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Creating Better Doctors or Merely Finding Better Patients?

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Current literature is replete with discussions of implicit and explicit discrimination against patients and, as of late, with studies regarding the benefits and drawbacks of the Physician Quality Reporting System (PQRS). This article investigates an area of overlap between these two topics that deserves more attention in the public discourse. The article sheds light on the current PQRS quality metrics with regard to HbA1c, blood pressure and LDL measurements and suggests that they encourage discrimination based on weight. The article outlines the clinical and moral drawbacks of the quality metrics as they stand and suggests that the current wording be reconsidered.

In this critical historical period in American medicine in which few assumptions about healthcare seem to go unchallenged, many providers and patients still cling to a basic premise that they hope will remain unscathed: healthcare is a fundamentally humanitarian profession and its providers are caregivers for society as a whole.

Although this assumption enjoys relative immunity in the literature, the field has seen considerable shifts that fundamentally undermine it in practice. In a recent article in the New England Journal of Medicine titled, "Discrimination at the Doctor's Office," Holly Fernandez Lynch responded to a growing trend by which physicians deny care to patients on "questionable grounds, including the patient's sexual orientation, parents' unwillingness to vaccinate… and most recently, the patient's weight" [1]. Lynch argues appropriately that such practices are legally prohibited and should not be deemed acceptable within medicine. She argues further that "we should condemn all types of invidious discrimination," and that "we should be particularly vigilant" against its subtle forms. While true, these words of advice don't begin to address the problem. Discrimination surfaces when societal and institutional norms allow it and when the healthcare system is designed to encourage it.

Of particular interest to the medical ethics community is the discrimination against patients based on their weight. The potential for a physician to act in a biased manner towards patients based on their individual weight exist both implicitly and explicitly within medical practice. Sabin et al., 2012 [2] demonstrate the strong implicit and explicit "anti-fat" bias expressed by physicians based on a statistical analysis of the Project Implicit® Weight Implicit Association Test (IAT). Physicians' performance on the Weight IAT demonstrated a strong implicit anti-fat bias on par with the general public. A similarly evident explicit bias was indicated in their self-reported preference for people who are thin versus overweight or obese [2].

Unfortunately, this problem is deepened considerably by the recent implementation of the Physician Quality Reporting System (PQRS) [3].

The very first measure listed in the 2013 PQRS Measures List is titled, "Diabetes Mellitus: Hemoglobin A1c Poor Control." The accompanying description reads as follows: "Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%" [4]. Similar phrasing is used for measures regarding controlled low-density lipoprotein as well as hypertension. Although most measures in the 2013 Measures List focus on physician interventions (such as administration of aspirin to patients with CAD), the ones previously mentioned focus on the health statuses of their patients. The significant impact of this particular system is that physicians' bonuses and deductions are not based on their efforts to control diabetes and hypertension, but on the actual degree to which they and their patients succeed in doing so. It is certainly true that appropriate medical care bears considerable responsibility for controlled hypertension and Hb-A1c, but the patient's unique condition, attitude and ability to comply is an undeniable ingredient in producing the best prognosis. These quality measures do not encourage good doctoring; they incentivize doctors to choose "good" patients.

Studies continue to suggest that PQRS raises the quality of reporting, but does not necessarily increase the quality of care. Federman and Keyhani, 2011 [5] demonstrates that not more than 1 in 5 primary care physicians found PQRS to significantly improve their quality of care with half of the study's participants (including other specialties as well) believing it had no impact on quality at all [5].

An earlier national opinion-survey, conducted in 2007 [6], predicted much of what is being suggested here. According to the survey, 88% of internists believed that quality measures are not accurately adjusted for patients' medical conditions and 85% believed that such measures do not adequately account for patients' socioeconomic statuses. Not surprisingly, 82% of respondents expressed concern that quality measures of this sort would push physicians to deny care to high-risk patients or those of low compliance. To quote one respondent directly:

"If my pay depended on A1c values, I have 10-15 patients whom I would have to fire. The poor, unmotivated, obese and noncompliant would all have to find new physicians" [7].

These concerns, it seems, may be well on their way to becoming a reality. The reasons to avoid such an outcome are numerous. First, it would undermine the purpose of the Physician Quality Reporting System (which is to provide better care to those who need it most) by encouraging physicians to deny much-needed care to that very population. Second, it forces physicians into a position that is ethically and professionally troublesome, making the moral risks equally threatening.

One might defend this practice of discrimination by appealing to the American Medical Association's (AMA) Principles of Medical Ethics, which states that a physician (in non-emergent instances), "shall be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care" [8]. Based on this alone, it would seem that discriminatory practice is in fact within the bounds of the medical profession.

However, the remainder of the AMA's code provides justifiable means to argue otherwise. It charges physicians to, "recognize

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a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health" [9]. Further, it demands that physicians, "support access to medical care for all people" [10]. The practice of denying care on the basis of existing conditions such as obesity is a breach of a physician's responsibility to the betterment of public health and certainly fails to support access to care for all people. Further, even if weight-discrimination should be deemed a morally acceptable practice for individual physicians, the institution of quality metrics that encourage and motivate this practice certainly is not. These metrics discriminate against those who need care the most and fly in the face of the fundamental mission of the Centers for Medicare and Medicaid Services: to make quality care accessible to all people, and precisely not to discriminate.

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