BRIEF REPORT

Talking About Money

How Primary Care Physicians Respond to a Patient's Question About Financial Incentives

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Patients sometimes express concern about the influence of "perverse" financial incentives on their care. We recruited a convenience sample of 101 primary care physicians and obtained information on their compensation. Then we audio-taped them as they role-played a response to a videotaped mock patient who asked them how they were paid and how their method of compensation affected clinical decisions. Overall, 36% of the physicians did not give enough information in their role-play response to allow an independent determination of how they were paid. Adopting a broad spectrum of attitudes and approaches, nearly every physician avoided discussing the role of incentives and stressed instead that he or she could be trusted under any circumstance.

KEY WORDS: financial incentives; doctor-patient communication; trust.

J GEN INTERN MED 2002;17:75-78.

Thanks for the advice, doctor. By the way, before I leave, I was wondering if I could ask you something. [Pause; eyes downcast] I've been reading in the newspaper recently about how some doctors are being paid to withhold care, while others get paid more if they do extra tests or operations. Now, I've never really thought about it much before, but I was wondering if you would mind telling me how my insurance company pays you, and how you think that it affects the decisions you make for me and the care I get?

Few physicians are likely to relish the opportunity to answer this question at the end of a patient visit. And yet, considerable anxiety has been created by the new, "perverse" financial incentives that health plans and provider groups use to create cost-consciousness among physicians.¹⁻⁴ Recent evidence demonstrates that most patients are unaware of how their physicians are paid, and disclosure of financial incentives to patients has been touted as the most useful way to address patients' concerns and improve trust.⁵⁻⁷ The goal of this study was to learn about the way that practicing primary care physicians

describe how they are paid and verbally defend their integrity before a concerned patient.

METHODS

We recruited a convenience sample of physician participants attending the PRI-MED primary care medical education conference held December 4-6, 1999 in Boston. We randomly approached physicians walking through the conference area to invite them to participate. Physicians who were interested joined a group of 4 to 8 other physicians to watch a video vignette of a patient, "Mrs. Anderson." In the video, Mrs. Anderson expresses concern about financial incentives and asks how the doctor is paid (see exact text above). Participating physicians were informed that Mrs. Anderson had the most common type of commercial insurance product seen in their practice, excluding Medicaid and Medicare. Immediately after the mock patient's question the video was paused and each physician, dictating privately into a hand-held dictaphone, responded to Mrs. Anderson as if she were his or her own patient. Each physician then completed a 1-page questionnaire on demographics, practice characteristics, experience responding to questions about compensation, and the specific breakdown of the sources of their compensation.

ANALYSIS

The dictations were all evaluated qualitatively by the 2 investigators in an iterative process looking for common themes within the physicians' responses. Each physician's response was also coded specifically for the following 3 features: 1) whether the answer distinguished among the 2 tiers of compensation: insurer to physician group, and physician group to individual physician; 2) the type(s) of compensation mentioned, if any; and 3) whether the payment method was named explicitly, i.e., salary, fee-for-service, or capitation.

RESULTS

We recruited 111 primary care physicians to participate in the study. Technical problems made the dictations of 10 physicians uninterpretable, leaving a final study cohort of 101. Of this group, 50 (50%) were general

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internists; 30 (30%) were family practitioners; 8 (8%) were general pediatricians; 8 (8%) were general practitioners; and 5 (5%) were obstetricians who said they provided primary care. Men outnumbered women 65 (64%) to 36 (36%), and the average age of all physicians was 47.8 ± 10 . The physicians came from medical groups of various sizes, with 27% of physicians in solo practice, 61% from groups of 2 to 50 physicians, and 12% from groups of greater than 50 physicians.

The majority of physicians reported that in the previous year they had been asked 1 or more times about their compensation or financial incentives by a patient or a patient's family. Only 39% of physicians had not been asked at all; 42% had been asked between 1 and 5 times; and 20% of physicians had been asked more than 5 times.

Physicians' written breakdown of their overall compensation is summarized in Table 1. Although 30% of the physicians indicated that they were compensated solely through salary, most physicians were paid some combination of salary and fee-for-service, with many physicians also having additional incentives based on productivity, group financial performance (i.e., a withhold), or quality indicators (Table 2).

PHYSICIANS' RESPONSES

Content and Styles of Responses

Physicians responding to Mrs. Anderson adopted a broad spectrum of attitudes and approaches, of content and style. Several physicians claimed utter ignorance of how the insurance paid for their patient's care; one physician even suggested that Mrs. Anderson consult with his secretary, who "would be able to give you a better answer than me (*sic*)."⁸ A few physicians seemed genuinely put off, as if they felt the patient's question was an inappropriate challenge to their integrity. As one physician bluntly stated, "Hi. I think it's unethical for me to discuss with you this question, or to answer your question." Another physician parried the question somewhat more diplomatically: "I can certainly assure you that my decisions are not at all based on what I'm paid and I really don't think I'd like to answer your question and give you a real answer. I don't think it's really a serious issue in terms of really being able to respond to you in a detailed way. I hope that satisfies your concern."

Table 1. Breakdown of Primary Components Comprising Physicians' Total Compensation*

Total Income, %	Salary	Fee-for-Service	Capitation
0	37	49	58
1 to 49	12	22	33
50 to 99	22	28	9
100	30	2	1

* Results are from the written survey (N = 101).

Table 2. Breakdown of Additional Incentives*

Additional Incentives	Physicians, n
Quality and/or patient satisfaction	17
Individual productivity	24
Group financial performance	20

* Results are from the written survey (N = 101).

Some other examples of the broad variety in response styles are shown below:

Physician A: "That's a good question, Mrs. Anderson. Actually, you have [] insurance and they don't pay me to do extra tests, but they do give a slight premium if I manage patients efficiently—meaning I don't do tests just because I'm bored. It's a very small amount of money I receive from [], probably about \$1 a visit, but it is a way of helping doctors to be a little more efficient. My job is to be your doctor. I would not let economics change your care at all. If you ever have any questions about this I would like for you to ask me further."

Physician B: "I think you have to face it, Mrs. Anderson, there are lots of barriers to care. Let's get down to brass tacks—you wouldn't have those questions in your mind if it weren't all true. You have to trust me as a physician to lead my way to you and your pain. I didn't invent this system; the system will collapse in and on itself. . . . I will try to be the one to make the very best health decisions for you that I can. I'm not a crusader and you shouldn't be either, but I will try to keep you alive with a minimum of punishment. Okay?"

Physician C: "Well, Mrs. Anderson, I will do what is best for you. Personally, I don't care about any insurance. If it's not paid by your insurance I will let you know. Don't worry about this too much."

Overall, 36 (36%) of the 101 physicians did not give enough information in their response to allow any determination of how they and/or their physician group was paid for the patient's care. Of the 65 physicians whose responses did include enough information to identify how they or their group were paid, 34 (52%) gave the actual name of the method; the other physicians instead described how they were paid without mentioning salary, fee-for-service, or capitation directly.

Among all 65 physicians who discussed payment directly, 35 (54%) described how the patient's insurance company paid them or their group, while 23 (35%) gave information only about how they were compensated by their physician group. The remaining 7 (11%) made note of a multi-tiered compensation system in which the type of payments given by the insurer to the physician group was distinguished from the compensation received directly by the individual physician from his or her group. Multi-tiered arrangements are the most common form of managed care physician contract in the country.^{8,9} They also introduce an extra layer of complexity in considering the potential for conflict of interest. For these reasons, we found it of interest to note how physicians described these arrangements. Several examples are given below.

Physician D: "What actually occurs is that I'm paid on a salary and the HMO clinic I'm affiliated with gets a certain amount of money from your insurance company per year. Obviously, we use some of that money if we see you 10 times as opposed to 3. Obviously, we would stand to make a little bit more money if we only saw you 3 times. However, we do try to do the right thing and not decide whether we are going to treat you based on a monetary reward, and so essentially I'm paid a salary and that's about it."

Physician E: "I personally work on a salary, so it does not affect me or how much money I make at the end of the year. A good clinic is paid a certain amount per month by your health maintenance organization, and we get that same amount each month whether you come in or not. But this clinic has a combination of both HMO and non-HMO patients and I don't check before making decisions whether you're an HMO or a non-HMO patient."

Physician F: "Mrs. Anderson, as you know this is a large clinic and I am on salary with the clinic. We have incentives that are rather confusing and complex. All the payments go directly to the clinic here. While these are considerations there are certain pressures for us to see a large number of patients, to care for as many patients as we can. There is also concern for the quality of care and we try to maintain standards that we believe as physicians are in our patients' best interest. There is, as in many things, a balance between costs, time, and expenditures. I think the underlying concern of us as physicians is that our patients receive good care and they get procedures and tests that are likely to benefit them and are up to the standards as recommended by current guidelines. I hope that answers your question. If there is anything else that I haven't addressed, please let me know."

No matter which approach was taken in answering the question about compensation, and no matter what the form of compensation was, nearly every physician took pains to express firmly that financial incentives would not affect the care the patient received. Some physicians explicitly defended their incentives as benign and trustworthy, and made a logical, deductive argument that the patient had nothing to fear. Most physicians, however, offered a more personal promise that, amidst the turbulence of the managed care world, the physician would ever be the patient's champion. These statements echoed the following 2 examples: "My job is to be your doctor. I would not let economics change your care at all." "When I first took on managed care patients, I made a promise to myself that I would never allow it to dictate to me how I would manage patients, and to this point and time, I have not been influenced by that."

DISCUSSION

Did the physicians in our study respond well to Mrs. Anderson? The answer to this question depends on how we define a "good" answer. In one discussion of this topic, Levinson et al. posited that physicians responding to patient questions about potential conflicts of interest should do 5 things: 1) empathize with the patient's concern

about conflict of interest and welcome more discussion; 2) affirm commitment to the care of the patient; 3) discuss the essence of financial arrangements in sufficient detail so that the patient can understand and judge their potential impact; 4) provide options so that the patient does not feel powerless; and 5) address the issue again at the close of the interview to reinforce willingness to discuss difficult issues and underscore the collaborative nature of the relationship.⁴

Because this study was performed within an artificial environment, without the benefit of a true conversation with a patient, we did not feel it was possible to make judgments of whether the physicians' responses met all 5 of these goals. However, our data pointedly suggest that most physicians may not meet the key third goal of discussing the "essence" of financial arrangements so that patients can understand and judge their potential impact. We were struck that over one third of physicians did not give enough information in their responses to even be able to figure out the basic outlines of how they were compensated.

In place of detailed discussions weighing the risks and advantages of specific incentives, what rang out loud and clear was a single, dominant theme: trust me. Whether to the ears of most patients this exhortation would be strengthened by providing the name(s) of compensation methods, or by a brief discussion of financial incentives, is not known. What kind of answer would best inform and satisfy patients is an intriguing question that will require further study.

This study has several important limitations. First, our video role-play method could not offer the benefit of a conversation between physician and patient. Physicians therefore may have given artificially curt, awkward, or circumscribed responses. Secondly, participants were a relatively small convenience sample of primary care physicians from one part of the country. Some bias was also likely introduced by our sampling of physicians who were attending a CME conference and interested and willing to participate in this kind of study. How these physicians might differ from other primary care physicians in the manner in which they discuss compensation and conflict of interest issues is unknown.

Nonetheless, this study provides an important early window into the communication occurring between physicians and patients about financial incentives in managed care. Physicians may feel that they can handle difficult conversations, but we know that even seasoned clinicians can find conversations about potential conflict of interest a real challenge.¹⁰ Our assessment of the physicians' responses revealed wide variation in style and a paucity of hard information. The uneven character of the responses may present an opportunity for medical practices to improve communication with their patients and strengthen patient loyalty.¹¹ Medical educators may wish to include discussion of this topic in the interpersonal skills training of medical students and residents. And further efforts should assess whether some more standardized

program of disclosure, including physician training in this area of communication, might provide patients with the information they want while strengthening patient-physician relationships.

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