Nephrol Dial Transplant (2000) 15: 1749–1750

# Clash of cultures: nephrologists meet the market economy

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## Introduction

Over the past decade, the delivery of medical care has undergone dramatic changes and the practice of nephrologists in their care of end-stage renal disease (ESRD) patients has been transformed. In the US, approximately 70% of patients are now dialysed in facilities managed and owned by corporate entities. These companies are publicly traded on the stock exchanges and thus have investor-owners. Some of these companies are vertically integrated, such that everything that is purchased such as dialysis machines, dialysers, accessories and tubing are products of the corporation. The dialysis nurses are employees of the corporation. While physicians managing their patients in these units are usually not corporation employees some exceptions exist. It is unclear whether these trends affect the outcomes of nephrology care, but at the very least they make the relationship between the doctors and their patients more complex. Decisions regarding drugs and medical interventions including the administration of erythropoietin are often dictated by corporate policy rather than individual patient needs. As an example, most experts agree that erythropoietin given subcutaneously is equally effective as given intravenously, and is certainly cheaper. Yet intravenous erythropoietin yields dialysis units and their proprietors maximum profit based on current reimbursement policies. Since it is often not the patient that pays for their drugs, the accountability for these practices is left to third parties such as insurers and the government. Peculiarly, erythropoietin prices are not negotiated by the major payers but instead with providers. Other cost saving manoeuvers by corporations have been decreases in nursing staff, and decreases in other amenities afforded the dialysis patient, such as meals and transportation services as well as dialysis schedules that are often inconvenient for patients. To make these changes even more complex, individual physicians, in addition to their patient responsibilities, often serve in a capacity as medical director of these corporate-operated dialysis units for which they receive a specific fee. In academic centres, these payments often go to divisions or departments to help cover other expenses. While it is against the current laws in the US to compensate these physician-directors based on number of referrals to a dialysis center, there is anecdotal evidence that such practices exist. The medical director's duties for which he/she is compensated in many units are unclear.

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## Physician's responsibility for patient outcome

There are few data that deal with the outcome of patients in corporate-run dialysis units *versus* non-profit health care providers. However, a recent publication in a peer-reviewed journal suggested that mortality was greater in these corporate units [1]. While there has been bitter criticism of these findings by industry representatives [2], the fact remains that data using the United States Renal Data System database raise questions as to the physician's role and responsibility for these outcomes. A further disturbing trend was that the 'for-profit' dialysis units also have lower referral rates for transplantation than non-profit units [1]. While there are many explanations for this it is hard to avoid the conclusion that one possibility is that loss of patients from these units results in loss of revenue.

## Differences in dialysis practice between countries

The nephrology profession is increasingly subject to questions about its ethics and behaviour. Physician visits to dialysis centres in the US are relatively infrequent compared to those of other countries. It is unclear if this factor results in adverse outcomes in mortality, morbidity and hospitalizations. Home dialysis rates are much higher in Canada, Australia and New Zealand than in the US with equal or better mortality statistics. These differences in practice are not simply explained by demographics, but probably reflect the influence of corporate dialysis and capitated reimbursement procedures in the US.

## Medical decision making: potential conflicts of interest

This is not to say that corporate involvement is bad but it does raise questions about the responsibility of physicians to their patients as opposed to their loyalty to corporate entities, and raises the spectre of medical decisions being made for non-medical reasons. While

the possibility of ethical conflicts does not mean that ethical conflicts necessarily exist, it is in my view in the best interest of the profession to be completely transparent about their relationships with industry, both to the major payer, usually the government, and to the patients they serve. One rule of thumb would be the old adage that says that any relationship you would not want publicized in the newspaper is probably not one you should be engaging in. Professional nephrology societies can play a role here: understanding the current practices of their members by obtaining data and setting professional standards.

## Performance measures *versus* doctor–patient relationship

The trust between a physician and his patient is in my view a sacred one and if eroded leads to cynicism and impacts the major role of the physician which is to be the patient's advocate. Societal goals and group outcomes based on performance measures such as average Kt/V, serum albumin and average haematocrit are fine but they can mask inadequacies in the delivery of individual patient care under the guise of quality improvement. Medical care is much more complex than these surrogate markers can possibly reveal with the doctor–patient relationship being the most difficult factor to measure.

## Patient care: an alternative to profit or institutional programmes?

The market economy is here to stay in the western world and this is probably a good thing in terms of products and services available to patients. However, the nephrology profession should not compromise or subjugate its ideals and practices to the needs of corporate shareholders or profits. Non-profit dialysis units also should be open to similar scrutiny because while their profits do not go to anonymous shareholders they often disappear into an abyss and are used to cover administrative and bureaucratic needs rather than benefiting patients. Many academic medical centres use revenues generated by their dialysis populations to offset money losing programmes in the institution rather than putting the money back to improve patient care or even nephrology activities.

## Transparency of market-orientated research

The market economy has also permeated research and education. Good clinical trials particularly focused on providing data for evidence-based clinical practice are a glaring need in nephrology yet the funding for these studies is difficult to obtain. Investigators therefore turn to corporate sponsors. Many corporate sponsors drive research protocols prior to drug approval based on regulatory mandates. Constricted dissemination of data, proprietary needs and prior approval for publication all may be negative incentives to present data as they are developed especially if they are contrary to the sponsor's goals and bottom line.

## Transparency of physicians' relationship with industry

Professional education is also heavily subsidized by industry and while there are established guidelines for relationships between sponsors and educational activities, the guidelines have become increasingly blurred with frequent incomplete disclosure of direct and indirect perquisites for speakers and the use of other incentives such as resort travel to deliver the sponsor's messages to physicians. There are disturbing data that marketing influences physician behaviour whether or not physicians like to think so [3]. Marketing budgets of companies would tend to confirm this.

## From a sound cooperation with industry to optimal patient care

Obviously, complete disconnection between nephrologists and industry would result in little industry involvement in nephrology innovation, research or education. In some countries where there are government-mandated policies, this trend already exists resulting in markedly reduced choices in prescribing. In New Zealand, for example, erythropoietin is not given to any patient pre-dialysis because of cost considerations. Also, relatively few patients are placed on centre haemodialysis because of the expense, and acceptance for any haemodialysis care is limited for those individuals in whom home dialysis is not feasible. Rehabilitation potential is felt to be a major selection criterion for acceptance for ESRD care although these predictions are seldom precise enough to use in specific cases to deny treatment. Thus, somewhere between these two extremes, the nephrology profession must try to maintain its ideals and the primacy of the doctor–patient relationship. We should demand transparency and honesty in all of our relationships with industry so that hopefully in the future nephrologists will not be just corporate employees without any autonomy to provide care for individual patients who need help. These issues are obviously difficult and it seems to me that each nephrologist needs to look at their own practice and relationships and ask whether or not these relationships stand up to outside scrutiny.

## References

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