Best-Of Undergraduate Student Research

Hypocritical Oath: Money, Values and Medical Treatment

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The following paper is the first of our Best-Of Student Research. Papers considered for publication must be researched, including all data collection, by a student in the School of Business at Utah Valley State. The paper must also be accepted and presented at the National Conference of Undergraduate Research (NCUR) or another academic conference. This paper was supervised by Dr. K. S. Whelan-Berry.

The Hippocratic Oath pledges, in part, that all doctors "apply, for the benefit of the sick, all measures which are required..." The oath is apparently forgotten, yet the popular press and some movies or books often portray doctors as refusing to treat patients due to their inability to pay. This paper investigates this portrayal, and finds that in the sample of doctors interviewed for this paper, none had refused to treat a patient because of their inability to pay, but had refused to treat patients for other reasons. The values that doctors feel are currently driving or should drive the American healthcare system are also discussed.

Keywords: Values, Beliefs, Healthcare

Introduction

Topics including medical savings accounts, health insurance premiums, prescription drug benefits, and healthcare generally are all daily headline news. The popular press often portrays doctors as refusing to treat patients because they can not pay. This study explores the personal values of doctors and how those values influence their decisions in the treatment of their patients. This research focuses on the effects of a patient's ability or inability to pay, and the doctor's decision to treat or not to treat. This study also explores the values doctors feel are driving the American healthcare system and what values they feel should drive the system.

Literature Review

The Progression of Healthcare in America. In early American society the family was the primary caregiver for the sick. As medical practice evolved, American doctors acquired most of their medical knowledge and practices from England (Starr, 1982). Over time, the practice of medicine evolved from a cottage industry into something much larger (Johnston, 2001). Medical schools and associations helped to create licensing requirements, standards for the practice of medicine, and provided accrediting bodies. As early as the late 1800's, rising medical costs became an issue; for example, providing a sterile environment was emphasized and this raised operating costs. Despite efforts to improve efficiency, these ever-increasing costs have been passed on to the patient ever since (Starr, 1982).

When the medical profession was in its infancy, financial returns were small; and many doctors only practiced part-time. Cash was the preferred method of payment but many doctors accepted payment in kind. During most of the 1700s the prices physicians could charge was set by legislation. A per annum fee system was also developed during this period but it never became popular (Starr, 1982). The American Medical Association created hospitalization plans during the 1930's and these plans evoloved into a form of health insurance (Starr, 1982; Vogel, 1979). Currently a third party payer system is used, where a fixed premium is paid by the insured or their employer to an insurance company and the amount of this premium determines what

services or levels of services the insured is eligible for (Barlett, 2004).

Most hospitals were operating as not-for-profit organizations well into the early 1980's. The Reagan administration, in an effort to control the rising costs of healthcare, fundamentally changed healthcare in America and created a free-market environment. The theory was that insurers, doctors and hospitals would form groups or companies that would compete with each other based on price and the quality of service (Barlett, 2004), and these costs would fall.

Table 1: The Progression of Healthcare in America

Timeline	Evolution of the Medical Practice	Impact on Payment of Physician
Founding of America-1700s	Most medical care provided by family. Medicine practiced as second occupation. Standards and medical schools begin to evolve.	Most payment of medical services was in kind or barter style agreements.
1700s-1800s	Medicine begins to be practiced full time. Standards of practice are adopted. Associations of doctors form to establish standards for medical care and provide guidance for the practice of medicine.	Many doctors begin to provide medical care on credit; they bill quarterly or annually. A per annum system evolves which is a crude form of health insurance but is later discontinued.
1800s-1900s	New forms of transportation begin to impact how medicine is practiced. Civil War hospitals place an emphasis on cleanliness. Hospitals evolve and became a critical part of American healthcare.	Patients still responsible for payment for services. Hospital funding often provided through charities, as most hospitals are non-profit.
1900s-1930s	Physicians form group practices. Hospitals become better managed and more efficient. Healthcare and costs become the subject of legislation.	The consumer continues to pay healthcare costs. Rising hospital costs are shifted offset by increasing patient bills. Political debate about a national healthcare system surfaces several times and is defeated each time. The AMA introduces hospitalization plans in the 1930s.
1940s-1980	Medical practices and techniques continue to advance.	Hospitalization plans develop into the current health insurance system. In 1973 the HMO act is passed to provide government funding for hospitals. Reagan administration then cut this funding and created a free market system.
1980s-Present	Medical practices and techniques continue to advance.	Free market system creates current payment system with insurance companies paying doctors. Many million do not have insurance and have to pay for services themselves.

Definition of Individual Values, Beliefs and Attitudes. Doctors act according to their values and beliefs, and it is their values and beliefs that determine in part how they interact with patients. Values are a reflection of what a person believes is right or wrong and also reflects what they think *should* happen. There are two basic types of values: terminal values are what a person wants to achieve, and instrumental values are how a person wants to reach a goal or end state (Schermerhorn, 1994).

Values combined with beliefs are the basis for the formation of attitude (Fishbein, 1975). Beliefs can be viewed as subjective probability judgments related to a certain part of a person's world. Beliefs can be descriptive or inferential, but it is the combination of values and beliefs that create attitudes which are reactions toward objects or situations. An attitude is the predisposition to react favorably or unfavorably toward a person, place, thing or situation (Fishbein, 1975).

Methodology

The sample consists of 12 practicing physicians, 10 male and 2 female, of varying specialties. The average age of the doctors was 43. All twelve of the doctors were Caucasian; nine were born in the US, and three were born in Canada. The mean years of practice were 10.5 years, and residency/fellowship time were 4.67 years. Interviews were conducted in a semi-structured, open-ended format and were audio taped and then transcribed.

The data were summarized for analysis following the transcription using content analysis (Sandelowski, 2000; Marshall and Rossman, 1999; Miles and Huberman, 1994). Responses were first coded according to broad thematic areas specified in the interview questions such as personal values or treatment of patients. Each interview was then re-read for additional comments about each thematic area and analyzed to identify specific aspects of a given theme.

This study was conducted in a limited geographic area dominated by a strong religious culture, and this could affect the findings of this study. Further, the sample is small and the research was conducted in a limited time-frame, thus the study should be viewed as a pilot project.

The following tables present the data as discovered in the transcribed interviews through content analysis. All responses were volunteered individually by the 12 doctors interviewed, and all the open-ended questions have a response rate of 12/12.

Data and Discussion

Do doctors refuse to treat patients?

Table 2: Values

What do you value most in life?	
Family	12
Religious Beliefs	7
Free time	7
Health	4
Honesty	4
Education	3
Work	3
America	2
Freedom	2
Friends	2
Autonomy	1
Reputation	1
Respect	1
Being a good doctor	1
Why did you become a doctor?	
Being able to help people	6
Love of science	3
Felt like they should	2
Parent was a doctor	2
Doctors are perceived as respected members of the community	2
Others said they should	2
Influence of doctors as a child: good/bad	2
Thought it would be fulfilling	1
Love of children	1
Challenge of learning	1
What are two or three things you enjoy most about your job?	
Helping people	10
Compensation	3
Working with children	3
Working with their hands	1
Being their own boss	1
The new technology	1
Delivering babies	1
Experience with brand new parents	1
The dynamic work environment	1

Monetary reasons. The original question of this research was "Is there a difference in the core values of doctors who treat patients who are unable to pay and doctors who refuse to treat patients who are unable to pay?" None of the doctors interviewed had ever refused to treat a patient based on ability to pay. A doctor said "Not to treat a patient because they cannot pay would be morally corrupt." Some doctors said that they would modify how they treated a patient according to how the patient was paying, however, such as modifying the medications they prescribed or only using certain types of medication because they had samples of that particular type. One doctor said he has no problem contributing his time and skill in the treatment of a patient but would be unwilling to purchase other items such as tests or hospitalization to perform that treatment. The doctor stated: if he goes into a grocery store the grocer does not give him food simply because he needs it, but, this is what he feels people expect of him; to give his services at no cost because someone needs them. Overall, the doctors seem willing to donate time and skills, but not monetary support to treat patients.

Relationship based reasons. When asked if doctors refused to treat patients one physician's metaphor was this: "to refuse someone care outright is to place myself in front of an oncoming train called a lawsuit." The doctors all agreed that emergency situations must always be treated.

All of the physicians felt that the practice of medicine is based on relationships. If the doctor does not feel he or she has a good relationship with the patient he or she may suggest the patient find another doctor. One doctor said, "Medicine is all about relationships, without a good relationship nothing good will happen." Bad relationships may lead to different types of care. One doctor said that he is unable to give the patient the best treatment possible because he is distracted by other factors.

Obstacles in a doctor/patient relationship, from the physician's point of view, are: rude or hostile patient demeanor, a patient's litigious nature, patient not following doctor's orders, patient requesting inappropriate treatment or drugs, or a patient's lack of respect for the physician's staff. Sometimes the doctor and patient will simply feel uncomfortable with one another. One doctor described it by saying, "it is like everywhere else in life, you get along with some people and not with others." One aspect of the relationship that is crucial is trust. Patients who do not feel that they can trust their doctors are unlikely to disclose all of the relevant information about their illnesses. Doctors who do not feel they can trust a patient are more likely to practice defensive medicine while treating that patient. One doctor said, "Practicing defensive medicine means I am more worried about not being sued than I am for caring for my patient."

Individual values and the decision to treat or not

Table 3: Treatment of Patient

What values drive your treatment of patients?	
Giving the best possible care	6
Treating them like family	4
Golden rule	1
Honesty	1
Desires of patient	1
Respect of patient	1
A way to serve God, by serving man	1
Receive personal gratification	1
Work ethic	1
Is the treatment of your patient influenced by outside factors?	
Yes	10
Minimally	1
No	1
Hospital policies	7
Insurance policies	7
Group practice policies	2
Private practice policies	1
Does a patient's ability to pay influence your decision to treat?	
Yes	0
No	12
Limit Medicaid patients	4
Modify treatment	3
Have you ever treated a patient who could not pay?	
Yes	12
No	0
Why did you treat a patient who could not pay?	
The patient was in need/moral obligation	12
It is the right thing to do	2
Because they have the skills to do so	1
Gratifying experience	1
What approaches are used to help someone pay for a treatment they cannot initially afford?	
Payment plan	12
Write off	9
Reduce bill amount	6
Refer to financial services	3
Never used a collections agency	2
No charge	1
Do you work for an organization that promotes free patient care?	
Yes	1
No	11
Will perform it when needed	9
Do you participate in a free clinic?	
Yes	4
No	6
Not available	2
Have previously	4
Plan to in the future	2
Have you ever refused to see a patient?	
Yes	10
No	2
Why did you refuse care to a patient?	
Rude to doctor or staff	6
Unrealistic wants or expectations	5
Litigious nature	4
Bad doctor/patient relationship	3
Previous bad payment experience with that patient	3
Lack of equipment and backup to perform a procedure safely	1

Values + Beliefs = Attitudes. The three major terminal values expressed by the physicians in table 2 are: families, religious beliefs, and free time. Doctors also listed values such as honesty, doing the right thing, and helping others and these instrumental values help them to achieve their terminal values. These are the core values that drive the physician's decisions in this sample.

Helping people, a terminal value, was mentioned by ten of the doctors interviewed when asked what they most enjoy about their job. When asked what values drive treatment of patients, the doctors listed the instrumental values including the golden rule, honesty, giving the best possible care, and work ethic. All of the values volunteered in the data can be interpreted as helping the doctor achieve the goal of helping people.

The combination of values and beliefs creates an attitude that doctors are morally obligated to treat all patients regardless of their ability to pay: because it is the right thing to do. One doctor mentioned that this type of attitude is important for a physician to have, "If you are not in this to help people then you will get out. We go through too much school and training to do this for the wrong reasons." This attitude is affirmed in that all the doctors interviewed claimed they had treated patients who could not pay their bills.

Cognitive Dissonance. Doctors seem to experience a state of cognitive dissonance when outside factors such as patient behavior, hospital, or insurance policies enter the decision making process. These outside factors override the attitude that a doctor has to treat patients. Cognitive dissonance occurs when a person has an attitude supporting a specific type of behavior but their behavior does not support that specific attitude (Schermerhorn, 1994). Doctors sometimes do not treat a patient because the insurance carrier will not reimburse the charges for the services or pay for the equipment necessary. Doctors justify the non-treatment of this patient by saying, "I would have treated them but the insurance company will not allow them to be treated." This could be seen as an effort by the doctors to rid themselves of the discomfort created by cognitive dissonance.

The urban myth. Are there really patients in America being refused care solely because they cannot pay? Some doctors interviewed said that perhaps there have been, somewhere, but they are exceptions and not the rule. All the doctors interviewed were willing to donate time and skills to help someone in need. Why then are doctors sometimes portrayed in the popular press as refusing to treat patients who cannot pay? This myth could exist because medicine is about relationships. Doctors, according to this

sample, will refuse to treat people because they are hostile, rude or otherwise create a bad doctor/patient relationship. If a doctor asks a person to find a new physician for one of these reasons it is likely not the type of reason that this person would share with other people. Instead, they may claim that the doctor refused to treat them because they could not pay. Another reason this myth exists could be because the doctor is a human face in a complicated system of third party payers, and so the patient may attribute to the doctor the non-treatment of their illness simply because they have contact with the doctor. Doctors may inform patients that although they would perform a procedure, they need the use of a hospital, equipment, and drugs. These items are what an insurance company or some other party must cover in terms of cost.

Values in the American Healthcare System

During the course of the interviews most doctors had difficulty describing their own personal values and how these values affect their treatment of patients. However, all of the doctors easily described their perception of the values relating to the American healthcare system; each doctor felt strongly about the subject and discussed it at some length.

Table 4: Values in the Healthcare System

What values are currently driving the American Healthcare System?	
Money	9
Fear of litigation	5
Business orientation	4
Lack of financial responsibility of the consumer	2
Sense of entitlement	1
Government manipulation	1
Power	1
Demanding patients	1
What values should drive the American Healthcare system?	
Providing best possible care with funds and resources available	6
Capitalist system with consumer responsibility	4
Different role for insurance companies	4
Knowing when to stop prolonging life	2
Doing the right thing	1
Patient education	1
Preventive medicine	1
Do you think healthcare is a right, something everyone is entitled to regardless of condition or ability to pay, or a responsibility that people should plan for and finance themselves?	
Right	0
Responsibility	3
Both	9

Current Values. Doctors interviewed listed a business orientation, fear, and money as the main values driving the healthcare system.

Business orientation. The business orientation of the healthcare system has lead to cost saving measures that doctors feel are often not in the best interest of the patient. Outdated procedures are still sometimes performed because they are less expensive than updated techniques, which require more sophisticated technology and specialized skill, and so patients can be in pain for longer periods of time. One doctor said, "The decision about treatment has been taken away from doctors and placed in the hands of some high-school graduate [agent in the insurance company call center] with no medical training." Doctors feel insurance companies who determine treatment do not appreciate the unique circumstances of each patient, and also believe the person making the decision about treatment is not qualified.

Doctors feel that the introduction of business practices such as cost controlling and risk analysis have negatively affected the way they interact with their patients. One doctor said she feels disconnected from her patients, she does not have the type of doctor/patient relationship she would like to have. "I remember my father getting Christmas cards from his patients; he was a part of their family." This disconnection is caused in part by the many hurdles that patients must clear before they are allowed to see a doctor. The doctor must be on the patients list of primary providers, patients must determine which doctor they should see, make an appointment, present proof of insurance or ability to pay, sit in an office, wait for other patients to be seen by the doctor, see a nurse, and finally they are able to see a doctor. It is not as simple as in early American times when a person scheduled an appointment with the town doctor and the doctor came to their house. Doctors feel that this complication of the process has detoured many people from seeing a doctor on a regular basis and in some cases people do not go to the doctor at all.

Fear. Fear of litigation and the rising costs of malpractice are major concerns driving the American healthcare system. Fear of litigation causes doctors to practice defensive medicine, and this means they order more tests and prescribe more medications than likely needed to treat the patient. Defensive medicine means that the cost of healthcare will continue to rise for unnecessary reasons. One doctor described it by saying, "It is terrible, but I have to do it. I can be 99% sure of the diagnosis but that one percent could

cause me a malpractice lawsuit so I have to order the extra test and prescribe the more aggressive medication." These rising costs force the healthcare system to implement cost saving measures in other areas. This is a cycle that physicians feel is financially driving the system out of control.

Several doctors felt that one of the worst aspects of the malpractice cycle is the out-of-court settlement of lawsuits. Doctors feel that settlements are perceived by the public as an admission of guilt on the part of the doctor. Doctors interviewed felt this perception feeds the number of malpractice lawsuits that are filed. Because of out-of-court settlements, patients perceive doctors to be guilty in all malpractice lawsuits. Doctors interviewed felt that the majority of lawsuits filed have no basis and the doctor is not guilty of the claim. But, it is often less expensive to settle out of court than to have a trial. Malpractice lawsuits send doctors out of practice early because they cause insurance premiums to rise to higher levels. One doctor said, "I would like to slow down a little and see fewer patients over more years; but I can't because the insurance premium is so high. So, I work full bore now and retire a little sooner because of it."

Money. Seven doctors mentioned money being a driving value in the healthcare system. Each of the previously listed values driving the healthcare system intertwines with this most mentioned driver. Another aspect of money is that doctors perform procedures or treatments for financial reasons. Some of the doctors interviewed said that some doctors perform unnecessary procedures and treatment on patients simply because it is something that their insurance or Medicaid will pay for, thus also feeding the rising cost and wasting resources within the healthcare system.

National healthcare system. When asked what values should drive the healthcare system many doctors first mentioned a government managed national healthcare system. Many people cite a national system as a solution for all the problems of the current system. Several doctors mentioned a national system as something that would be ideal but that would never work in the long term for America. All of the doctors agreed that national coverage systems existing in other countries have some problems. Many doctors felt that the expectations of the American public for immediate care would ultimately cause the failure of a national healthcare system because they would have to wait even longer than they do currently. Doctors also felt that Americans would be unwilling to have their healthcare decisions made by the government.

Values that should drive. The doctors agreed that the current system needs changes but none of them were sure exactly what changes are needed. Over half of the doctors said that the healthcare system should provide the best possible care for patients while using a reasonable amount of resources. Other values listed were doing the right thing, practicing preventative medicine, educating patients, establishing a different role for insurance companies, and increasing consumer responsibility.

Some of the doctors interviewed felt that the capitalist system would create enough competition in the marketplace to keep prices and access to healthcare competitive. Doctors felt that this type of environment would provide the best possible care for the patient while using a reasonable amount of resources. The system described by doctors would change the role of insurance companies and increase consumer responsibility. Doctors felt that if the patients were responsible for greater portions of their bill they would use healthcare more prudently. One doctor said, "People do not realize the cost of medicine, if they did they would not be walking in the emergency room with the flu." Shifting more of the financial burden to the patient means there is also a greater shift in the responsibility of how people care for themselves.

Patient education and preventative medicine are in many ways connected. As a person is educated about medicine and their health in general they learn how to better maintain their bodies. One doctor described preventative medicine by saying that it is like changing the oil in your car. Knowing when to change the oil in your car will help the car to run better and longer. If people knew more about how to keep their bodies healthy and did those things then they would be healthier for a longer period of time, thus reducing overall healthcare costs.

Healthcare: Right or Responsibility? Doctors were asked whether they viewed healthcare as a right, something everyone is entitled to regardless of medical condition or ability to pay, or if they view it as responsibility. All twelve doctors interviewed responded by saying it was a responsibility. Nine of the doctors also felt that access to certain types of care should be a right. The doctors believe that patients have the responsibility to plan for and finance their own healthcare. Determining what type of care is a right and what care is a patient's responsibility is very difficult. Many doctors used this type of analogy; it is a better use of medical dollars to vaccinate 1000 children than to provide knee replacement surgery for an older person. The doctors interviewed offered suggestions of age limits and sliding scales as ways to determine what care is a right and what care is a patient's responsibility.

The three doctors who felt that access to healthcare should be strictly a responsibility all explained that when a person is given a right to something that person has responsibilities that are linked to that right. People who are given the right to access *free* healthcare should act responsibly in use of that right. One doctor said if people drive recklessly, smoke or behave in some other risky way; then they have not fulfilled the responsibility that comes with *free* healthcare. If people have a right to free healthcare then they have a responsibility to live as healthily as possible.

Conclusion

This research can be applied to both doctors and patients. Doctors who openly discuss payment procedures, inform patients about payment plans, and discuss fully a patient's diagnosis and treatment options may be able to create an environment in which the patient feels more comfortable and will trust the doctor more. This may also help to dispel the myth that patients are refused treatment because they are unable to pay. Patients are more likely to receive quality care if they are courteous, friendly, avoid mentioning litigation, and comply with doctor's orders. These actions will lead the doctor to treat the patient without fear of litigation. These types of behaviors will help to strengthen the doctor/patient relationship for both parties.

The results of this study show that doctors do not refuse to treat patients who are unable to pay. There are other reasons that doctors refuse to treat patients, and each of these reasons evolves from a bad doctor/patient relationship. The findings in this study about the values currently driving the healthcare system and the values that doctors feel should drive the healthcare system merits further study. Each of the doctors interviewed agreed that the current healthcare system needs to be changed to better serve the public. Many suggested a market driven system that resembles the system already in place, but with different roles for both insurance companies and the consumer.

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