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ESSAY

Federal Health Care Reform and Texas

Health care for all, or at least health insurance for all, promises to be expensive. In an effort to reduce the sticker shock of proposed health reforms, the current administration is looking for ways to bring government funded health expenses under control. Minimizing waste and using the savings to cover some of the anticipated growth in costs is one strategy under consideration. According to various news reports, the administration claims that savings in the billions can be achieved through crackdowns on Medicare and Medicaid fraud and abuse.¹ Texas health care providers may be among the first scrutinized for evidence of profligate use of public resources.

Multi-agency task forces, to be created at an estimated cost of \$311 million, are expected to root out most of the fraudulent billing and overutilization that have contributed to out-of-control health care costs.² Similar task forces used in South Florida and Los Angeles have proven

successful in uncovering blatant fraud. Houston and Detroit are reportedly the first planned targets for implementation.³ These task forces, otherwise known as *strike forces*, will rely on both new and existing laws for the authority to scrutinize health care billing and to rein in practices that unnecessarily drive up the cost of health care. A new law, The Fraud Enforcement and Recovery Act (FERA),⁴ enacted in May, was created largely to address the abuses of the financial industry. However, its clarification of the meaning and intent of the False Claims Act⁵ may have an enormous impact on health care and health care related activities. FERA extends the reach of the False Claims Act and the government's ability to recover inappropriately obtained government funds.

As is widely known, the False Claims Act allows whistleblowers, usually co-workers or employees who have reason to believe that violations of the Act have occurred, to file lawsuits on behalf of the federal government to recover the falsely claimed government funds. These lawsuits, called *qui tam* lawsuits, allow the whistleblower

Please see page 3

Report on the 2009

Ethics of Scientific Research Course

Beyond their contributions to the ethics of research involving human subjects, IMH faculty are involved each year in teaching a course on the ethical issues inherent to basic science research. Titled the *Ethics of Scientific Research*, this course focuses on the following topics—most of which are federally mandated for basic scientists:

- The meaning of scientific integrity
- Fraud and falsification in research
- Plagiarism
- Reporting scientific misconduct (whistle blowing)
- Ethical issues in biomedical publications
- Scientist's responsibilities to the public
- Ethics and regulations involving the use of animals



Dr. Harold Vanderpool is the director of this full two-day course. Under his directorship or co-directorship, he has, with outstanding editorial and organization support of the IMH staff and whole-hearted financial support

Please see page 2

from UTMB's Graduate School of Biomedical Sciences, produced a course syllabus of topics, readings, teaching exercises and discussion questions that has been used by other academic institutions.

All of UTMB's first-year graduate students in the biomedical sciences and the humanities, along with UTMB's post-doctoral candidates are required to take this course—67 students this year. With the aim of creating “a culture of concern for the ethical dimensions of biomedical research,” Vanderpool recruited 18 of UTMB's outstanding basic science and graduate nursing faculty, along with 14 medical humanities faculty and graduate students. These participants served as speakers, panel members, and, importantly, as co-facilitators of small discussion groups of graduate students and post-docs.



Distinguished keynote speakers over the last few years include University of Texas historian, Dr. David M. Os-hinsky; Dr. Julius Younger (who worked with Jonas Salk on the development of the Salk Polio vaccine) from the University of Pittsburg; UTMB's Provost Dr. Garland Anderson; and UTMB's Dr. David Niesel, chair of the Department of Microbiology and Immunology and co-host of Medical Discovery News, a widely aired radio program on science.

One of this year's highlights involved an analysis of several protocols presented by Dr. Scott C. Weaver, director of tropical and emerging infectious diseases at UTMB's Center for Biodefense and Emerging Infectious Diseases. The protocols involved research initiatives in biodefense that raise critical questions involving scientists' and scientific committees' duties to protect the public from possible infectious disease outbreaks. In a breakout session, student representatives of each discussion group presented and debated each of the group's ethical evaluations of Dr. Weaver's protocols.



The course evaluations from both students and faculty were by-and-large positive, and at times, enthusiastic. Representative responses included comments that:

This was a very well planned and organized course.

The interaction among participants in the large forums were very helpful.

The small group discussions gave us a chance of one-on-one discussions of questions for those who aren't comfortable talking in the large conference group.

This course dealt with important topics that are relevant to all students conducting scientific research.

It was hard to get a straight answer out of the speakers at times.

I think this course did not do justice to the topic of ethics. It is an extremely important set of topics that requires an intensive semester-long course as opposed to two days.

From a course director's point of view, the first four of the above responses validate the time, effort and content of this short course. But the last two are delightfully instructive. The first voices the ardent hope for, but continuing illusiveness of, “straight answers” for those who are wrestling with complex ethical questions. The second flags the frustrations of instructors and students alike who want ethics courses to be more substantive than appetizers.



Health Care Reform

From page 1

to keep a portion of the funds recovered from the violator. Such lawsuits are likely to become more attractive. The task forces sought by the Obama administration are likely to identify more instances of fraud and abuse than ever before. The advantages of remaining silent about inappropriate billing and resource use may rapidly disappear.

The Houston area is an obvious target for investigating Medicare and Medicaid fraud and abuse, because it is a medical Mecca. More than 100 hospitals and medical centers serve the greater Houston area.⁶ It is common knowledge that patients come from all across the country and all over the world to obtain care at the Texas Medical Center in Houston. However, Texas is likely to be a target for investigations of Medicare and Medicaid fraud and abuse for other reasons. One of those reasons can be found in an article by surgeon-writer Atul Gawande that recently appeared in *The New Yorker*.

Gawande's article "The Cost Conundrum: What a Texas Town Can Teach Us About Health Care," explores why McAllen, Texas, is "the most expensive town in the most expensive country for health care in the world," and why the cost of health care in the U.S. has created an economic crisis that threatens the financial security of the country.⁷ The conundrum about which Gawande writes is not just that government funded health care costs so much in a part of Texas that has lower-than-average rates of cardiovascular disease, asthma, HIV, infant mortality, cancer and injury; it is about the fact that, despite enviable facilities in McAllen, the health care is of no better quality than in areas where health care is provided in lesser facilities and at a substantially lower cost.

Gawande compared hospitals in Hildalgo County (of which McAllen is a part) to El Paso County hospitals to make his point. He chose the two counties because of their similar populations and demographics. The differences in Medicare expenditures were startling. The most recent Medicare figures available (2006) showed that expenditures "in El Paso were \$7,504 per enrollee—half as much as in McAllen."⁸ Furthermore, when the quality of care is compared using Medicare's list of 25 measures of quality, on average El Paso's five largest hospitals outperformed McAllen's five largest hospitals on all but two measures.⁹

Questioning almost everyone he encountered on his visit to McAllen, ranging from hotel desk clerks to promi-

nent physicians, Gawande tried to find an explanation for the out-of-proportion Medicare spending. Most of the answers did not fit with the evidence. Claims that the people were poorer, less healthy, more likely to be immigrants, or more likely to file malpractice lawsuits could not be substantiated by population statistics and other records.¹⁰ Ultimately, a group of McAllen doctors gave Gawande a plausible explanation for the extraordinarily high health care costs—overutilization. They blamed the overutilization on young doctors who are trained to use all of the technology available, instead of using judgment about what is necessary and what is not. They also suggested that many of their younger colleagues had come to understand medicine as a business, a way to maximize profits, instead of a way to help others. "[T]he way to practice medicine has changed completely. Before, it was about how to do a good job. Now it is about 'How much will you benefit?'"¹¹

It could be argued that comparing two counties in places far from the Houston area has little relevance to the quality of care and the level of Medicare expenditures in Houston or even in the state of Texas as a whole. However, Gawande states that Dartmouth economists Katherine Baicker and Amitabh Chandra "found that the more

Please see page 4



Due to Ike, the Institute for the Medical Humanities is now located in the PCP. The Institute's main office is PCP 2.301. Below are the office locations and current phone numbers for our faculty.

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Howard Brody	PCP 2.309	772-9385
Michele Carter	PCP 2.259C	772-5835
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Jason Glenn	PCP 2.310	772-9332
Laura Hermer	PCP 2.314	772-9379
Anne Hudson Jones	PCP 2.312	772-5839
Cheryl Vaiani	PCP 2.259B	747-9113
Harold Vanderpool	PCP 2.259F	772-8865

Robert Rose and William Winslade can be contacted at 772-2376.

Eric Avery can be contacted at 747-9667.



Medicare spent per person in a given state the lower that state's quality ranking tended to be. In fact, the four states with the highest levels of spending—Louisiana, Texas, California and Florida—were near the bottom of the national rankings on the quality of patient care.”¹² It seems clear that more is not necessarily better, and McAllen alone cannot be responsible for all of the extraordinary expenditures and quality rankings. Gawande notes another relationship between quality of care and Medicare expenditures. Research he cites shows that where the Medicare costs are high, patients are less likely to receive low-cost care that could prevent serious morbidity.¹³

If Gawande and his interviewees are right, Texas may be the first state prepped for fat-trimming surgery. At this point, it is unclear whether overutilization will fall within the statutory meanings of fraud or abuse as interpreted by strike forces. However, there is a good possibility that whatever attracts attention to Medicare expenditures in Texas will prove costly to Texas health care providers in the long-run.

— E. Bernadette McKinney, JD, PhD

Notes

1. See e.g., Gregg Blesch, “Feds Targeting Billing Fraud; Recoveries Eyed as Source of Healthcare Reform Funds,” *Modern Healthcare* 9, no. 21 (May 25, 2009): 12.
2. *Ibid.*
3. *Ibid.*
4. Fraud Enforcement and Recovery Act of 2009, [Pub.L. 111-21](#), 123 *Stat.* 1617. The act addresses matters related to fraud and abuse involving federal funding in general, <http://www.gpo.gov/fdsys/pkg/PLAW-111publ21/content-detail.html>, last visited June 22, 2009. See section 4 of the Act.
5. The False Claims Act, 31 U.S.C. § 3729 et seq., allows a private individual, a whistleblower, to sue on behalf of the government to recover funds obtained from the government through fraudulent means. Depending on the extent to which the government is involved and other factors, the private citizen who sues may receive 15-30% of amount recovered in a successful *qui tam* false claims lawsuit. Under the False Claims Act, [31 U.S.C. §§ 3729-3733](#), those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 (the statute actually says not less than \$5,000 or more than \$10,000 as adjusted by the Federal Penalties Inflation Adjustment Act) per false claim. See The Taxpayers Against Fraud Education Fund, The False Claims Act Legal Center for easy to understand materials about The False Claims Act. <http://www.taf.org/whyfca.htm>
6. See <http://www.houstonareaweb.com/hospitals/> or http://www.houstonmedcenter.com/hospitals/texas_medical_center_hospitals.php for listings of Houston area hospitals.
7. Atul Gawande, “The Cost Conundrum: What a Texas Town Can Teach Us about Health Care,” *The New Yorker*, (June 1, 2009), http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande, last visited June 22, 2009 (hereinafter referred to as “The Cost Conundrum”).
8. *Ibid.*
9. Critics have argued that the measures used to determine the quality of health care are of questionable value. Nevertheless, they are standard measures used evaluate all hospitals that receive Medicare and Medicaid funding. If the measures are subject to manipulation, it appears that some hospitals are more capable at manipulating them than others.
10. Gawande, “The Cost Conundrum.”
11. *Ibid.*
12. *Ibid.* See Katherine Baicker and Amitabh Chandra, “Medicare Spending, The Physician Workforce, And Beneficiaries’ Quality Of Care,” *Health Affairs*, Jan-Jun Supp Web Exclusives 23, (April 27, 2004): 184-197 <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.184v1/DC1>, last visited June 22, 2009.
14. Gawande, “The Cost Conundrum.” Gawande attributes this finding to a 2003 study by Elliot Fisher et al. at Dartmouth. See Elliott S. Fisher, David E. Wennberg, Therese A. Stukel, Daniel J. Gottlieb, F.L. Lucas, and Etoile L. Pinder, “The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care,” *Annals of Internal Medicine* 138, No. 4 (February 18, 2003): 273-287, and Elliott S. Fisher, David E. Wennberg, Therese A. Stukel, Daniel J. Gottlieb, F.L. Lucas, and Etoile L. Pinder, “The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care,” *Annals of Internal Medicine* 138, No. 4 (February 18, 2003): 288-299.