Medscape

Are More Doctors Cherry-Picking and Lemon-Dropping Patients?

By Leigh Page | February 15, 2017

More Than One Third of Doctors Would Be Selective

So-called "cherry-picking" and "lemon-dropping" of patients remains deeply controversial. Many physicians say it's unethical and wrong, and maintain that doctors should make the extra effort to care for "high-maintenance" or "difficult" patients. Other physicians don't admit that they sometimes cherry-pick or lemon-drop. However, the practice has a good deal of support among many doctors, as the healthcare system moves toward reimbursements based on outcomes and care budgets.

Cherry-picking involves choosing healthier or more adherent patients and referring more time-consuming ones to specialists. A related behavior called "lemon-dropping" involves rejecting less promising patients, especially those who would use a lot of resources. But "cherry-picking" is often used to describe both methods.

Asked in a new Medscape survey[1,2] whether they would cherry-pick or lemon-drop patients "to avoid those with comorbid disease or those who won't follow treatment regimens," fully 63% of doctors said no. But 17% said yes, and another 20% said it would depend on the situation.

By asking whether they "would" cherry-pick, the survey may have drawn doctors into the cherry-picking camp who haven't yet exercised the option but reserve the right to do so sometime in the future.

In comments gathered by the Medscape survey, some doctors specified that they might rate and evaluate patients if reimbursements changed. "There's no reason to treat an uncooperative, noncompliant [patient] if I'm not going to then be paid for the efforts," an oncologist said.

The Ethics of Cherry-Picking Are Complicated

Cherry-picking and lemon-dropping are "unethical," says Jim Bailey, MD, director of the Center for Health System Improvement at the University of Tennessee Health Science Center, in Memphis. "These practices go directly against the central tenet of the Hippocratic Oath, which says, 'Into whatever houses I enter, I will go for the benefit of the sick,'" he says.

Rather than run away from patients with complex conditions, Dr Bailey advises doctors to embrace these patients. "Physicians should seek out payment sources that will cover the extra work they need, such as using multidisciplinary teams that reach out to them to make sure they stay adherent," he says.

Although cherry-picking may be unethical in the eyes of many physicians, it isn't illegal. The newly revised Code of Ethics[3] of the American Medical Association (AMA), issued in June 2016, could be construed as ambiguous about its use. Although the new AMA code doesn't refer specifically to cherry-picking, it states, "Physicians are not ethically required to accept all prospective patients," which reiterates the view of the previous AMA code.

The Right to Select Patients

In fact, most doctors have exercised their right to select patients. A 2008 survey[4] of primary care physicians published in the Journal of General Internal Medicine found that up to 85% had dismissed a patient, usually for verbal abuse or drug-seeking behavior. However, only 14% of them had dismissed more than 10 patients altogether.

In line with this very selective use of dismissals, the new AMA code restricts the right to reject prospective patients to "certain limited circumstances," such as the physician's lack of expertise or lack of needed resources, or when patients are abusive.

The code's fourth circumstance, however, is a wide-open category. It states that physicians can exclude patients who "could seriously compromise" their ability to treat other patients. Conceivably, nonadherent and high-acuity patients might make a medical practice lose money and thus could "seriously compromise" its ability to treat other patients.

Once patients have been accepted into the practice, the AMA code seems, at first glance, to be unequivocally against dropping them. "Physicians should not decline patients for whom they have accepted a contractual obligation to provide care," it states, without creating any exceptions. Later on, however, it sets up a process for "terminating a patient-physician relationship."

Nonadherence is "a weak reason" for dismissing patients, according a 2013 article[5] in the ACP Internist paraphrasing Lois Snyder Sulmasy, director of the Center for Ethics at the American College of Physicians (ACP). "It would be wrong to discriminate against obese patients or smokers," she told the ACP publication. "These are the very people who need help."

Timothy Pawlik, MD, a colon cancer surgeon who is chair of surgery at the Ohio State University, had a similar opinion in a 2009 article[6] in the Journal of Oncology Practice, which he lead-authored when he worked at Johns Hopkins. Rather than dismiss a cancer patient who won't give up smoking, "the oncologist should provide the patient with appropriate treatment that accounts for the patient's smoking-related comorbidities and includes an appropriate complement of supportive care," the authors stated.

Practicing Physicians Have Their Own Views

Some physicians simply ignore the advice of the ethicists. The 2008 survey in the Journal of General Internal Medicine found that almost one quarter of the surveyed primary care physicians were willing to dismiss nonadherent patients.

This finding shocked the authors of the study, who stated, "Such physician behavior has serious ethical and medical ramifications for patients who are cared for by physicians in pay-for-performance programs."

However, many doctors get upset with flagrantly nonadherent patients, regardless of whether their outcomes would affect payment. "I would have a low threshold for dismissing noncompliant patients, especially if they missed appointments or did not take their medication," an internist commented in the Medscape poll.

Furthermore, some physicians reject the idea that they should work with patients to get them to be more adherent. They say this isn't their job—and in any case, it's hard to get reimbursed for the extra work.

Deciding whether to cherry-pick should be a personal decision, says Keith C. Borglum, a healthcare business consultant in Santa Rosa, California. "There's no one answer on how you should select patients," he says. "It has to do with your own ethical framework—what lets you sleep at night."

Some physicians have come up with their own parameters. In comments to the Medscape survey, a neurologist said he would limit cherry-picking to conditions that aren't life-threatening. "For migraine headache or Parkinson disease, I would definitely cherry-pick," he said. "For a life-threatening condition, such as epilepsy or a cerebrovascular event, I would not."

Others say their ethics shouldn't be any different from that of any businessman. "The ethical obligation to society that separates a physician from, say, a businessman, is no longer valid," an internist commented on a previous Medscape article on cherry-picking, in 2013. Physicians with limited payment have to care for "the

legions of chronically ill obese diabetics," he wrote, in essence justifying physicians' choice to cherry-pick as a form of professional self-preservation.

Culling Out Patients With Complex Conditions

As the internist in the previous scenario alluded to, many physicians are worried about having a lot of patients with complex conditions, and go back and forth about what to do about it.

"Some of my clients think that limiting patients by complexity is ethically abhorrent," Borglum says. "But those same doctors are enormously concerned about drawing in too many complex patients. It remains a dilemma for them."

As a group, surgeons are already used to rejecting patients with more complex conditions. They've always selected patients on the basis of their ability to recover from the operation, and higher payment for better outcomes may simply prompt them to tighten their selection criteria.

"As a surgeon, outcomes are always important," a cardiac surgeon commented in the Medscape poll. "Therefore, it's very advantageous to have the option to 'cherry-pick' patients when possible."

An orthopedic surgeon said that if he were rewarded for better outcomes, "I would be more strict about whom I performed elective total joint replacements on. Morbid obesity carries a higher rate of complications."

A pulmonologist who responded to the Medscape survey was blunter: "Smokers can find a salaried physician somewhere who doesn't get dinged by a bad outcome."

In the Medscape survey, surgeons were more likely to endorse cherry-picking than doctors in most other specialties. Whereas 17% of all physicians said they would cherry-pick, fully 38% of orthopedic surgeons and plastic surgeons felt that way, and so did 31% of urologists, 27% of ophthalmologists, and 24% of gastroenterologists.

On the other hand, only 7% of critical care doctors, 9% of pediatricians, 11% of oncologists, and 14% of neurologists endorsed cherry-picking. Meanwhile, 18% of both family physicians and internists would cherry-pick.

Will New Payment Programs Encourage Cherry-Picking?

When physicians worry about being forced to select patients, they're often thinking of the future.

Those commenting on cherry-picking in the Medscape poll used a lot of "ifs." A family physician said the pressure for him to cherry-pick "depends on if I was getting paid fairly for each patient." And an HIV/AIDS doctor stated, "If my ratings and livelihood depended on outcomes, I would probably cherry-pick patients to some extent."

The much-anticipated value-based payment system is still very much a thing of the future. Many physicians are in accountable care organizations in the Medicare Shared Savings Program (MSSP), which pays physicians for their outcomes, but only 30% of accountable care organizations earned shared savings in 2015, the latest reported year, according to a September analysis[7] in Health Affairs.

Meanwhile, Medicare is launching several new mandatory bundled payment programs in which payments for hospitals and doctors will be based on patient outcomes. The first and only one so far, the Comprehensive Care for Joint Replacement (CJR) for orthopedic surgeons and hospitals, just started in April, so it's too early to tell how much cherry-picking will ensue.

"Bundles represent a huge risk," says Alexandra E. Page, MD, an orthopedic surgeon in San Diego who chairs the Health Care Systems Committee of the American Academy of Orthopaedic Surgeons. She noted that in an earlier orthopedic bundling program, some practices took out reinsurance to cover their financial risk.

Dr Page says that the CJR lacks a good risk-stratification system, putting orthopedic surgeons at risk for big losses if they have a lot of high-acuity patients. She argues that CJR should have been made voluntary while the bugs were being worked out.

One long-standing incentive to cherry-pick patients is report cards issued by health systems, payers, and state regulators, which rate physicians on their outcomes or their ability to meet various process-of-care measures. Sometimes the scores help determine payments, but usually they're simply posted on public sites.

A 2003 study[8] found that in New York and Pennsylvania, two states that collected and reported surgeons' results for coronary bypass operations, heart surgeons engaged in a significant amount of cherry-picking.

Meanwhile, under Medicare's Physician Quality Reporting System (PQRS), physicians have been reporting metrics on meeting certain process-of-care measures. PQRS is being folded into Medicare's new Merit-based Incentive Payment System (MIPS), which started in January.

Many people fear that MIPS will prompt physicians to cherry-pick. PQRS scores have begun to be posted on the Physician Compare website, and MIPS scores will be posted there as well.

Should Cherry-Picking Be the Norm?

An internist in the Medscape survey was concerned about these postings. "How many physicians would choose to take care of more complex patients, get penalized for it, and then have their name placed on a public Internet site as a bad physician?" he asked. "The question is not, would you cherry-pick? The question is, why would you not cherry-pick?"

David Zetter, a practice management consultant in Mechanicsburg, Pennsylvania, basically agrees with this assessment. "What government has just done with MIPS is going to create all kinds of cherry-picking," he says. "Physicians will be assessed under the quality performance category [formerly PQRS], and their scores will be posted on the Physician Compare website."

He added that low-scoring physicians might not be able to get into a payer network, which would be another reason to cherry-pick.

However, the full impact of MSSP, CJR, MIPS, and Physician Compare has yet to be felt, so it's not clear how much cherry-picking they would stir up.

Screening Patients Ahead of Time Isn't So Easy

It's often said that the best time to evaluate or select patients is during the initial visit, before the patient has been accepted by the practice. Once the patient is accepted, you would then have to start a process to sever relations with the patient.

Unfortunately, the initial visit is the time when you least know your patients, so you'd have to take extra steps to research them to see whether they have too many chronic conditions or whether they were nonadherent with past doctors.

"I think it would be hard to do this in an office setting, because you will not know the patient's medical history until they come in," a family physician told the Medscape survey.

MedPro Group, a malpractice carrier, advises[9] doctors to ask patients to supply their medical records in advance and use the initial visit to look for potential problems. "Initial consultations with new patients present practitioners with a unique opportunity to identify potential signs of noncompliant or difficult behavior," the company advises.

Borglum suggests having a "get to know you" visit with the patient. The visit "gives the doctor a chance to see whether the patient is obese, infirm, or has other obvious exclusionary health problems, allowing you to weed out difficult patients," he says. "But you can't diagnose, prescribe, or treat, because then they would become your patients."

Accepting All Patients

Another obvious source of data on patients is the medical history questionnaire they fill out on the first visit—or better yet, before they come in. Almost a decade ago, many Canadian doctors were using the questionnaire to screen for patients who would be more difficult to treat, and at least two provincial regulators introduced rules to stop this tactic. The Ontario regulator ruled[10] that doctors should accept patients on a "first-come, first-served" basis, and the Nova Scotia regulator stated[11] that the introductory interview "may not be used to select 'easy patients' and/or screen out those with more difficult health concerns, such as chronic or terminal disease."

Licensing authorities in the United States haven't yet moved against initial screenings, but Zetter reports that few US doctors bother because it's time-consuming and labor-intensive. "It's hard to pinpoint particular patients who are noncompliant before they become your patients," he says.

Instead, Zetter says, it's easier to dismiss existing patients later on. "Discharging patients isn't that hard. You just have to follow the rules." This mainly involves giving the patient notice in writing at least 30 days beforehand and offering to forward copies of their records to their new physician.

A Gathering Force?

Even though widespread cherry-picking hasn't become a reality yet, some doctors are beginning to see the effects incrementally.

"I have already observed referral patterns of patients with poorer-paying insurances or more difficult patients who get referred to us," a physiatrist said in the Medscape survey.

Physicians are concerned about being inundated with nonadherent or high-acuity patients. "I wouldn't take other people's castoffs," a general surgeon told the survey.

Even if there is no economic incentive yet, the simple fact that some physicians are cherry-picking could force others to do it, too. "I can't be the only person who takes care of the complicated patients," a cardiologist said.