Editorial:

Conflicts of Interest and Quality Care

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"Whose bread I eat, his song I must sing."
–old German proverb

"No one can serve two masters."
–Matthew 6:24

The fundamental problem in medicine today is that too many physicians have been "taking insurance" and singing the song of the third party (Medicare, Medicaid, HMOs, etc.) to obtain their daily ration of bread. And, too many physicians have been trying to serve two masters—the third-party payer, and the patient.

Physicians who have permitted this conflict of interest with their patients often rationalize their actions by referring to modern day medicine as a "balancing act"—doing what is best for the patient vs. doing what is required by the third party payer. As pressure mounts in the third-party system of care to provide more care for less pay, the balancing act becomes increasingly difficult and more transparent. What benefits the third-party payer often results in less than optimal care for the patient. Cost containment scams like "pay for performance" (P4P) flourish, and physicians are reduced to assembly line producers of Relative Value Units (RVUs).

The "Donut Shop" Theory

Hospitals and clinics that have become totally dependent on third-party payers for their survival frequently make decisions that benefit the organization at the expense of the patient. Meanwhile, patients are unwittingly reduced to mere "donuts" under the third-party system. A recent Quality of Care Survey conducted by the American College of Physician Executives (ACPE) provided some strikingly candid disclosures about the effects of conflicts of interest on quality care. The ACPE consists of physicians who hold leadership positions in hospitals or group practices. Here is what one of the survey respondents had to say about the role of the hospital in serving patients, as told to him by a hospital chief operating officer (COO):

"The 'Donut Shop' theory of medicine: This is from a new (and very young) CNO [chief nursing officer] who—at our facility—was serving as COO as well. 'We are like a donut shop. Our job is to sell donuts. If we don't sell a lot of donuts, we go out of business. Your job, as Chief of Emergency Services, is to convince patients they need to be in the hospital and to convince doctors they have to admit patients. It is not your job to decide if the admission is good for patients. Donut shops still force donuts on the morbidly obese and the brittle diabetics. We need to force admissions on everyone. What might be "best" for the patient really isn't relevant.' I resigned shortly thereafter" (question #4, comment #182, Q4:182).[1]

"Length of stay" (LOS) has become the whip used on physicians in hospitals to put more "donuts" through in shorter and shorter periods of time, so as to accommodate the diagnosis related groups (DRG) payment system established by the government.

Physicians who complain about pressure to discharge patients prematurely, poor-quality care, and unsafe conditions in hospitals are often subjected to retaliation by sham peer review, which has become the weapon of choice to silence physician whistleblowers.

In the 2007 ACPE survey, 77% of respondents said that fear of reporting quality and safety problems was an obstacle (28% major obstacle; 49% sometimes obstacle) to providing high-quality care and to patient safety initiatives. Other common obstacles were identified as follows (major obstacle; sometimes obstacle): Federal government policies (18%; 62%); insurance companies' practices (30%; 50%); administrative culture that doesn't support quality/safety initiatives (17%; 41%).

The Role of JCAHO

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) was also repeatedly cited in the ACPE survey as an obstacle to patient safety. The following are just a few of the comments published in the survey:

"JCAHO requirements that become implemented are sometimes at odds with the real needs of patients even though they are supposedly driven to ensure patient safety. They take the control away from the physician/nurse-patient relationship, where it should be" (Q4:4).

"Many of the current JCAHO rules, while well intentioned add extra burden to the care team with little or no benefit to the patients. The organization sometimes puts compliance with these mandates ahead of patient care" (Q4:181).

"Locking up the drugs to satisfy JCAHO leaves us unable to respond in a timely manner to urgent/emergent issues with our pediatric patients in the OR. Being unable to treat laryngospasm immediately because the drugs are inaccessible occurred to me YESTERDAY in the PACU" (Q4:180).

"At some hospitals I work at: stool gu[a]iac cards needing to go to the lab to be read. No urine dip sticks in the ER, must go to lab for them to review. (Both deemed necessary to be congruent with JCAH objectives—both delay care). No pH strips in the ER at my major site of practice—laboratory took them away (delays prompt care in a chemical splash to the eyes)" (Q4:269).

Putting the Organization First

Most shockingly, the ACPE survey reported that 92.3% of the respondents said that decisions about quality/safety initiatives are often made that favor the organization rather than what is best for the patient (1.8%, always; 19.7%, frequently; 33.7%, sometimes; and 37.1%, seldom, but it happens). Here are some specific examples of decisions that were made to aid the organization rather than the patient(s):

Equipment & Supplies Decisions:

"Purchasing substandard medical supplies at deep discounts (with rebates from GPO system) despite medical staff concerns about safety and performance of materials" (Q4:372).

"Reusing disposable instruments in the OR to save a little money" (Q4:91).

"Inability to order supplies that are a safer quality than those which are less expensive for the hospital because of contracts" (Q4:270).

"We really need to upgrade our defibrillators for safety reasons, but due to finances this was nixed" (Q4:282).

Length of Stay Decisions

"Refusing to keep a deconditioned quad an extra few days in acute care for nursing care and antibiotics after a major flap reconstruction" (Q4:27).

"Early discharge from the hospital when a primary care MD wants to keep the patient a few days longer, but administrator wants early discharge!" (Q4:188).

"Homeless child admitted for RSV—not severe; mother new to area without any support system; I wanted to hold the child an additional 24 hours to get the needed support systems in place believing that the quality of what we do goes beyond the hospital walls; got into a bit of a tussle with URM and had to really go 'to the mat' on this matter; finally started nebulizations prn (really not needed) to allow the longer stay to be justified" (Q4:239).

"Discharging patients before they are really ready" (Q4:308).

Decisions Based Solely on Third-party Payment Policies

"Quality measure of documenting circulatory flow, tcpO2, bone scans for severe leg ulcers occurring in Rehab and SNF [skilled nursing facility] setting are discouraged since they will deplete the capped daily amount of Medicare reimbursement. Monetary resources of payment to SNF or Rehab are jeopardized when multiple needed exams are performed on these patients. Their profit is affected" (Q4:20).

"Current CMS quality indicators require that blood cultures be drawn from patients with community acquired pneumonia. There are a number of good studies showing that blood cultures have no bearing on the treatment or outcome of CAP. In order to comply with CMS quality indicators, the results of which are posted on the Internet, we are required to draw blood cultures on all patients with suspected CAP before we administer antibiotics. This adds to the cost of the visit, adds to the lab workload, adds to our checklist of things we have to remember, without adding anything to rational patient care" (Q4:339).

"Elderly patient who had malignancy diagnosed during hospitalization... waited until after discharge for staging MRIs, as the hospital got full reimbursement for MRIs for staging as an outpatient and gets none under DRG of hospitalization. Patient from rural community had to drive back for staging MRIs to great inconvenience" (Q4:40).

"Not performing PET scans on inpatients because of the cost of the radiopharmaceutical" (Q4:226).

"State funded [m]anaged care organizations severely restricting the use of appropriate medications" (Q4:225).

P4P Decisions

"Encourage testing at the short end of time-frame for benefit of P4P program" (Q4:82).

"Constructed Pay for Performance program that addressed revenue enhancement more than quality improvement" (Q4:97).

Electronic Medical Record (EMR) Decisions

"Information system implemented that did not have the best of patient care in mind" (Q4:74).

"Implementation of a component of the EMR that was so buggy that it distracted the care giver from the patient in an inordinate manner. After four months and several patient care accidents, it was finally removed and taken back to the drawing board" (Q4:276).

"We are struggling with an EMR that has had some major safety issues, but we continue because of the investment in the product" (Q4:300).

Decisions to Maximize Revenue at Expense of Quality Care

"We changed practice management systems to improve revenue cycle but disrupted our web portal with the patients in order to do this" (Q4:272).

"We are a Critical Access Hospital, so have very limited inpatient beds. The Organization has made the decision to encourage orthopedic surgeons to operate at the hospital and routinely 'saves' inpatient beds for surgeries the next day, even if there are sick patients in the ED that need them now, forcing transfers of the sick patients to another facility" (Q4:307).

"[A]dding physician assistant to our emergency room.… [W]ait-time is shorter but quality of care is questionable" (Q4:323).

"The hospital partnering with a surgical group to increase volumes of surgeries performed—however, the outcomes of the incoming surgeons were not nearly as good as those already in the hospital" (Q4:335).

"Surgeon group who are known as 'butchers' and scam poor and Hispanic patients are allowed to remain on staff because of the revenue they bring in [*sic*]" (Q6:115).

"Administration protecting high producers despite obvious breaches of quality care" (Q4:8).

"Physician tiering based solely upon cost rather than upon value (cost & quality concurrently)" (Q4:338).

"Group with largest amount of patients [*sic*] gets benefits despite performance below average" (Q6:112).

Who's Responsible?

A hospital's board of directors is ultimately responsible for everything that goes on in a hospital. However, since the flow of information to the board of directors is typically controlled by the hospital chief executive officer, board members are often left in the dark about what is really going on in a hospital. One survey respondent said: "Board of directors is publicly elected (i.e. popularity contest); essentially clueless about running a health care organization—all have their own agenda which is not always putting quality first in spite of their public comments. Most have a serious conflict of interest" (Q21:227).

So, what is the greatest obstacle to quality care and patient safety? "Greatest obstacle is not having the decision-making financial relationship between the patient and the physician (not the insurance company). This, along with caps on non-economic malpractice judgments, would allow market forces to come into play, and would significantly reduce the overall cost of health care, with a likely increase in overall quality" (Q21:83).

Universal Coverage

Those who favor, promote, and seek to impose the *Sicko* concept of socialism on the American public ("universal coverage") depend on their ability to mislead the public about the consequences of creating one of the biggest conflicts of interest between physicians and patients of all times—a single-payer system.

Whose money I take, his wishes I must follow. A socialized medicine monopoly constitutes an unalterable conflict of interest that, if adopted, will result in the destruction of the patient-physician relationship and quality care. A fully informed and educated public is essential to preventing the destruction of American medicine.

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REFERENCE:

1 American College of Physician Executives. Quality of Care Survey; 2007. Available at http://www.acpe.org/education/surveys/quality/. Accessed Jul 12, 2007.