

Outcome Data and Ethics: Getting Doctors to Pay Attention

BY PHILIP BOYLE, PhD

Under a collaborative agreement, a health maintenance organization (HMO) representative recently challenged a hospital administrator about a staff urologist's increased number of prostatectomies and associated higher charges relative to local and regional urologists. The complaint was simple: Research reveals that where prostatectomies vary in use from region to region, the higher and often unwarranted application is associated with higher morbidity and mortality.

The HMO wanted to designate an alternative preferred urologist who would offer more cost-effective care that more nearly approximated national standards. The administrator was torn—committed to protect patients by avoiding inappropriate use of technologies, yet obligated to ensure her staff's professional integrity. Even if the HMO's allegation was justified, she was uncertain whether any attempt to change physician practice would be feasible, let alone moral.

AN AVALANCHE OF DATA

Little did the administrator suspect that an avalanche of similar data on technologies' effective-



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iveness will soon be bearing down on her in the form of reimbursement practices, practice guidelines, and other incentives and disincentives. With increasing momentum, she, like all administrators, will be pressed to act on the data.

No doubt the assessment of therapies' effectiveness is welcomed as a means of reining in runaway healthcare costs, promoting high-quality care, and even expanding access to care. Currently, no evidence indicates conclusively that technology assessment will be the magic bullet for cost-containment. Even so, hospital administrators concerned with responsible use of resources and high-quality care must wrestle with what means, if any, can be used to conform practice to data.

CONTRADICTORY DATA

Anyone who wades into the moral problems of technology assessment will be confused by the range and varying reliability of the data. The ocean of facts about existing technologies, obtained from clinical trials, insurance data bases, and expert opinion, is difficult to evaluate when much of it appears to be contradictory. Making it operative in a hospital is an even greater challenge.

The heart of the problem is this: Even when data conclusively indicate a clear course of action, evidence suggests that physicians tend to minimize or overlook the data (e.g., *Intrapartum Fetal Heart Rate Monitoring*, College of Obstetricians and Gynecologists, Washington, DC, 1989). The exact reason physicians set aside the information is unclear. They often pursue an independent course in desperation over a patient's condition or because they strongly believe their own clinical experience indicates the proper treatment. Studies also show that the simple fact that a technology is available, or capable of increasing a physician's income, motivates some physicians to dismiss data (David Banta, "Embracing or Rejecting Innovation: Clinical Diffusion of Health Care Technology," in Stanley J. Reiser and Michael Anabar, eds., *Machines at*

WHAT ADMINISTRATORS CAN DO

Hospital administrators can do the following to ensure that physicians pay attention to outcome data:

- Offer forums where physicians' moral objections can be voiced, identified, and responded to
- Teach physicians how to deal with ambiguous data
- Ask physicians to better inform patients of surgery's risks and benefits
- Establish practice guidelines to ensure effective care

Bedside, Cambridge University Press, New York City, 1984, p. 81).

EDUCATING PHYSICIANS AND PATIENTS

Any attempt to persuade physicians on moral grounds to pay attention to outcome data will have to be preceded by an understanding of how physicians obtain data—whom they listen to. The first step in an education program is to offer forums where physicians' moral objections to the use of data can be voiced, identified, and responded to (similar to the forums used for airing opposition to terminating life-sustaining care).

Physicians will also have to learn to deal with the ambiguity of some data. For example, the risks and benefits of a prostatectomy for non-chronic obstruction are unclear, and doctors in some parts of the country perform this operation far more than doctors in other regions (e.g., John Wennberg et al., "An Assessment of Prostatectomy for Benign Urinary Tract Obstruction," *JAMA*, vol. 259, 1988, pp. 3,027-3,030). The operation may provide a patient with a sense of relief, but it also increases the risk of mortality. In this and similar cases, the outcome data indicate that patients should be better informed of the risks and benefits, so that they can decide for themselves whether to undergo the procedure. Interactive videos are being tested as a teaching device, but some populations might require augmented informed consent procedures.

ESTABLISHING PRACTICE GUIDELINES

Sooner or later, administrators will need to establish practice guidelines as a means to ensure effective care. Several national organizations, most notably the U.S. Preventive Health Services, have attempted to provide rough guidelines by reviewing data and guidelines generated by professional groups for specific technologies.

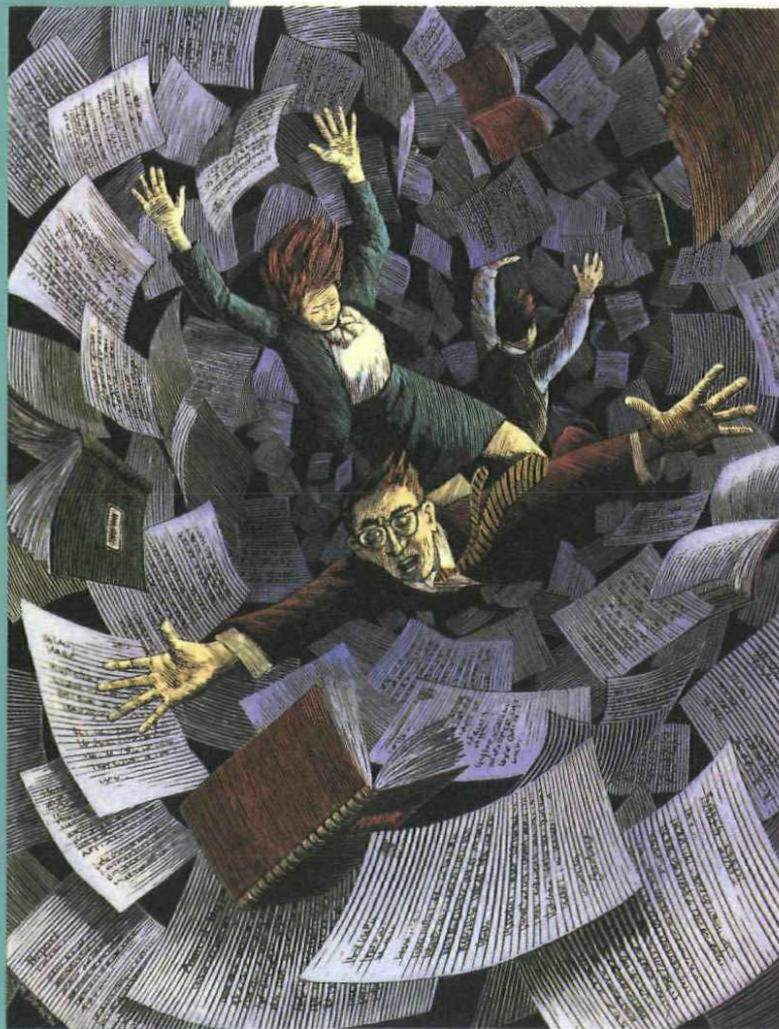
However, an administrator might still be confused by this information. Even if everyone agreed on the guidelines, it is difficult to see how the guidelines could be implemented and enforced. Furthermore, even if enforced, it remains questionable whether they will have the desired effect of ensuring appropriate care.

The push to use technology assessment data will be fueled by federal efforts such as those by the Agency for Health Policy Research, which is already studying and promulgating results on

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technologies' effectiveness. But hospital administrators must also breed in-house methods of evaluating the data. Where the data are ambiguous, they must develop augmented forms of informed consent. Where the data are convincing, administrators might want to consider using the information in ways that present the fewest restrictions on doctor's medical practice.

Administrators can remain passive, waiting for pressures to dictate hospital policy, or they can take the initiative with proactive and reasonable efforts to use technology assessment results in ways that fit their institution's special circumstances and ensure effective, high-quality care. □



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