

Letter to the Editor

Justifiable deception in everyday practice

To the Editor:

Consider this clinical scenario. A 6-year-old girl with allergic rhinitis and chronic sinusitis was prescribed a nasal steroid, 1 spray in each nostril once daily. The adult dose is 2 sprays in each nostril daily. The mother was given an instant voucher for \$25 off the copay. Under their insurance plan, the product was listed as tier 2 with a \$35 copay. With the copay coupon applied, the mother anticipated an out-of-pocket cost of \$10.

Later, the mother phoned upset and requested a change to a generic drug when she was informed her copay would be \$70 (\$45 with the voucher). The pharmacy, typically compensated more if they dispense a generic drug,¹ said the copay for the generic equivalent would be \$20 (listed as a \$10 copay as tier 1). After verifying the patient's insurance benefits, the pharmacist discovered that an obscure clause stipulated a patient would have 2 copays if the prescription spanned 2 months. Thus, the pharmacy was charging the patient for 2 months of medication, because each nasal spray dispenses 120 sprays (1 spray each nostril for 60 days). Because an adult would expend the same canister in 1 month, it suggested to us that the child was being penalized financially because of her age.

What should a prescriber do in this situation? Options include substitution of a generic product, submission of an appeal to the insurance company, or alteration of the current prescription.

When selecting a drug many factors are considered: cost, efficacy, generic versus brand, standards in manufacturing, bioequivalence and whether that insures therapeutic equivalence, carriers, smell/taste, adverse side effect profile, pregnancy category, delivery device, and so forth. Neither the clinician nor the patient may want to change to a generic for a variety of reasons,² including the clinician's experience that the drug chosen works best for a patient.

If a generic drug is an undesirable option, appeal to a third party may be considered but is often not chosen because of the "hassle factor." The more difficult—more of a hassle—the appeal is, the more likely a clinician will opt for another course of action to secure treatment.³

A third option, in this instance, was to change the nasal steroid prescription to 1 to 2 sprays daily, an adult dose. The cost for the copay would then shift back to \$10 after the voucher. At the same time, the parent would be instructed to give only the recommended dose for the child, 1 spray in each nostril each day. A significant number of clinicians are willing to use deception of some form to secure necessary treatment.³⁻⁸ A clinician's willingness to use deception directly correlates with the clinical severity of a patient's condition.⁴ Further, patients or families may also bring subtle or overt pressure for deception depending on their own sense of fairness, how sick they are, and/or whether they believe the physician should do whatever it takes to secure needed treatment.⁵

The time-held values of honesty and patient advocacy are being tested by efforts aimed at profit and cost control. In response, should providers bend rules to make medication more affordable so patients can better comply with prescribed treatment? Patients will likely be pleased when they receive the medication at an affordable price, yet what are the long-term consequences for

patients, pharmacies, insurers, and providers as well as the relationship among those entities, if any?

When examining the consequences of any deception, justifiable or not, the issue of harm is foremost. We are all charged with *primum non nocere*, to do no harm. First, the potential for patient harm is obvious in that the parents, in this case, could misinterpret the medication dosage instructions and, depending on the medication, incur unwanted side effects or overdose. One might also argue that the pharmacy or the insurer is harmed because of increased expense as a result of the prescriber's actions. Pharmacies and insurance companies, both profit-driven, tend to push the kinetic equation of health care in favor of increased revenue, not necessarily patient wellness. Last, what harm do we do to our patients and ourselves if we do not do our best to enable our patients to comply and adhere to our prescribed regimens?

Managed care organizations encourage clinicians to be gatekeepers of costly tests, treatments, and referrals by offering financial rewards. Yet some clinicians feel these incentives are morally troubling. Furthermore, clinicians feel that the current system has led to diminished patient trust and impinges on the traditional ethos of undivided patient loyalty.^{4,6-8} One must consider that providers who habitually alter prescriptions to their patients' economic advantage could ultimately be evicted from insurance plans.

This scenario raises important questions facing patient and clinician regarding the cost of generic versus brand medications and the relevance of copay vouchers/coupons in today's economy. Today's economy and health care environment are prime motivators for considering the alternative of deception. Twenty-nine percent of patients are failing to fill their prescriptions in this troubled economic time.⁹ As the pharmaceutical companies ratchet up to compete with generic products, more coupons with better savings for brand name medications become available. Clinicians and patients must take the initiative to seek and use these discount programs as well as become knowledgeable about their drug plans and their encoded nuances. Conversely, one would hope that insurance companies would also become more transparent in communicating their policies' restrictions. There are also ways for patients and clinicians to lessen the economic burden of medications. Websites such as <http://www.internet-drugcoupons.com> assimilate all of the various prescription drug vouchers in one location for patients and health care providers.

Ultimately, our success as providers depends on our ability to correctly diagnose and treat patients. As managed care organizations and third party payers increase their restrictions on medication coverage, prescribers encounter tension between their desire for patient advocacy and the need for cost control. To counter this trend, creative and compassionate strategies to help patients access and afford their health care are required. Covert advocacy tactics as described here are likely to become more frequent as use restrictions increase, but these are both time-consuming and costly.^{3,7,8,10}

Deception may be one creative and acceptable strategy to avoid an adverse consequence and subsequently achieve the best outcome for a patient's well being.^{4,6} Deception, in this setting, is a byproduct of a flawed health care system.^{7,8} Clinicians are asked to conform to a set of rules that, at times, run counter to their personal morality to do whatever is necessary to help their

patients. In ethical dilemmas such as this one, it is not completely satisfying to say one should never bend the truth. It is also not clear what defines truth and what constitutes deception and when deception might be justified, and therefore, permissible. The American Medical Association has gone on record to say, "in exceptional circumstances of unjust laws, ethical responsibilities should supercede legal obligations."¹¹

Thus, each clinician must weigh what the moral imperative is in a given situation. We feel that such situations do not have to be extreme or necessarily exceptional to dictate action. The degree of seriousness of an individual case may well be largely perceptual or contextual. In our example of a child's nose spray, financial hardship was a potential obstruction to her (non life-threatening) wellness.

Ethical obligations call on the integrity of the individual. Deception may not violate integrity if integrity is defined as discerning right from wrong, then doing the right thing (here, serving the patient) and not hiding from that action.¹²

Although truth exists as the ultimate end for some, truth is an abstract concept. For many clinicians, the health of a patient will remain a concrete construct that is *a priori* and, more often than not, paramount. Then, as now, in each case, we must examine our moral certitude and our own conviction to act.

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REFERENCES

1. Kirshe ML. Generic substitution spells big money for retail pharmacy. Drug Store News. August 2005. Available at: http://findarticles.com/p/articles/mi_m3374/is_10_27/ai_n15338806/. Accessed December 14, 2009.
2. Shrank WH, Cox ER, Fischer MA, Mehta J, Choudhry NK. Patients' perceptions of generic medications. *Health Aff* 2009;28:546-56.
3. Werner RM, Alexander GC, Fagerlin A, Ubel PA. The "hassle factor": what motivates physicians to manipulate reimbursement rates? *Arch Intern Med* 2002;162:1134-9.
4. Freeman VG, Rathore SS, Weinfurt KP, Schulman KA, Sulmasy DP. Lying for patients: physician deception of third-party payers. *Arch Intern Med* 1999;159:2263-90.
5. Werner RM, Alexander GC, Fagerlin A, Ubel PA. Lying to insurance companies: the desire to deceive among physicians and the public. *Am J Bioeth* 2004;4:53-9.
6. Helgesson G, Lynøe N. Should physicians fake diagnoses to help their patients? *J Med Ethics* 2008;34:133-6.
7. Macauley R. The Hippocratic underground: civil disobedience and health care reform. *Hast Ctr Rep* 2005;35:38-45.
8. VanGeest J, Weiner S, Johnson T, Cummins D. Impact of managed care on physicians' decisions to manipulate reimbursement rules: an explanatory model. *J Health Ser Res Policy* 2007;12:147-52.
9. Kaiser Family Foundation. Kaiser health tracking poll: many Americans still delaying care, struggling to pay medical bills. April 2009. Available at: <http://www.kff.org/kaiserpolls/upload/7891.pdf>. Accessed December 14, 2009.
10. Casalino LP, Nicholson S, Gans DN, Hammons T, Morra D, Karrison T, et al. What does it cost physician practices to interact with health insurance plans? *Health Affairs Web Exclusive*. April 2009;28:w533-w543. Available at: <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.4.w533>. Accessed December 14, 2009.
11. American Medical Association. Opinion 1.02: the relation of law and ethics: code of ethics. Updated June 1994. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion102.shtml>. Accessed December 14, 2009.
12. Carter SL. *Integrity*. New York: Basic Books; 1996.

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