

2007

Transcribed Speech of Dr. Arthur Derse

Arthur Derse
Medical College of Wisconsin

Follow this and additional works at: <http://lawcommons.luc.edu/annals>

 Part of the [Health Law and Policy Commons](#)

Recommended Citation

Arthur Derse *Transcribed Speech of Dr. Arthur Derse*, 16 *Annals Health L.* 365 (2007).
Available at: <http://lawcommons.luc.edu/annals/vol16/iss2/12>

This Colloquium is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in *Annals of Health Law* by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.

Transcribed Speech of Dr. Arthur Derse

DR. DERSE: I would like to thank Marissa Burke and, indeed, the committee who put together this conference because not only d[id] I come to participate in the [I]nstitute conference here, but I also get to come to a warmer climate than my own today, so I'm grateful for that.

I was asked to talk about some of the other legal issues that I see in diagnosing the data and specifically the data that we're looking at is with the purpose of affecting physician behavior or provider behavior, and I am going to use physicians as the prime example of providers here. I'd like to talk about some ethical issues that I see, specifically five of them: (1) effects of patient factors with patient case effects and [the] physician societal response to that; (2) the issue of confidentiality, which I'm going to define not just as HIPAA [the Health Insurance Portability and Accountability Act], but a doctor-patient relationship and the communication therein; (3) the issues dealing with informed consent; (4) patient refusal of treatment; and (5) potential use in litigation.

So we are going to be working out some of the issues here [along with] pay-for-performance, [which] you've heard defined. [Pay-for-performance is] specifically [the] use [of] financial evidence to encourage evidence-based medicine or good medicine to produce improved outcomes. Some of the examples are listed here, but [the goal of pay-for-performance is] essentially to affect provider behavior. That's what the data collection is for. This says "I'd love to chat longer, but I've got to get this guy to a hospital." I am an emergency [department] physician, as Dr. Kizer and Dr. [Schyve] are, and I do look at it from a practical perspective.

The first issue is something known as patient case of export patient factors; that is, depending upon the patient's condition, you, if you were being paid for performance, may take a look at patients [a] little bit differently. That is, patients who are more severely ill may raise red flags for you because you may want patients who are very well. If we're measuring the effectiveness of treatment of the patients who are severely ill and your performance measures didn't do well, you may find that you are, in fact, preferring not to take care of those patients.

Patients with communication difficulties, with inherent disability, cultural barriers, difficulty in follow-up, [and] economic disparities, these things are being measured and you are having a longer time getting the results you want because of the difficulties in communication. You may

also decide that these are not the patients you want to treat: older patients, chronically ill patients, if certain measures are being reimbursed.

I'd love to say that my colleagues in medicine are purely driven by non-economic factors and that a physician performing under capitation or fee-for-service would do exactly the same. But behaviors may be modified by financial incentives and favor different ones. The ones in our discussion may then become more normal and ones that are not being measured may become less so.

Also, for patients whose parameters are far from the goals, in a specific practice, you may, as a physician, give up on those people and decide to work with people whose parameters you can get much closer to. You basically go for the low hanging fruit, so to speak, rather than spending a lot of time on a few patients whose parameters are way off. Whether or not you can affect them in a small way, it still won't show up in the pay-for-performance data that's being acquired.

Finally, of course, non-compliant patients can [be] worse, because those who do not volunteer [information] are the ones that you're not going to have much effect on the outcome. You may as well take a look at those patients differently.

This says, "Unfortunately, you have no insurance." Better some insurance than none, but what about making sure that in pay-for-performance, risk adjustments are made for these patient variables? Without getting into the subject, not all pay-for-performance regimens will, in fact, take into account the patient characteristics. If they don't, then physicians are reporting for certain types of patients. Their responsibilities as a physician [lead to the] selection of patients, [which is] difficult, and above all, patient access will be limited.

Also [raised is] the issue of indigent patients who may be served by physicians who score poorly on these performance measures. What do [health] plans do with those folks? If they're the only providers providing care in the areas of the city that aren't getting the best care, is suboptimal care better than no care? Poor care is not a good thing, but if your alternative is no care, it may not be such a bad choice. We've heard earlier that geriatricians, for instance, can be measured on a number of measures. They've also heard that people in geriatric practice are dwindling because it's not something in which our medical students—I teach at medical school—see as being financially rewarded. And so people who expect to take care of patients—and we're going to be doing these measures on primary care versus the subspecialties—now have an added burden. So right now they have a shortage, certainly of geriatricians and somewhat [of] a shortage of our primary care physicians, and then, of course, the cumulative societal impact of small [numbers of] physicians at the bedside

on the ultimate access to health care. So those all fall into that category of the response to the various patient case mix load or factors.

Our next issue is, of course, confidentiality and communication, but I really do want to talk about confidentiality in the doctor-patient relationship because there [is] sensitive information, a certain [part] of which we were talking about earlier. I think you can make an argument, for instance, [that] HIV maybe shouldn't be treated the same way as, perhaps, psychiatric illnesses or drug abuse. But nonetheless, there are some sensitive information concerns in the doctor-patient relationship and as the pay-for-performance is measured, it's possible that if the patients with these sensitive information concerns fall into the category of disfavored conditions because the physician does not want to have to come to the best performance on treatment of drug abuse when, in fact, he or she may have just a few patients and decide I'm not going to do this at all. The impact on doctor communication may be that patients may not want to reveal the important information that would make them less desirable to physicians, no longer worrying about insurance companies or governmental agencies but, in fact, thinking about what's going to make [them] less desirable to this physician, maybe [they] shouldn't tell this physician about this problem.

You remember that I mention[ed] possible side effects and, of course, one of the requirements of informed consent is risk status as well as forms of treatment and the informed consent required for testing, treatment, and procedures. The objective patient standard that was set out in *Canterbury v. Spence* is really one that says the reason for objective patients' weighing of whether or not a piece of information is material is really the bottom line for the states that [use] it.

The question is, what financial incentives would be considered material? Well, in general, financial incentives have not been considered material. There is an exception in the [Eighth Circuit], but in general, [financial incentives] have not been [determined as material]. But let's think about whether or not performance measures that actually take a look at incentives would actually be weighed by a patient as something material in making an informed decision about testing, treatment, and procedures.

And as an example, if you take a look at the Women's Health Initiative that looked at the treatment of women over fifty years old with estrogen and progestin, you find out that something that was the standard of care was, in fact, harmful to women and, yet, it was part of the best practices until it was actually looked at critically to look at what are the side-effects. And the question is, if people adhere to what's seen as the current best medicine, is that, in fact, something that a reasonable patient might want to know—that the doctor is not only using his or her own judgment, but [is] going along

with these national standards? Some patients may want to know and may consider it material.

This next issue is “What part of ‘no’ don’t you understand.” “No” is not the Japanese age-old drama but, in fact, a statement that recognizes that some patients can make and refuse life sustaining and altering treatment. Patients can refuse any treatment, including antibiotics, nutrition, and hydration. There is an experience in our state with long-term care providers if a patient refuses any nutritional hydration. Yet, the measures that look at the weight of patients in the long-term care facility [consider] an average drop as something that is bad medicine when, in fact, it may be a legitimate patient’s refusal of care, whether it’s nutritional hydration or [is] in the case of [antibiotics] that also can be refused by families and surrogates. Suddenly we’re measuring things, not recognizing that patient autonomy and obviously drug products through immunizations may be involved. Certainly the implication of patient refusal on performance measures, I think, is another of the ethical issues.

Does it hurt when my attorney does this? Well, there are other issues, and potential use in litigation runs along the current lines—opposite to what’s disclosed by the universe. There is a study cited in your handout that specifically analyzes whether or not specific measures might be used as evidence for litigation. The short answer is, the more specific the measure that is ranking physicians and tracking outcomes, the more likelihood [exists] that it will be admissible as evidence, [using] the Federal Rules of Evidence as a standard. Obviously lesser evidentiary standards are needed for licensure boards, health care traditionally, appeals, and medical specialty boards. So the potential use in litigation obviously is something that should be considered, I think, as an ethical issue because it will affect physician behavior.

So those are the five ethical issues. I guarantee that we are not going to spend a lot of time on all these issues. On these five issues I think we have to think ahead. Specifically, we do know that patient deaths can be expected in hospice and in end-of-life care, so just the fact that a patient dies, for instance, is not necessarily a bad outcome. This also has [implications] if you want to think about survivors. And certainly, I think, in pay-for-performance, these ethical issues [are] important to think of. Sometimes choices are not important. In implementing something that says “We’re going to measure this, we choose to do this better than you’re doing now,” I think we have to think about whether or not there are other choices. Obviously it’s important to think a few steps ahead. Thank you.