IS IT EVER ETHICAL FOR A PHYSICIAN TO CODE A PATIENT’S DIAGNOSIS falsely in a medical record to gain benefits for the patient? The small amount of empirical research available suggests that many physicians do indeed choose to deceive third-party payers. In a decade-old survey, 70% of a sample of clinicians stated that hypothetically, they would write “rule out cancer” to secure funding for screening mammography if the patient’s insurance would not otherwise fund it. Nearly half the physicians in a more recent survey admitted to exaggerating the severity of patients’ conditions to get the care they felt the patient needed. In another study, in 1998, 39% of the physician sample admitted to exaggerating the severity of patients’ conditions, changing official billing diagnoses, and documenting nonexistent symptoms—all to gain additional benefits for patients.

Several approaches to such a dilemma have been articulated. One considers the ethics of lying. Sissela Bok champions the “principle of veracity,” which emphasizes the intrinsic moral undesirability of a lie because no one likes to be deceived. Others worry about the effect lying would have on trust on the patient-physician relationship. Because no one likes to be deceived.4 Others worry about the effect lying would have on trust on the patient-physician relationship. Still others worry that exaggerated and inaccurate diagnoses may frighten patients and compromise their future clinical care.

Alternatively, the question may be interpreted as one of distributive justice. The reimbursement boundaries set by third-party payers are a de facto resource allocation mechanism. Much has been written about whether physicians should ever withhold available interventions because of a high cost-to-benefit ratio.7,8 The same reasoning applies to the question of whether physicians should ever transgress reimbursement boundaries to secure benefits not covered by insurance plans.

ENTRANTS IN THE 1999 JOHN CONLEY ETHICS ESSAY CONTEST FOR MEDICAL STUDENTS were asked: “Suppose a potentially useful procedure is available that is not covered by a patient’s medical insurance. Under what circumstances, if any, would you consider it appropriate to miscode (and thereby make available) the needed procedure?” Peter Ubel, MD, frames the issue as a question of distributive justice. Then, from opposed perspectives, the winners of this year’s contest argue that miscoding is unethical because of its effect on the “medical commons” (Dena Rifkin) and that miscoding is sometimes justifiable based on the role society accords physicians (Greg Webster). On reading these essays, we hope readers will be better equipped to answer this question for themselves.
Physicians’ Duties in an Era of Cost Containment: Advocacy or Betrayal?

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The explosion of medical technology in the late 20th century has forced physicians to think seriously about cost containment. When my father first practiced medicine in the 1950s, his pharmaceutical armamentarium included a handful of antibiotics and 2 or 3 antihypertensives. The most expensive diagnostic tests were plain film radiographs. It was easier to give patients the best health care money could buy, because there was not as much health care to buy.

Now, however, physicians can order $2,000 magnetic resonance imaging (MRI) scans that may have little chance of finding anything clinically relevant. Screening women annually for cervical cancer by Papanicolaou smear costs over $1 million per life saved.1 Screening people a sixth time for colon cancer with fecal occult blood testing costs over $26 million per life saved.2 In short, today we can offer our patients many interventions that bring small benefits at great financial cost. From my perspective as a physician who did not begin practicing medicine until the late 1980s, the cost of health care has always been an issue to consider.

Pressure to contain health care costs places physicians and other health care practitioners in difficult positions. If we pursue our patients’ best interests without regard to costs, we will accelerate health care inflation, a serious concern in an era in which governments throughout the industrialized world are struggling to offer health care to their populations. But if we forsake patients’ best interests in favor of society’s pocketbook, we risk alienating our patients, who expect that we will be their untiring advocates.

Most contemporary medical ethicists argue that physicians should pursue patients’ best interests regardless of cost. According to this view, health care rationing should be done at higher levels than the patient-physician encounter,3,4 such as by formulary committees, which limit the medications available to clinicians, and by utilization reviewers, who tell us when insurers will stop paying for extra hospital days. It is my position, however, that physicians need to relax their advocacy duties in order to control health care costs.5

Debates about the moral status of bedside rationing do not often recognize its already pervasive presence in clinical medicine. Suppose, for example, that a physician who believes that she should not ration care from her patients is faced with a formulary committee that restricts the use of proton pump inhibitors to patients with severe gastroesophageal reflux. Should she advocate for her patients’ best interests by liberalizing her interpretation of what qualifies as “severe reflux”? If not, she is participating in the rationing of care. When should this physician accede to and participate in third-party rationing mechanisms, and when should she fight them, even to the point of misrepresented patients’ conditions to get them what is in their best interests?

Often, an extra hospital day is only mildly beneficial, or a new medication is only 1% better than an older, less expensive one. At the same time, health insurance in the United States is so expensive that many employers no longer offer health benefits to their employees, thereby swelling the ranks of the uninsured. In times like ours, physicians need to be willing to forego small benefits for their patients by acceding to reasonable third-party payer rationing mechanisms.

Each physician must decide what constitutes a “small benefit” and a “reasonable rationing mechanism.” When very important health care resources are being withheld from our patients, we need to fight third-party payers aggressively to obtain the resources. But other times, when the resources being withheld are only slightly better than available resources, we need to take third-party payer restrictions as a reminder that not all benefits are worth pursuing, given the great importance of controlling health care costs.

It is, of course, often possible to bend third-party payer rules without technically breaking them. The difference between moderate and severe gastroesophageal reflux, for example, is a judgment call. A physician who has a low threshold for classifying reflux as “severe” is not necessarily breaking a rule. In fact, most third-party payer rules leave generous room for interpretation.6 Ultimately, though, deliberate bending of the rules amounts to a deliberate misinterpretation of their spirit.

Physicians need to think hard about the societal and personal consequences of such rule-bending. The societal consequences are clear: frequent rule-bending will fuel continued health care inflation. The personal consequences, however, can be even more dramatic. A physician who always errs on the side of providing additional resources will be unpopular with third-party payers, who may refuse to contract with him or her in the future. In interpreting third-party payer reimbursement rules, we need to remember that such rules exist because society wants us to control health care costs. If physicians bend too many rules, the health care system is bound to break.

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Community Considerations: The Many Effects of Miscoding

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Mrs Paul walks stiffly into the office, settling into a chair with obvious relief. “This pain is just the worst thing there is. Even getting the mail is bad. What in the world can I do?”

Dr Jones removes Mrs Paul’s shoe. The woman’s foot is grossly misshapen, and she winces in pain throughout the examination. The bunion clearly has affected her mobility; Dr Jones notes that Mrs Paul has gained 15 pounds since her first appointment with this Medicaid HMO. Yes, Dr Jones thinks. I could remove that bunion surgically. Of course, bunion removal isn’t covered in this new insurance plan—but bone spur removal is. Mrs Paul wouldn’t know the difference. I can’t get all my patients everything they need—people would begin to notice—but at least I can help one person at a time.

Whose interests must the physician uphold? Those of the insurance organization that formulates the rules and provides the payments? Or those of the patient, who cannot afford the procedure but possibly would have less pain and better mobility if she were treated? The ethical challenge facing physicians like Dr Jones is one that has long been the province of law and jurisprudence: the tangled morality of breaking rules in order to provide “true” justice.

Health insurance plans have created a legal microcosm of rules and regulations. By buying or qualifying for a health insurance policy, an individual enters into a common set of rules with all the other people covered by that particular insurer. The insurers may try to create a system that philosopher and ethicist John Rawls might call “formally just”: the rules are clearly stated, changed only with due notice, and applied equally to all cases, with proper opportunity for appeal and judgment.¹ The actual rules that are being enforced in this way may or may not be what Rawls calls “substantively just”; the content of the rules, regardless of the system in which they are enforced, may or may not provide what the community considers to be good and fair treatment.

The physician has a dual role in this system. First, he or she has the responsibility to act for the insurers by upholding the rules of coverage, both to preserve the integrity of the system and to protect patients from unfair and unequal treatment. Second, the physician has the often opposing responsibility to act for the patient by deciding whether a policy or rule is substantively just; that is, whether it provides the patient with a basic standard of health care or whether upholding the rules would damage the health of the patient.

In miscoding a procedure on an insurance form, how-ever, the physician violates both of these responsibilities. By furtively disobeying an unjust rule, the physician violates the rights of other patients within the system and fails to defend openly the patient’s need for the procedure. Even if the physician believes that the insurance system is antithetical to good care, the ethical step is not to evade the rules but rather to fight them openly for the sake of all patients within the system.

In the immediacy of the traditional patient-physician encounter, the needs of an individual patient are more salient than this ethical responsibility to the community. The increasing control of health care by insurance organizations, however, has forced population-based medicine into doctors’ offices and given physicians far greater accountability to patients outside their own practices.

Misrepresenting a diagnosis seems like an innocuous way to deal with insurance rules because unlike an individual patient, the insurance provider is anonymous and has tremendous resources. If insurance has a face, it is often that of a highly paid CEO; expenditures for health care totaled over $1 trillion in 1997, making the cost of a bunion removal seem trivial in comparison.² Why, then, should doctors honor the rules of this twisted game?

The “Medical Commons”: The Physician’s Duty to Consider Other Patients

In medicine, the patient-physician relationship has always been held sacred; physicians have a responsibility to treat patients appropriately, respect their confidences, and act as their advocates in a confusing and impersonal health care system. But what responsibility does a physician have for the faceless other patients, the people who could be adversely affected by preferential treatment of his or her patients? For example, aggressive use of broad-spectrum antibiotics has created the specter of vancomycin-resistant staphylococci and other pathogens that threaten new populations of patients. Analogously, miscoding procedures so that insurance will finance them depletes the shared pool, leaving other patients to face stricter rules or to be denied insurance altogether. The “tragedy of the commons,” as Garrett Hardin put it, happens when every person pursues his or her own interests within a shared community resource.³ Each individual may reason that taking a bit more of the pie will not damage the resource; however, when each individual acts on this reasoning, the commons are destroyed. Medical insurance, private or public, cannot command an infinite system of resources. Instead, insurance creates a finite “medical commons,”⁴,⁵ which should be distributed according to a sound system of rules.

In Oregon, an attempt to distribute the medical commons by rationing Medicaid resources has led to strict cut-offs for procedures of lower priority.⁶ The cut-off line on a list of prioritized procedures is adjusted according to budgetary considerations and Health Care Financing Administration (HCFA) restrictions.⁷ However, doctors have cir-

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cumvented the guidelines by miscoding uncovered procedures; the increasing costs of the system have led to abandonment of the original goal of covering all uninsured citizens and exclusion of more procedures from coverage. In other insurance systems, the losses due to miscoding are more difficult to pinpoint; or premiums rise so that some people cannot afford them, or a preventive program is cut, or perhaps an administrator’s raise decreases. Certainly, the patient in the office with the throbbing foot is of more immediate concern than these considerations. Yet the physician must weigh these unseen costs against the benefits to the individual patient, just as he or she must consider the risk of creating resistant bacteria, which could harm unknown patients, when prescribing powerful antibiotics. The medical commons is a reality: there is only so much health care to go around.

**Preferential Treatment—for Whom Do We Break the Rules?**

For a physician to break the rules selectively on behalf of certain patients is biased medicine, patently unfair, and discriminatory. The discrimination arises because the only way to “game the system,” or to subvert the rules of the insurance plan, is to do so occasionally. An unusual pattern of cases, such as miscoding a large number of deviated nasal septae for an uncovered procedure like rhinoplasty, would be too recognizable. The physician, then, must choose which patients merit this procedure and which do not. The hotly debated case of baseball player Mickey Mantle illustrated dramatically how these choices can be biased: although Mantle had cancer of the liver, a condition that often rules out transplant, he was placed at the top of the waiting list and quickly received a transplant, prompting accusations of medical favoritism.

In daily practice, the basis for preferential selection may be more subtle, even unconscious; it may involve personal sympathy for particular patients or implicit judgments about the value of health for different people. Miscoding procedures necessitates ad hoc, bedside rationing of care, a practice often decried as discriminatory. Preferential selection violates the integrity of a system in which similar cases should be treated similarly.

**Faking the Data: Physicians’ Responsibility to Science**

If a scientist invents or misrepresents data, we call it intellectual dishonesty; so, too, a doctor who miscodes a diagnosis is falsifying data, an act that can have widespread ramifications in the scientific community. A system rife with miscoded procedures may lead researchers to track an inaccurate pattern of disease, which could lead to inappropriate allocation of research to the fabricated diagnosis or procedure and corresponding neglect of the true disease. Statistical analysis of insurance records, particularly those collected by HCFA, is used extensively in epidemiological research and in economic forecasting. Miscoding corrupts these data and, paradoxically, will tend to lower the priority of the very procedure that the physician is underreporting.

**Is Miscoding Selflessness or Self-interest?**

More insidiously, the idea that physicians miscode solely to provide the patient with needed care masks a less noble ethical decision: the choice not to provide care pro bono. Pro bono care has long been a part of medicine, and many physicians consider it an essential part of their work. Between 1990 and 1994, the percentage of physicians providing uncompensated care and the amount of time spent on such services both rose, with about 68% of physicians providing some pro bono care. Despite Medicare and Medicaid subsidization, hospitals still finance a key component of uncompensated care for indigent patients. While physicians and hospitals cannot and should not bear the full burden of supporting inadequate insurance systems, they can continue to help needy individuals by providing service free of charge for procedures that may be useful but are of low priority. In this way, the rules of the insurance system are upheld, the patient receives care, and the physician preserves both professional and personal integrity.

**Responding to an Unjust System: Undercover or Aboveboard?**

For the sake of all the patients in the system, the physician should appeal unjust rules, voice opposition publicly, and advocate openly and honestly for the needed treatment. This kind of activism takes time and effort, jeopardizes the physician’s relationship with insurance providers, and may well threaten a career with an HMO. Physicians feeling helpless and alone in the face of unjust insurance regulations would do well to remember the lessons of civil disobedience, first expressed by Henry David Thoreau and taken up by Martin Luther King, Jr, and other civil rights leaders: the collective voices of all those opposed to an unjust rule can break it, while silence and subterfuge only make it stronger.

For most physicians, population-based medicine is antithetical to the goals of bedside care. Yet considering the needs of the population can save lives as well, by distributing the medical commons equitably, by determining which treatments can maximize the health of the community, and by providing accurate data on health trends. Physicians must bridge the gap between people and numbers, treating individuals fairly and humanely while recognizing the impact of individual decisions within a larger system.

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Serving Two Masters: Medical Practice vs Administrative Ethics

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Miscoding looks like the quick movement of a black pen. If one stood and watched 1000 doctors miscode and 1000 doctors check the appropriate boxes there would be no telling the white hats from the black hats. Perhaps a certain doctor chewed her pen a moment before scribbling. Perhaps the other paused thoughtfully before writing down his recommendations. Good physicians who feel forced to miscode must first consider a number of moral issues. They must be able to discern the greater good and must believe that the miscoding deception serves the greater good. Given that, when the physician’s conscience and the larger ethics of professional conduct would allow the omission of an appropriate diagnosis and when those same ethics condone inserting a new one, the physician may ethically miscode a patient’s diagnosis.

A debate on miscoding leads nowhere if a physician is not allowed to deceive under any circumstances. Benign deception, however, is widely practiced in medicine. Every physician commits ethical errors of omission during a commonplace physically for instance, telling the patient who queries about a thump, “I’m just seeing what’s going on,” or “I’m just listening to your lungs here.” The physician has decided not to discuss all possible diagnoses with the patient. Few physicians would argue that every patient who comes in with swollen lymph nodes should be told that he or she might be carrying the plague. Hopefully, the doctor has dismissed that possibility by the end of the examination and the omission has served both the physician and the patient.

Withholding an obscure diagnosis for 5 minutes so that it can be dismissed quietly is a minor breach, if one at all, and perhaps attributable more to a nebulous pool of “people skills” than to an ethical dilemma. Perhaps the idea of misinformation is better illustrated by examining a more active lie. Mr J, an 82-year-old gentleman, walks into a clinic in a small town presenting with a complex spectrum of complaints. The new doctor begins to take his history and Mr J reveals that he has a “bad back” and it is being effectively managed. The patient responds that he is being treated by his family doctor. The physician asks how it is being managed. The patient reveals nothing more exciting than a handful of M&Ms. The placebo is an ancient crutch of medicine. It would serve a heartless clinician indeed who would deprive Mr J of his M&Ms back pills either by snatching them out of his grasp or by shredding the illusion of their effectiveness. There is a time and a place for placebo medications, and there is certainly a point where their use is deleterious. Judicious use of placebos, however, has allayed a great deal of suffering.

These cases intimately relate to the original question of miscoding because they establish benevolent deception as a tool of physicians. We do not vilify physicians who occasionally practice this form of deception. Rather, we call them compassionate and look up to them as keen students of their patients’ needs. If we as a profession will admit to these deceptions, then it is not a large leap to apply deceptions in other situations, similarly warranted by necessity and the greater good.

Miscoding appears at first, however, to be a greater ethical breach than prescribing placebos. The physician must pick up a pen and check the wrong box. He or she must fill in a date and time and affix a signature, just as if no error in judgment were occurring. To make matters more difficult, the physician may even find it necessary to scribble “Rule out _______” in a hand quite unrecognizable in many ways from his or her usual, honest scrawl. There it sits, a black and white testimony to the physician’s arrogance, using someone else’s money to cure the patient’s illness. The act does not seem like something to take pride in. Prescribing placebos and checking the wrong box are, after all, both acts of lying, and are therefore not different in nature.

Miscoding may be ethically inappropriate because physicians can always try to change the insurance rules. The ethically untainted solution would be for the physician to appeal to the insurance company, document the evidence, and request a special dispensation. On discovering that the special permission has been denied, the physician could then crusade to have the disease recategorized so that the test is covered for everyone who presents with similar symptoms. That course of action is pleasing but impractical in the real world. Not only does a physician not have the time or inclination to rail against the corporate structure each time an institutional blockade is presented, but other patients in the practice would necessarily suffer from inattention.

The physician who is considering miscoding must be assured (1) that the test truly is the best and only means of obtaining the necessary information and (2) that the test will bring substantial gain to the patient relative to inaction as well as to alternate, perhaps multiple, insured actions. This logic applies to all tests, treatments, therapies, and procedures, regardless of cost. Size or price does not alter ethical responsibility.

These breaches of confidence, by omission and by commission, must be balanced against some nebulous idea of the greater good. The most weighty question concerns determining whether the physician has the ability to discern the greater good. Every day, decisions are placed in physicians’ hands that involve weighing the good of the one against the good of the many. Is it appropriate to give antibiotics if the overuse of antibiotics may increase resistant organisms? It is
the family physician who must decide every day. Is this par-
ticular newborn really the best use of these cardiac funds? The cardiac team must make that decision. If we refuse to admit that physicians are equipped to make decisions about the greater good, we make the profession impotent. Society should expect physicians, as professionals, to be able to make responsible decisions about the allocation of medical resources. If that prerogative is refused, then the practice of medicine must grind to a standstill. We must therefore conclude that doctors can and should make decisions pertaining to the greater good.

But does the miscoding truly represent the greater good? The process of being forced to miscode heightens a physician's awareness of the circumstances that led to the miscoding. If a desired procedure is unavailable, the physician must either miscode—a situation that is ethnically disturbing—or cumbersomely work around the unavailable procedure. Either way, a large enough number of physicians sufficiently troubled about the same problem will eventually create a critical mass, enabling direct appeal to insurance companies to change their policies. In the meantime, the physician has continued to serve patients to the best of his or her abilities. Being able to serve both the patient and the administrative machinery of medicine can be an elusive goal. Achieving a reasonable balance between these ends, though, speaks of a decision rooted in the greater good.

The process of assuring an ethical miscoding depends on the ability of the physician to exercise sound judgment. The only way to sort out these judgments is, first, to convince oneself that the miscoding is the best clinical opinion available and, second, that the miscoding substantially and materially helps the patient. The third task is for the physician to weigh the immediate gain for one patient against the cost to society. Society relies on physicians not only to look after people's medical health but also to prevent other sectors of society from disrupting medical care. Miscoding to save a patient is the last resort for the physician with experience and talent. If physicians are not granted the ability to apply their judgment and do not take the responsibility into their own hands, there is no other source to fill the void.

Community Considerations (Continued from p 1677.)


2000 John Conley Ethics Essay Contest for Medical Students

The Medical Student JAMA is pleased to announce its sixth annual essay competition for medical students, sponsored by the John Conley Foundation for Ethics and Philosophy in Medicine. This year’s topic examines an issue raised by the expanding technology available in medicine. Traditionally, preservation of life has been the foremost concern of medicine. With new technologies available to prolong life, ethical issues have emerged around who determines and how one measures the quality of life. In their essays, medical students are asked to address the following scenario: Suppose that a neonate with trisomy 21 is found also to have a medical condition that is easily repaired surgically, but lethal if not corrected. The parents of the newborn are not prepared to raise a child whose quality of life they believe will be impaired and ask that no further medical intervention take place. What are the ethical obligations of the physician?

Essays will be judged based on clarity of presentation and writing and applicability to actual decision-making. Essays should address the ethical dilemma presented in the scenario and not focus on the science of genetic testing or the mechanisms of the disease. The author(s) of the best essay(s) will be awarded $5000 or a portion thereof and will be encouraged to use some of the funds to attend an ethics conference of their choice. Winning essays will be considered for publication in MSJAMA. Essays must not have been previously published in print or electronic format and must not have been submitted to any other journal during the review period.

All current medical students are eligible. Essays should be less than 2000 words in length. Please submit essays typed and double-spaced, with the author’s identification (name, address, telephone number, and medical school class) on a cover sheet only—not on the essay pages, which will be anonymously judged. Entries must be postmarked by January 15, 2000, and sent to:

John Conley Essay Contest, c/o MSJAMA, 515 N State St, Chicago, IL 60610

Essays winning honorable mention in the 1999 John Conley Ethics Essay Contest can be found online at http://www.ama-assn.org/sci-pubs/msjama/index.htm. The honorable mention winners are Matthew R. Cooperberg, Yale University School of Medicine, “Justified Deception? Miscoding on Insurance Claims”; Rishi Agrawal, Northwestern University School of Medicine, “A Change of Heart”; and Stephen Jae Kim, Johns Hopkins University, “The Choice.”