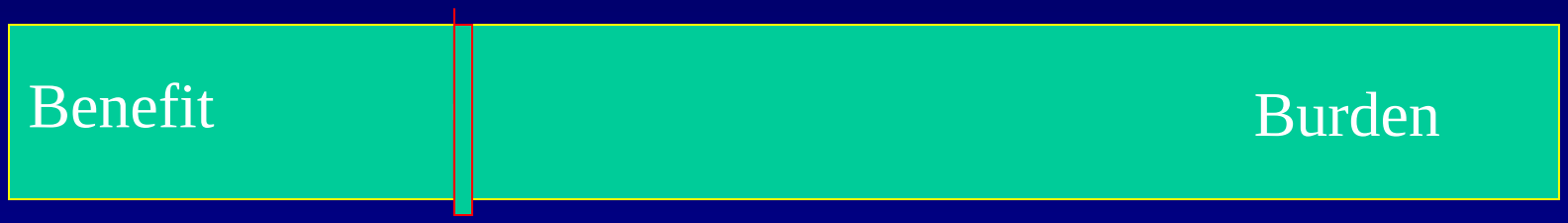
Ethical Dilemmas--Patient vs. Society

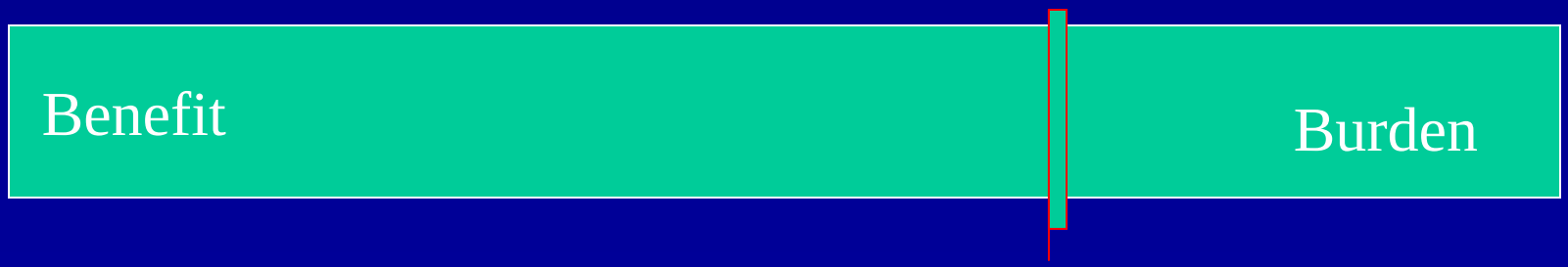
- Benefit/burden of the patient vs. the society
- Examples—
  - Deception
  - Confidentiality
  - Clinical research
  - Capital punishment
  - Patient vs. physician benefit

Balance of Burden and Benefit to Individuals and Society

Patient



Society



Deception

- Unethical to mislead others
  - Truthfulness required for individuals to make informed choices
  - Difficulties with trust when deception is discovered
- Types of deception
  - Medical training
  - Giving bad news
  - Disclosure of medical errors
  - Placebos
  - Gaming the system

Gaming the System

- Conflict is patient beneficence vs. societal non-maleficence
- Also at stake: professionalism
  - Fraudulent behavior?
  - Illegal?

Behaviors in Gaming the System

- Attempt to get diagnostic or therapeutic treatments paid for patients
  - When health insurance will not cover them
- Different strategies can be employed
  - Exaggerating signs or symptoms
  - Changing billing diagnoses
  - Creating signs or symptoms not present

Physician Manipulation of Reimbursement Rules

- National sample of 1124 practicing physicians
  - Response rate of 64% (720 respondents)
- Use of 3 tactics in previous year to obtain services for patients not covered by insurance
  - Exaggerating severity of condition
  - Changing patient's billing diagnoses
  - Reporting signs or sx patient did not have

Wynia MK et al. JAMA. 2000; 283:1858-1865

Physician Manipulation of Reimbursement Rules

- 39% of respondents used at least 1 tactic in previous year
- Respondents not worried about prosecution
- Several factors associated with use of tactics
  - Belief that gaming the system is required 3.67
  - Requests from patients to deceive 2.44
  - Pressed for time during office visits 1.69
  - >25% of patients on Medicaid 1.60

Confidentiality

- Autonomy of individual vs. non-maleficence for society
- Rights of individual based on 14th Ammendment
  - Right to privacy

Breaching Confidentiality

- In some cases burden to society far outweighs rights of individual
  - Communicable disease
  - Impaired drivers, pilots
  - Future harm to another--Tarasoff decision
- Some situations are less clear
  - Previous crime
  - Insurance fraud by patients

Study to Examine Breaching Confidentiality

- Residents in Internal Medicine
- Given case vignettes of patients who committed past crime or were intending to commit crime
- Asked how likely they were to inform the police
  - Based on 7 point Likert scale (1= very unlikely to 7 = very likely)
- Asked their understanding of the Tarasoff decision

Farber NJ et al. JGIM 1989; 4: 31-33.

Case Vignettes

- Vignette with no sociocultural variables served as null case
- Other cases with sociocultural variables compared with null case
- Two case of intended future crime

Variables Tested

- Violence (murder) committed during the crime
- Threatened violence during the crime
- Presence of previous record of violent crime
- Previous record of minor crime (shoplifting)
- High vs. low cost of goods stolen
- Age (teenager vs. middle-aged)

Likelihood of Breaching Confidentiality

Variable	Mean +/- SD	P Value (vs Null)
Null Case	2.57 +/- 1.46	--
Violence (murder)	5.01 +/- 1.90	<0.001
Violence (threat)	4.90 +/- 1.90	<0.001
Violent Record	4.31 +/- 2.13	<0.001
Large Theft	3.04 +/- 1.77	0.007
Minor Record	2.95 +/- 1.70	0.003
Age (teenager)	2.08 +/- 1.10	0.001
Future Violence	5.41 +/- 1.76	<0.001
Future Nonviolent	3.70 +/- 1.90	<0.001

Understanding of Confidentiality

Interpretation	# Residents	% Residents
Any Info Shared	1	1.4
Medical Info Shared	1	1.4
Share Only If Threat	66	94.3
No Info Shared	2	2.9

Health Insurance Fraud

- Another increasing problem is patient-initiated health insurance fraud
- Some physicians are encountering this problem
- Ethical dilemma
  - Patient autonomy—preserve confidentiality
  - Societal non-maleficence—prevent fraudulent use of health insurance ($)

Ethics and Legal Issues

- No clear legal guidelines in most states
  - Cannot engage in health insurance fraud
  - But no legal requirement to report past fraud
- Ethically—should preserve confidentiality
  - No violence or bodily harm
  - Usually past event

Study to Determine Physician Attitudes

- 1000 members of ACP
- Two sets of three case vignettes
  - 3 acutely ill, 3 terminally ill
- Variables tested
  - Acutely vs. terminally ill
  - Past hx insurance fraud
  - Wealthy vs. poor patient
- How likely to report based on 5 point scale
  - 5 = very likely
  - 1 = very unlikely

Farber NJ. Arch Intern Med 1997; 157: 501-505.

Willingness to Report Insurance Fraud

		P Value
Acutely ill	**Terminally ill**	
3.0 +/- 1.5	2.8 +/- 1.5	< 0.05
Previous Hx	**No Previous Hx**	
3.3 +/- 1.5	2.8 +/- 1.5	< 0.001
Wealthy Patient	**Poor Patient**	
3.7 +/- 1.5	2.8 +/- 1.5	<0.001

Clinical Research

- Benefit to individual based on several factors
  - Therapeutic vs. on-therapeutic research
  - Type of therapeutic trial
    - Phase I vs. Phase II or III
  - Data of potential benefit from previous research
- Should always be of benefit to society
- Checkered History in the U.S.

Study of Uninformed Consent

- Ascertain physicians' attitudes about enrollment of patients who cannot give informed consent or of a vulnerable population
- Determine the factors that are associated with physicians' decisions to enroll patients
- Specifically examine attitudes of physicians who conduct clinical trials or who sit on IRBs

Farber NJ. Accountability in Research 2004; 11: 63-78.

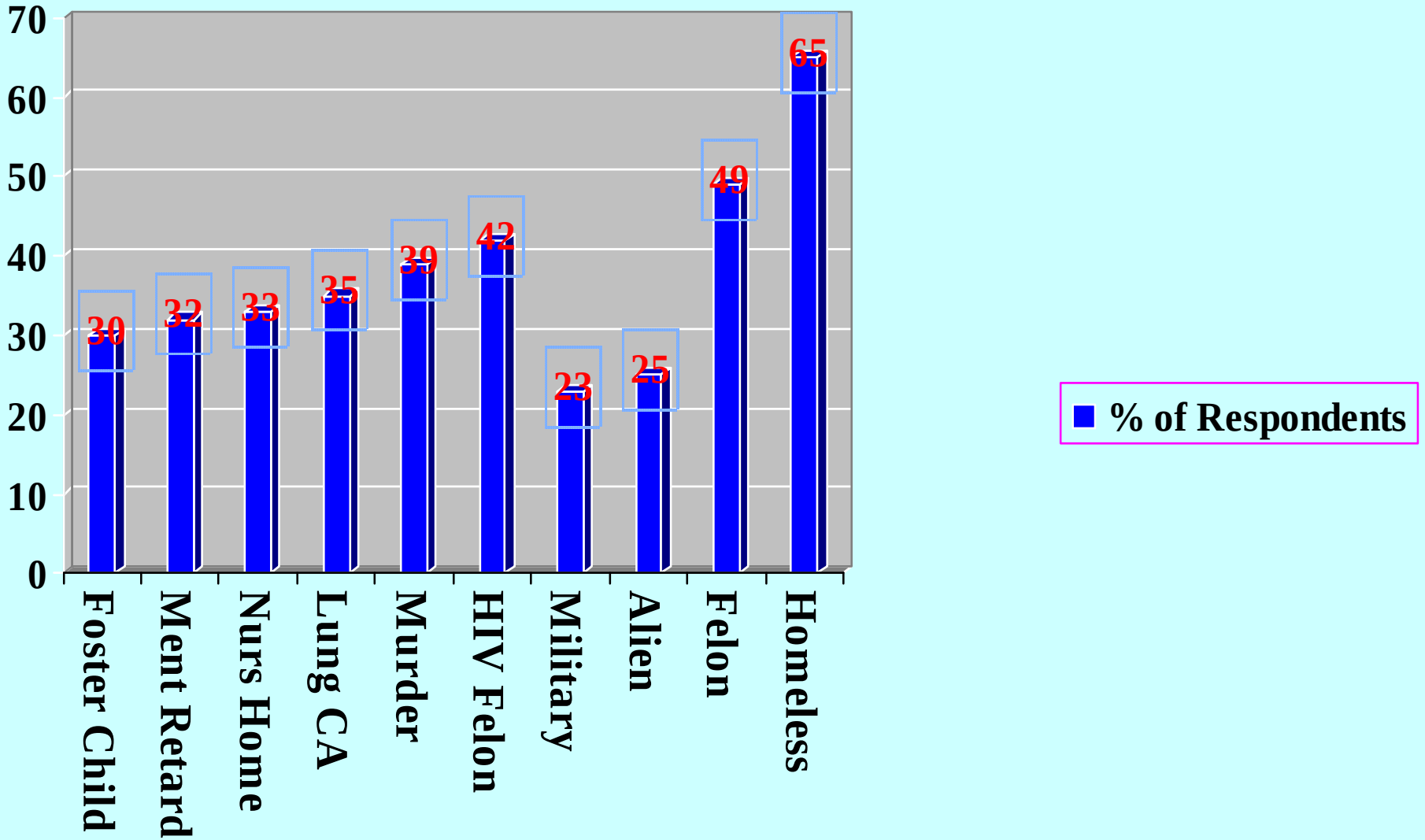
Clinical Scenarios

- 85 year old nursing home resident with dementia
- Patient in prison with dementia due to HIV encephalopathy
- Patient with dementia due to metastatic disease of the brain from lung cancer
- 11 year old foster child with cognitive deficits due to fetal alcohol syndrome
- 55 year old man with mental retardation

Clinical Scenarios (cont)

- Prisoner who is competent, offered to enroll to lessen his sentence
- Illiterate illegal alien
- Military recruit ordered to participate
- Homeless person who is competent offered $1000 to participate
- Prisoner on death row for rape/murder who has dementia

Approved Scenarios



Number of Scenarios Approved of By Respondent Subgroups

Subgroup	At Least 1 Scenario	Six or More Scenarios
Clinical Trials	85 (72%)	23 (19%)
No Military	235 (82%)	72 (25%)
Training	128 (78%)	39 (24%)
IRB	55 (83%)	20 (30%)
Academic	49 (74%)	8 (12%)
Oppose Death	62 (71%)	16 (18%)

Capital Punishment

- AMA and ACP proscribe involvement in capital punishment
- Physicians are involved in some states
- Controversy exists about physician involvement
- Ethical dilemma
  - Patient autonomy & non-maleficence
  - Duty to Society?

Study of Physician Acceptance of Colleague Involvement

- Determine physicians' attitudes toward colleague involvement in capital punishment

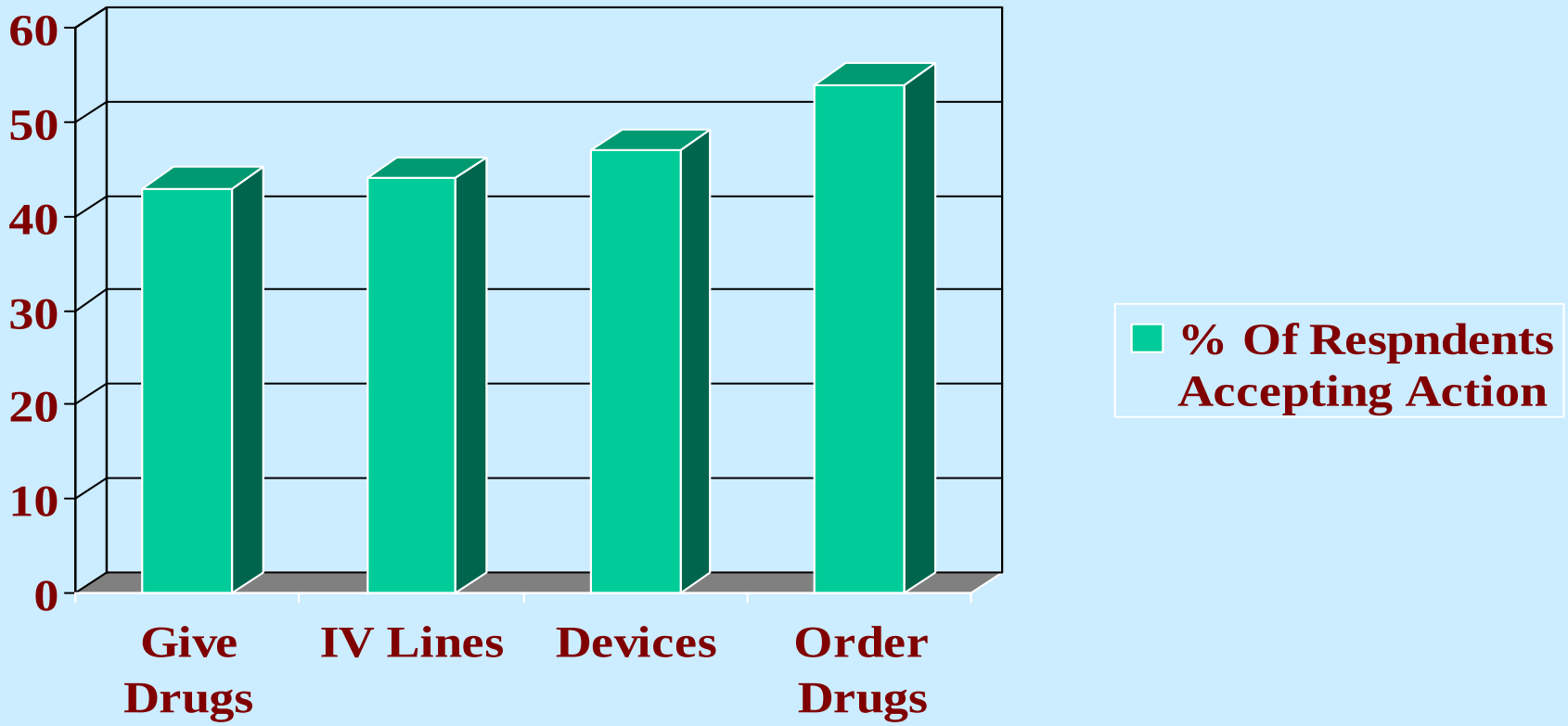
- Determine demographic and attitudinal factors that impact on physicians' opinions about colleague involvement in capital punishment

Farber NJ. Arch Intern Med 2000; 160: 2912-2916.

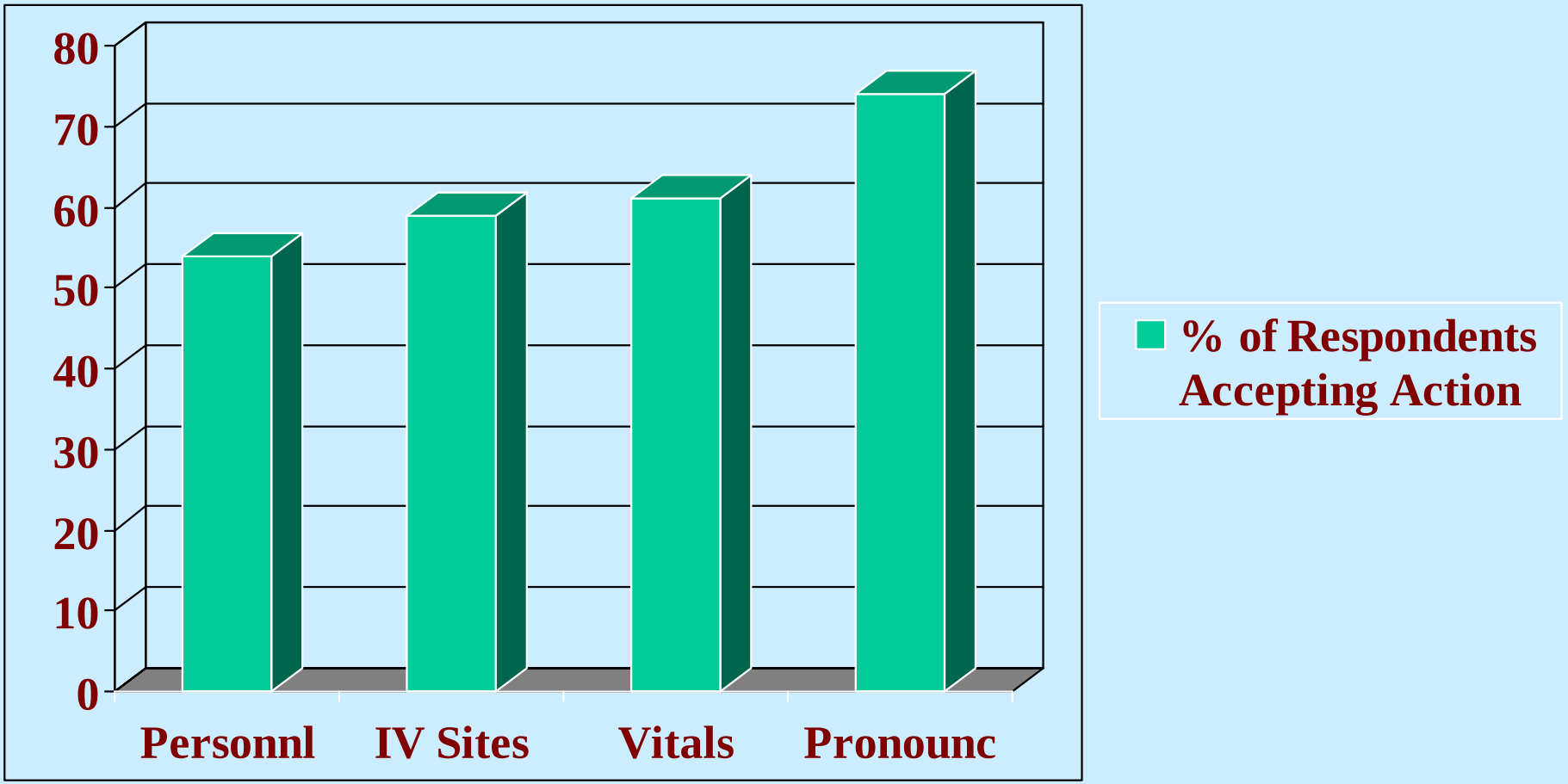
AMA Proscribed Actions

- Administering lethal drugs
- Starting IV Lines
- Inspecting/maintaining injection devices
- Ordering lethal drugs for the prison
- Supervising personnel who give drugs
- Selecting IV sites
- Monitoring vital signs during execution
- Determining death during execution

AMA Proscribed Actions That Are Acceptable To Respondents



AMA Proscribed Actions Acceptable To Respondents



Attitudes On Death Penalty and Acceptability of Proscribed Actions*

Attitude On Death Penalty	# Proscribed Actions (Mean +/- S.D.)
Favor All	5.9 +/- 3.0
Favor/Oppose	4.8 +/- 3.1
Oppose All	1.9 +/- 2.8

* $p < 0.001$

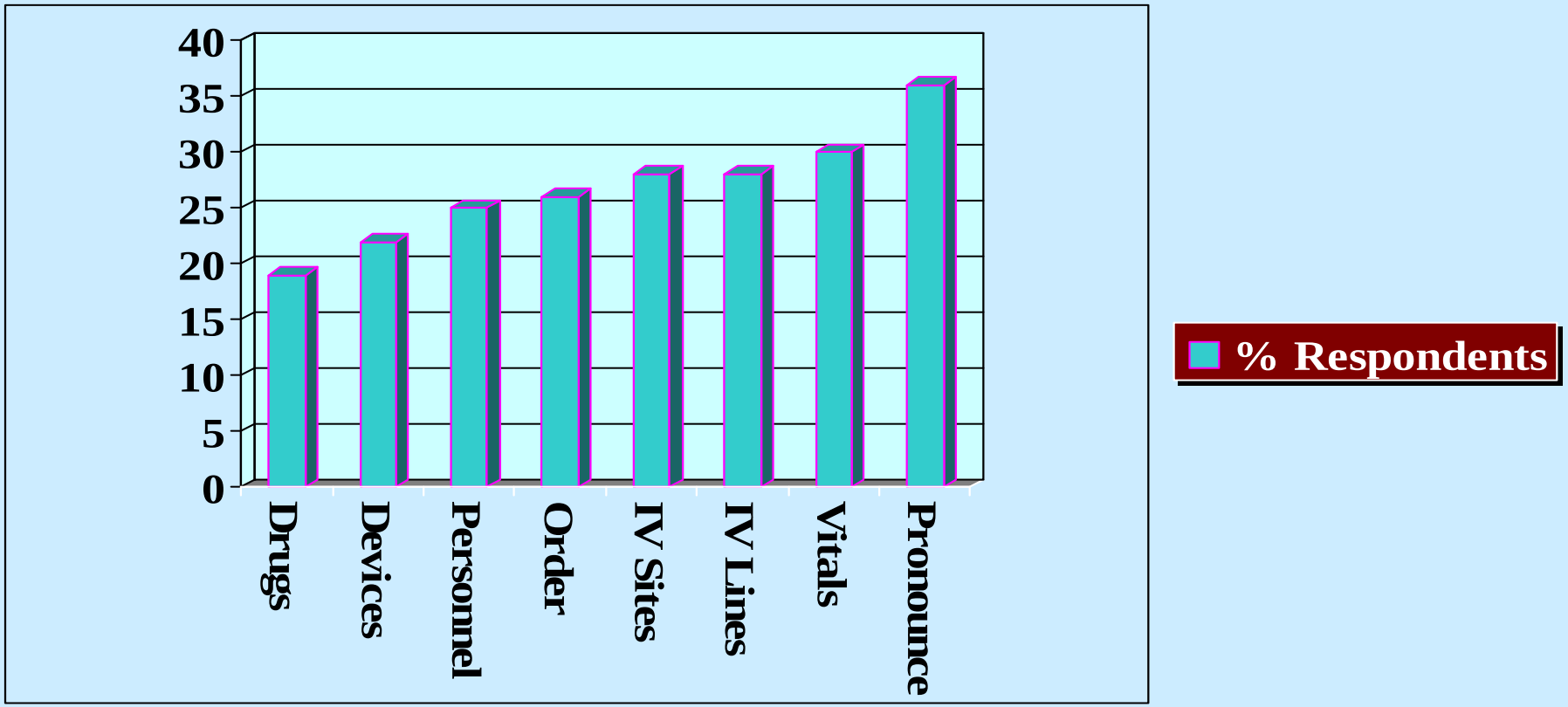
Second Study on Capital Punishment

- Determine physicians' willingness to be involved in cases of lethal injection for the purpose of capital punishment

- Determine demographic and attitudinal factors that impact on physicians' willingness to be involved in capital punishment

Farber NJ. Ann Intern Med 2001; 135: 884-888.

AMA Proscribed Actions That Respondents Would Perform



Attitudes On Death Penalty and Willingness of Proscribed Actions*

Attitude On Death Penalty	# Proscribed Actions (Mean +/- S.D.)
Favor All	4.5 +/- 3.6
Favor/Oppose	2.1 +/- 3.0
Oppose All	0.2 +/- 0.7

* $p < 0.001$

Duty to Society and Willingness of Proscribed Actions*

Reason For Involvement Is Duty to Society	# of Proscribed Actions (Mean +/- S.D.)
Strongly Agree	6.2 +/- 3.0
Agree	5.3 +/- 3.2
Disagree	1.7 +/- 2.6
Strongly Disagree	0.6 +/- 1.8

$P < 0.001$

Physician vs. Patient

- At time, physician must decide to benefit self vs. patient
  - Disruptive patient
  - Non-payment

Purpose

- Survey internists on attitudes about discharging troublesome patients from their practices.
- Survey physicians about their actual experiences with discharging patients from their practices.
- Examine effects of demographic variables on likelihood of discharging hypothetical and real patients from their practices.

Farber NJ et al. JGIM 2008; 23: 283-287

Methods

- Cross sectional mailed survey
- 1000 primary care physicians in US
  - 500 general internists
  - 500 family practitioners
- Pretested among 50 Delaware physicians
- $5 incentive, two mailings
- Survey contained 12 scenarios involving patients who were problematic
  - 4 point Likert-type scale
- Demographic data

Case Scenarios

- Violent/illegal behavior
  - Verbal abuse; violent threats; narcotic seeking
- Behavior interfering with patients' health
  - Missed appointments; non-adherence; refuses information transfer
- Unethical behavior
  - Illegitimate work excuses; refuse to inform spouse of HIV; past insurance fraud
- Behavior that is disliked
  - Questions rx; nonpayment; malpractice suit

Figure 1 Likelihood of Discharging Hypothetical Patients

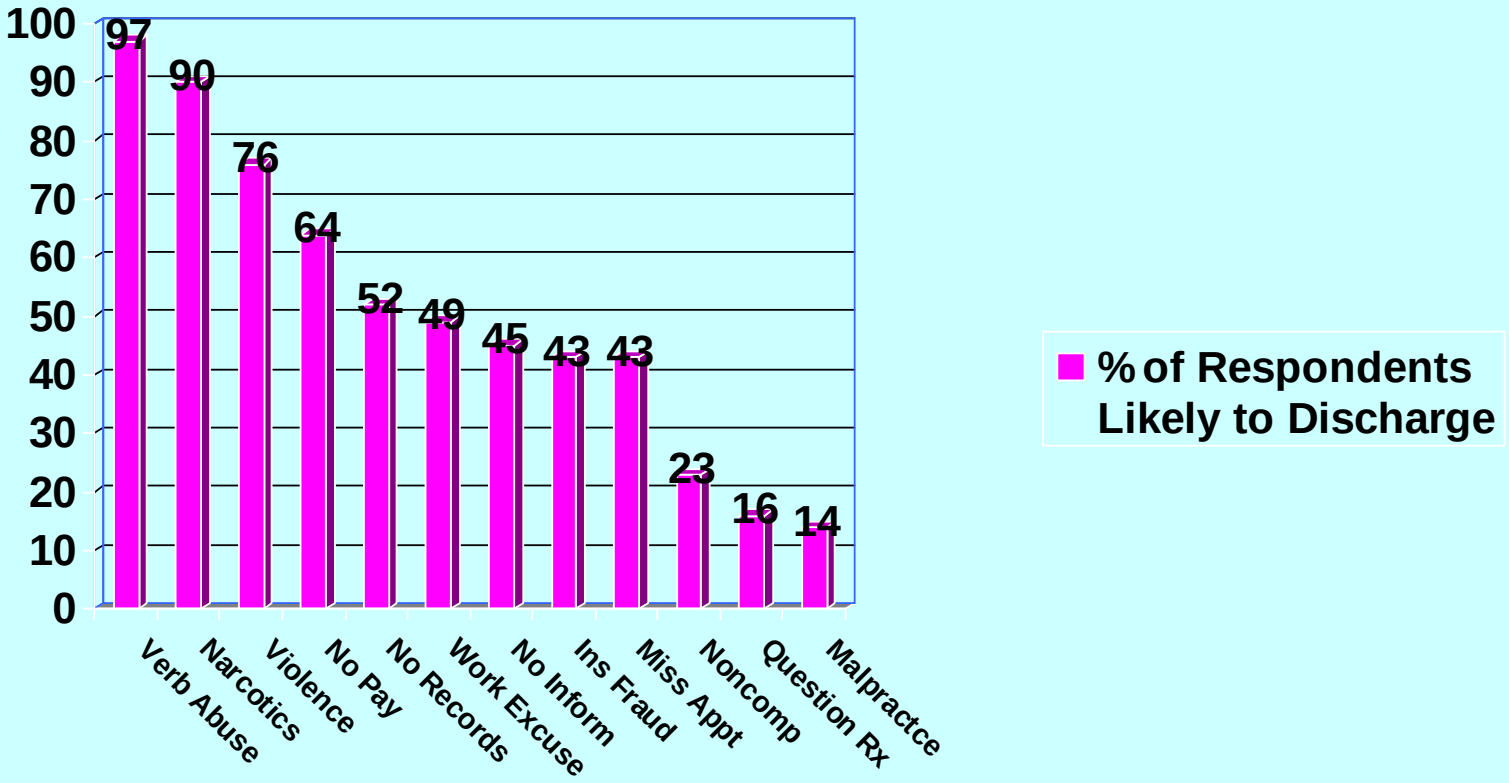
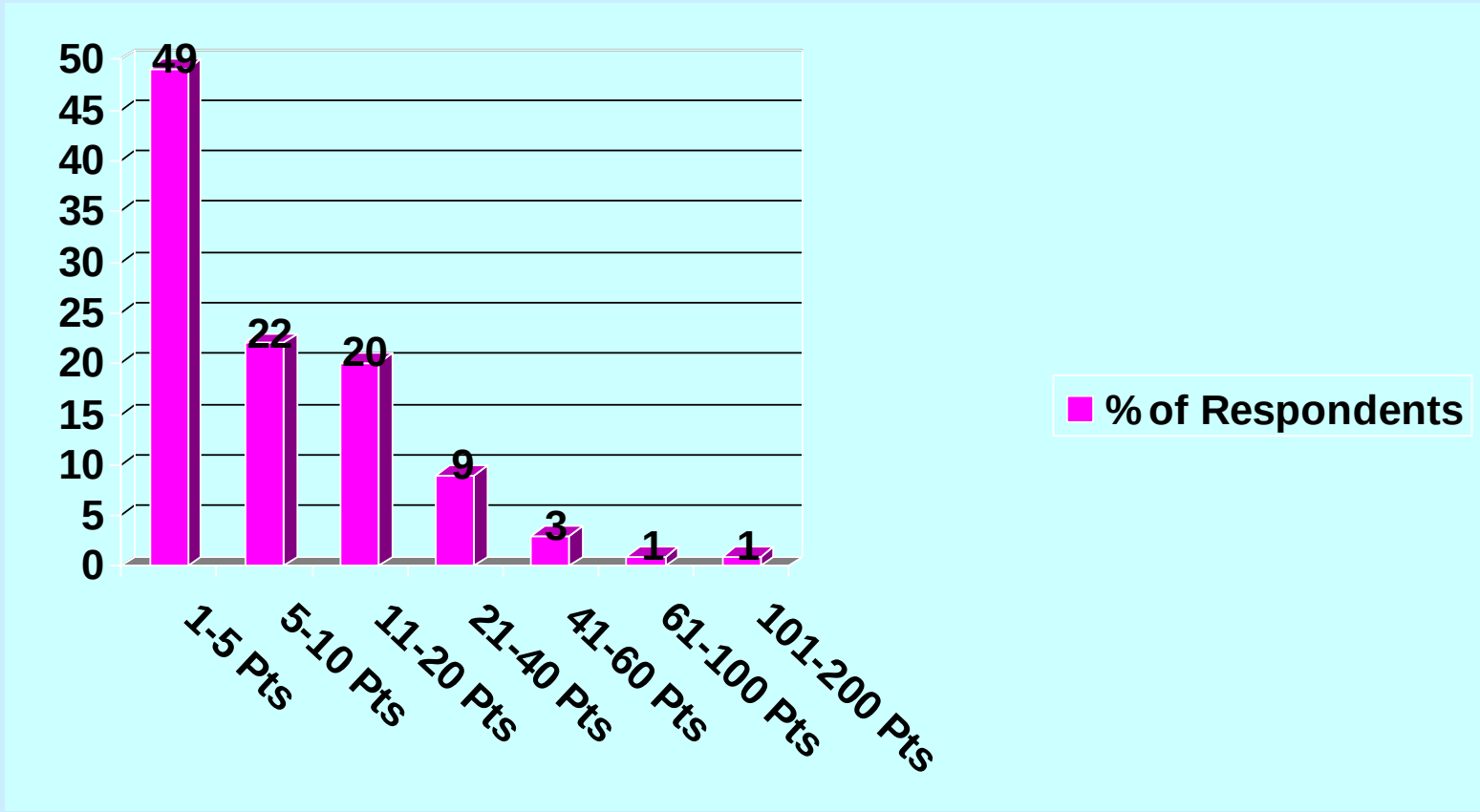


Figure 2 Number of Patients Discharged From Respondents' Practices



Association of Variables With Likelihood of Discharging Hypothetical Patients

Variable			**P Value**
Private Practice		#Scenarios +/- SD	<.0000001
	Yes	6.3 +/- 2.4	
	No	4.7 +/- 2.7	

Association of Demographics With Actual Patients Discharged

Variable		Discharge	Not Discharge	P Value
Priv Prac	Yes	289 (89%)	35 (11%)	0.009
	No	94 (76%)	29 (24%)	
Age	≥48	204 (91%)	21 (9%)	0.005
	≤47	179 (81%)	43 (19%)	
Locale	Urban	126 (80%)	32 (20%)	0.003
	Suburban	159 (87%)	23 (13%)	
	Rural	98 (92%)	9 (8%)	

When the Patient Does Not Pay: A Survey of Primary Care Physicians

Purpose

- Survey primary care physicians on attitudes about withholding various types of services from patients who do not pay their bills to the physician.
- Survey physicians about their actual experiences in withholding services from such patients.
- Examine effects of demographic variables on likelihood of withholding services from hypothetical and real patients who do not pay their bills.

Methods

- Cross sectional mailed survey
- 1000 primary care physicians in US
  - 500 general internists
  - 500 family practitioners
- Pretested among 50 Delaware physicians
- $5 incentive, two mailings
- Survey contained 13 services which could be withheld by physicians
  - 4 point Likert-type scale
- Demographic data

Case Scenarios

- Complete form for life insurance/ disability
- Perform minor office procedure
- Order screening lipid profile/review lab test results
- Provide meds for a mild acute illness
- Pre-operative evaluation for elective surgery
- Refer to dermatologist for benign rash
- Refill prescriptions
- Admit to hospital
- Provide copies of medical records
- Return phone call on non-urgent matter
- Refer for breast biopsy

Figure 1 Likelihood of Withholding Services From Non-Paying Patients

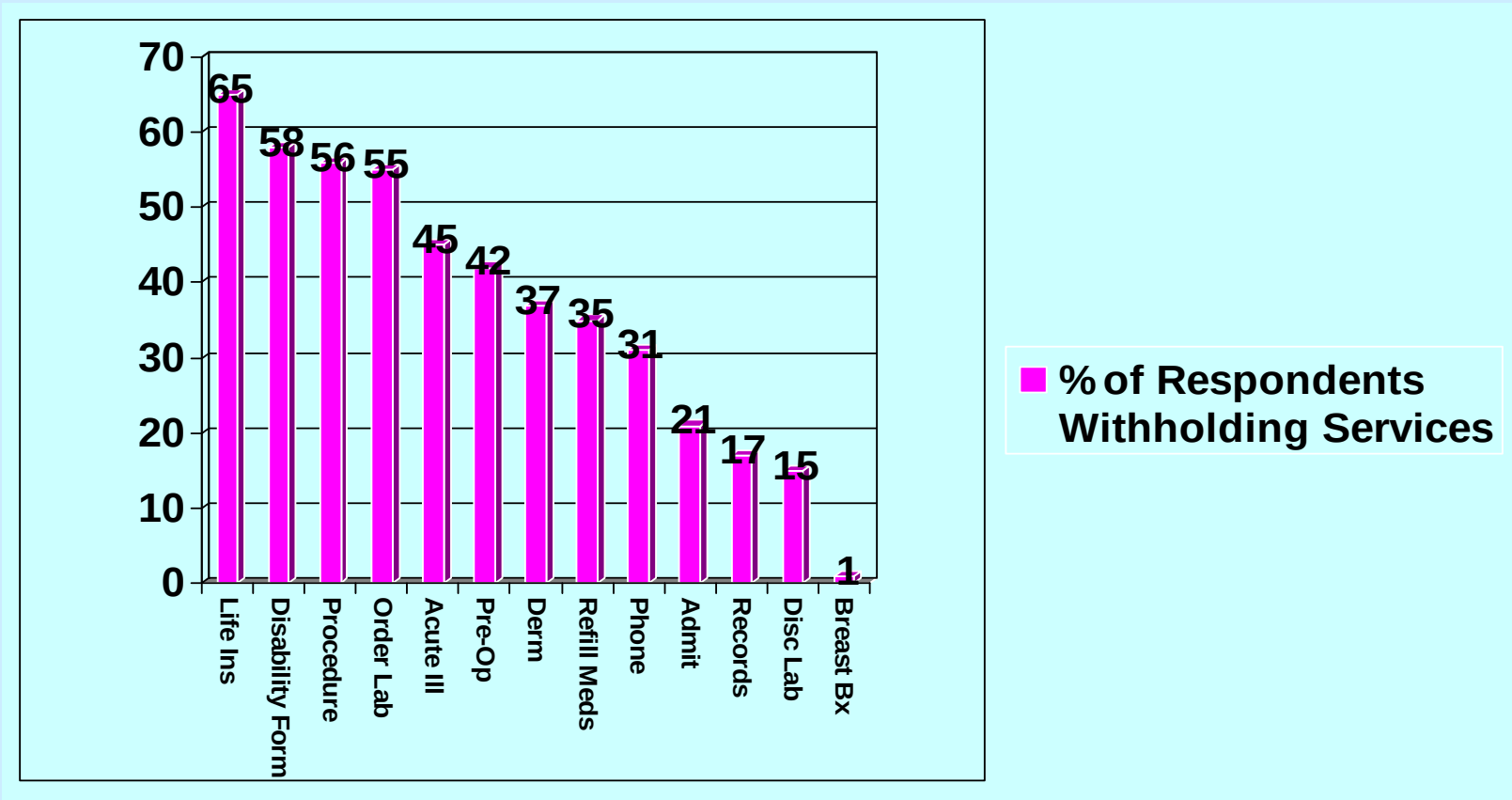
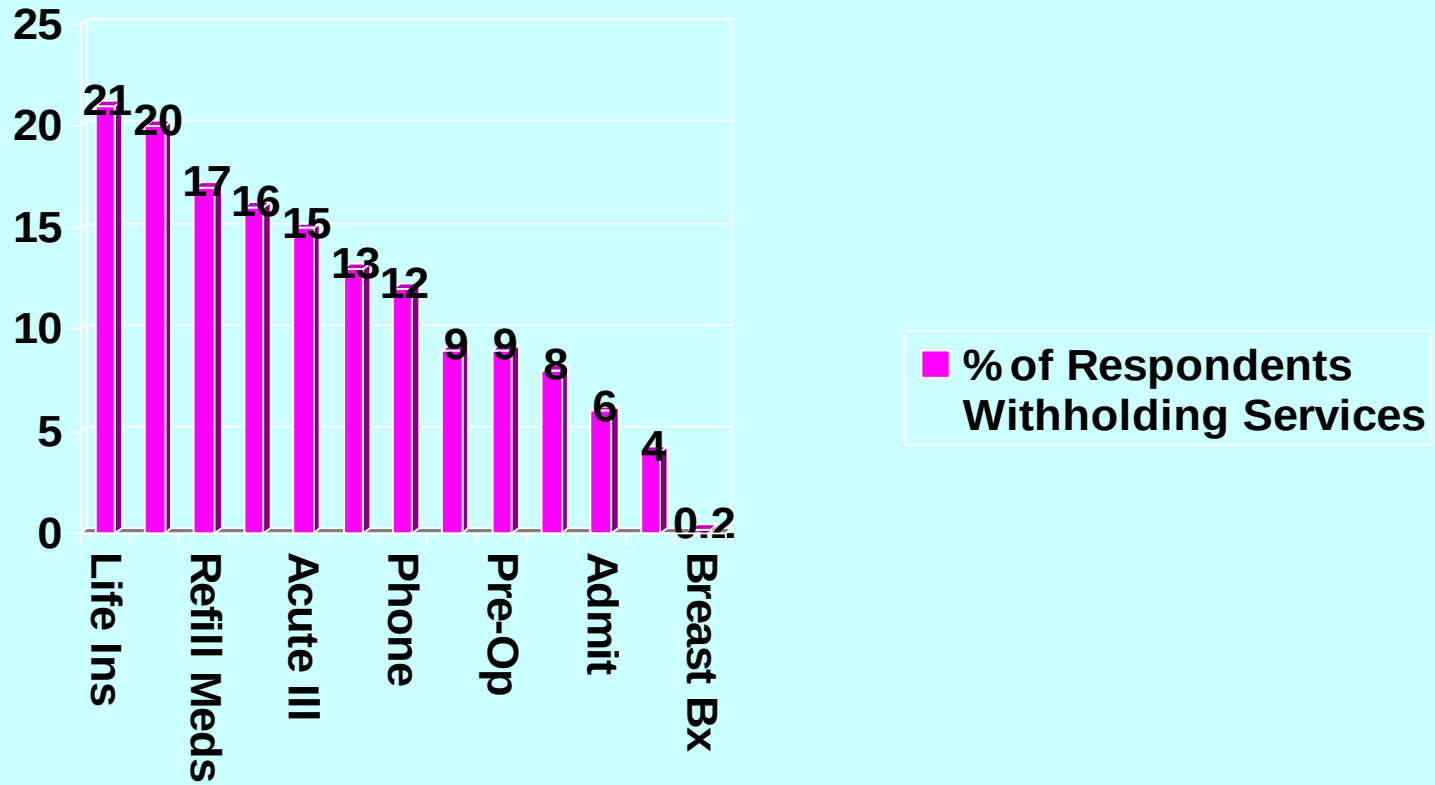


Figure 2 Physicians Who Withhold Services From Non-Paying Patients



Association of Demographics With Services Willing To Be Withheld

Age			P value
	≤46	5.2 +/- 3.6	
	≥ 47	4.3 +/- 3.3	.003
Entitled to Care			
	Yes	4.5 +/- 3.5	
	No	5.7 +/- 3.4	.002

Association of Demographics With Services Actually Withheld

Terminate			p value
	Yes	2.2 +/- 3.0	
	No	0.9 +/- 1.9	.000001
Entitled			
	Yes	1.4 +/- 2.4	
	No	2.1 +/- 2.9	.05
Locale			
	Urban	1.8 +/- 2.9	
	Suburban	1.5 +/- 2.5	
	Rural	1.2 +/- 2.2	.03

Model for Assessing Conflicts Between Individuals and Society

Society \ Individual	Benefit	Burden
Benefit	Positive effects for both--can proceed	Conflict—where a clear risk to society can proceed
Burden	Conflict—can proceed in most cases except if danger to society	Negative effects for both--should avoid