POINT: Are surgeons ethically obligated to treat Medicare patients despite substantial reductions in reimbursement?

Edward D. Verrier, MD

See related articles by Robert M. Sade on pp 37 and Tea E. Acuff on pp 41-3.

Before addressing the question of whether surgeons are ethically obligated to treat Medicare patients despite a substantial reduction in reimbursement, I must make some disclosures. First, as a professor of surgery and chief of the Division of Cardiothoracic Surgery for 25 years, I have worked in an academic medical center my entire career and not in a fee-for-service reward environment. I have had responsibility for the financial viability of the Division of Cardiothoracic Surgery but was only indirectly influenced by reimbursement patterns by private payers, Medicare, or Medicaid. I have not had to directly deal with the issues of increasing practice support expenses, more administrative support needs, or a strict fee-for-service remuneration environment that might affect my salary or the salary of our faculty. Second, some variables based on context and circumstances shade the debate, although at the end of the day, in the predominantly urgent and emergency world of cardiothoracic surgery where healing is the primary end point, such issues should be relatively minor in relevance.

First, location of practice and the availability of other specialists can cloud the fundamental ethical imperative and make the decision easier for the urban surgeon to justify not accepting a Medicare patient. One surgeon may be surrounded by many younger surgeons, eagerly trying to develop a sustainable practice, and therefore make the decision to personally withhold care easier. In comparison, the lone practitioner in a smaller, rural practice environment may not have other surgical alternatives and may be under closer local, environmental scrutiny. Therefore, the decision to withhold care based on personal remuneration, if publicized, may be more visible and difficult.

Next, there might be a difference between “emergency” versus “urgent” versus “elective” versus “cosmetic” surgical practices. Clearly, many plastic surgeons doing primarily cosmetic surgery demand cash up front before accepting any type of patient, never mind just Medicare patients. Such behavior appears to be widely accepted ethically by societal standards. In contrast, the life of the patient with an acute aortic dissection may depend on emergency surgical therapy regardless of the payment scheme. The ability to deny care on any basis other than solid medical decision making would be more difficult.

The next context deals with the issue of personal income based on the fee-for-service model versus basically receiving a salary whether that be hospital based as is increasingly occurring in the United States or societal based as in countries with universal access or global insurance. If one removes from the table the fee-for-service issue, where personal income is based on reimbursement minus operating expenses, is there a different moral imperative? If the financial issue is eliminated, would you treat one patient differently from another given similar medical issues?

Finally, one cannot confuse broader health care allocation of resources and end of life issues in the Medicare population, which might also be an ethical societal dilemma in withholding care based on physician reimbursement. This discussion is not one of age discrimination. This question is phrased on the basis of Medicare remuneration, but in reality it is a broader ethical question: can a surgeon refuse to care for any patient because of a substantial reduction in reimbursement?

In the case of cardiothoracic surgery, we have to be a little careful in the public eye to use the argument of a “substantial” reduction in surgeon income unless there is clear evidence such a trend is occurring. Substantial has a variety of potential meanings, but according to the Oxford English Dictionary, substantial is defined as “of considerable importance, size, or worth, concerning the essentials of something, or real and tangible rather than imaginary.” The evidence that substantial applies to our discussion is speculative at best. The last significant reported trend analysis based on analysis of Medicare reimbursement for coronary artery bypass surgery was reported in 2006 in the *Bulletin of the American College of Surgeons*.¹ From 1995 to 2007 there was an estimated 8.2% decline in inflation-adjusted income for cardiac surgeons based on a decrease in reimbursement for coronary artery bypass graft operations from \$3957 in 1988 to \$2051 in 2003. There have been relatively minor reductions in reimbursement for bypass

From the Division of Cardiothoracic Surgery, the Department of Surgery, University of Washington Medical Center, Seattle, Wash.

Disclosures: Author has nothing to disclose with regard to commercial support.

Read at the 92nd Annual Meeting of The American Association for Thoracic Surgery, San Francisco, California, April 28-May 2, 2012.

Received for publication Sept 13, 2012; accepted for publication Sept 24, 2012.

Address for reprints: Edward D. Verrier, MD, Cardiac Surgery Clinic at UWMC, 3rd Floor, 1959 NE Pacific St, Seattle, WA 98195 (E-mail: edver@u.washington.edu).

J Thorac Cardiovasc Surg 2013;145:38-40

0022-5223/\$36.00

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<http://dx.doi.org/10.1016/j.jtcvs.2012.09.065>

surgery since that time. Cardiothoracic surgeons have compensated for that trend by increasing volume, adding new operations, or improving coding skills. There is little corroborating evidence that a significant reduction in surgeon salary has occurred. If one goes to the Bureau of Labor Statistics² and looks at all occupations in the United States, the occupation title for the very highest paid employment is “surgeon” at an average salary of \$225,390. If one then looks at the site of practice, the annual income in the offices of physicians is \$241,060 in comparison with general medical or surgical hospital (\$204,970) or university/professional schools (\$155,740).³ Thus it appears that the office practitioner has not been affected more than alternative sites of practice. If one then looks at the national 6-year income average for cardiothoracic surgeons reported in 2011, the figure is approximately \$522,875, which ranks second behind neurosurgeons as the second highest surgical income level.⁴ Similar data exist for general surgery and most other surgical specialties. In the current real world, we cannot argue that the word “substantial” as applicable; we can later discuss this as a theoretical concept. Initially, we should now address the fundamental question of this debate: are surgeons ethically obligated to treat patients despite a reduction in reimbursement?

Basic medical ethical principles include autonomy, beneficence, nonmaleficence, dignity, and, finally, truthfulness and honesty.⁵ In very simple terms, *autonomy* refers to the right of individuals to self-determination, to make their own choices and decisions; *beneficence* refers to the physician’s moral obligation to promote the wellbeing of others; *nonmaleficence* refers to first, do no harm; *justice* refers to fairness and equality in the treatment of all with due reward and honor; *dignity* refers to the intrinsic worth of patient and provider; and *truthfulness* and *honesty* basically refer to informed consent. The 2 primary ethical principles involved in this debate are justice and beneficence. The concept of justice dates back to Aristotle, who conceptualized justice as the rendering to each individual that which is due to him or her. More recent influences in biomedical ethics originate from John Rawls’ *A Theory of Justice*,⁵ in which he argues that a social arrangement forming a political state is a communal effort to advance the good of all in society. Most socioeconomic considerations fall under the concept of justice. This concept has evolved into a patient’s bill of rights. Although not formally adopted by Congress in 2001 (McCain-Edwards-Kennedy Patient Bill of Rights), most of the concepts in the patient’s bill of rights were adopted locally in every state and by health care organizations like the American Medical Association. Among the 4 positive rights of a patient, the following 2 are included: (1) to be treated by a knowledgeable, competent practitioner and (2) to have his or her health and wellbeing more highly valued than the surgeon’s own economic interest.

Beneficence, or this concept of a moral obligation to act for the benefit of helping others, is often argued as the essential foundation of medical ethics. This leads to the concept of a physician as having a moral fiduciary responsibility toward the patients. The surgeon is a person holding the character of trustee in respect to the trust and confidence involved in it and scrupulous good faith that it requires. In other words, the surgeon is someone who undertakes an act for and on behalf of another in a particular matter of circumstances that give rise to a relationship of trust and confidence. Opinion 10.15 from the American Medical Association states: “The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups, and to advocate for their patients’ welfare.”⁶ The question then becomes, is such behavior a moral obligation or a moral ideal? The obligation of social nonmaleficence (do no harm) is widely accepted, but the obligations of social justice and social beneficence are more widely debated.

The historical precedence for this line of argument is based on the Hippocratic Oath but even more on the moral-sentiment theory of David Hume, the utilitarianism theory of John Stuart Mill, and the moral imperative theory of Immanuel Kant. The original Hippocratic Oath requires that “whatever houses I may visit, I will come for the benefit of the sick.” The oath has evolved over time, and one newer version of the oath states “the provider (surgeon) undertakes to care for the health of the purchaser (patient) to use his or her best endeavors to correct any defects therein and to prevent the development of further harm.”⁷ Edmund Pellegrino⁸ more recently reinterpreted parts of the Hippocratic Oath to say, “physicians are not and must never be, commercial entrepreneurs, gate-closers, or agents of fiscal policy that runs counter to our trust.” Hume⁹ argued that benevolence accounts for the origins of morality rather than psychologic egoism or private interest. Whereas he felt justice was a social virtue, he believed benevolence was a “principle” of human nature. Mill’s theory of utilitarianism¹⁰ states that one must act so as to produce the greatest aggregate happiness among sentient beings, within reason. When harms and benefits are weighed to both parties involved, harm to the patient will always outweigh benefit to the surgeon. Finally, Kant¹¹ stated that everything has either a price or a dignity ... whatever has a price can be replaced by something else as its equivalent; on the other hand, whatever is above all price, and therefore admits of no equivalent, has a dignity. Providing care for our fellow beings has dignity, is a moral imperative, and we as physicians have a duty to provide such care.

We finally come back to the gray shading of this discussion, probably not black and white. I believe the surgeon as

a medical fiduciary is a moral ideal, approaching a moral obligation. Reimbursement should not affect the physician–patient relationship. In reality, many economists argue that economics actually drive the moral behavior of physicians.¹² There are multiple examples where reimbursement goes down but volume goes up or coding for reimbursement changes. Surgeons should be paid on the basis of the difficulty or uniqueness of the services rendered, the time, skill, and expertise required, the fee customarily charged for similar services, some sort of overall societal value in comparison to other professions, the quality of performance, and maybe the experience, reputation, and ability of the surgeon performing the service. If a “substantial” reduction in reimbursement occurs, is there a point where the surgeon can say no? Obviously, inadequately reimbursed care that significantly affects quality does heighten these ethical questions. One can argue that if the fee-for-service mentality that is unique to the United States went away, this type of ethical question would be much easier to face. Care would be provided based on doing the right thing, for the right person, at the right time. At this point in history, culture still holds cardiothoracic surgeons in high esteem and compensates us well, substantially because it still trusts us to behave ethically, emphatically, and to serve our patients’ best interests before our own. As stated in *The Ethics of Surgical Practice*: “... continue to practice surgery on the basis of scientific evidence, clinical indications, fiduciary responsibility,

and empathic regards for the genuine needs of patients remains the best response to the forces that have buffeted medicine.”¹³

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