

In addition, bundled payment may promote better teamwork between doctors and nurses. Medical and nursing educators have long talked about the importance of interprofessional learning, yet successful programs are rare. In most hospitals, much of the work of doctors and nurses is not as integrated as it should be. Except in intensive care units, communication is too often indirect. Nurses' observations are usually documented separately from those of physicians, as are the treatments they provide. Bundled payment will be an incentive for hospital leaders to help their medical and nursing staffs reduce these inefficiencies by integrating their work more effectively. Among the results should be an improved learning environment for students of all the health professions.⁵

Bundled payment may also improve the environment for primary care providers at AMCs. The presence of a strong, professionally satisfied primary care group is essential for the successful implementation of bundled payment — and for producing graduates who wish to pursue careers in primary care. Many department heads at leading medical schools still see their mission as training subspecialists only. But many physicians who enter practice after completing their residencies or

fellowships settle within 50 miles of where they trained. So if there is to be a strong referral base, faculties must understand the importance of vigorous academic primary care programs.

Bundled-payment systems will require AMCs to address income disparities between primary care physicians and subspecialists — disparities that tend to be less pronounced in highly integrated delivery systems. AMCs will need to develop more centralized financial systems and management philosophies, although doing so will require a culture change at medical schools. High priority must be placed on recruiting faculty members committed to the health of the overall enterprise. Faculty search committees will need to focus less on candidates' research accomplishments and more on their leadership skills.

Some argue that bundled payment will place AMCs at a financial disadvantage, but these centers have thrived regardless of how they are paid. They are the sole providers of many complex services, and the fact that private insurers pay them more than community hospitals for less complex services reflects their competitive advantage. Academics who collaborate with industry in developing medical products will continue to introduce new technologies; under a bundled-payment system,

the key will be to determine, early on, whether each technology truly has an appropriate and necessary role in patient care.

I would urge medical and nursing educators to begin a dialogue with the directors and governing boards of teaching hospitals about the importance of payment reform in preparing students to become wise stewards of health care resources. These leaders, through their national organizations, should explore opportunities for receiving bundled payments. As a start, the Association of American Medical Colleges and the American Hospital Association have expressed their support, in concept, for these payment reforms.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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The Power Proxy

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The patient looks better than I expected. Investigations for a septic episode revealed a liver replaced by tumor, the primary obscure. He cuts a handsome fig-

ure at 70. His handshake is brisk, his expression open and warm.

"Hello," I greet him. "I'm the oncologist."

"I know all about you, doc!"

Smiling, he produces a sheaf of papers: my photograph, my résumé, and snippets of my writing. "My son is an executive. He did this!"

I am at a loss for words.

The patient had undergone nephrectomy 20 years earlier. “At that time, if your doctor said you needed one less kidney, you just did it,” he says. “How can you be sure it’s cancer?”

“The scans look convincing. However, absolute proof requires a liver biopsy,” I say. I explain that such a procedure might establish a primary tumor site, but with his liver on the verge of failing, it’s doubtful that chemotherapy will help.

He nods understandingly. “I’m not afraid of dying. We all have to go sometime, and I’ve had a good life.”

“Do you work?”

“I cleaned buildings all my life, but my kids are professionals,” he beams.

He decides to have a biopsy. “I’m curious, that’s all. But my sister had chemo. It’s awful stuff.”

He returns for the biopsy results with his frail wife and the executive son, who charges authoritatively through his question list: Is the liver simply filled with abscesses? Are the tumor markers a laboratory error? Why can’t we find a primary?

“I believe the tumors are malignant,” I reply gently, “but. . .”

“The biopsy will tell.”

“Unfortunately, it shows only inflammation, which can happen if the needle hits the wrong spot.”

“Or it could be something else entirely,” says the son, “so we need another biopsy.”

“Only if you want to,” I tell the patient, who had much pain after the first biopsy.

“But how else will you treat the cancer?” the son glares. I explain to him, too, that chemotherapy might not help.

“And I say we all got to go some time,” the patient remarks amicably. “Might as well go peacefully.”

“You don’t know that chemo won’t work,” the son says to me.

“It’s merely an educated guess,” I acquiesce. He is mollified.

The patient’s wife asks about the side effects.

“Nausea, infection, fatigue — hang on, don’t I already have them?” the patient chuckles.

“They could worsen,” I warn.

though I hate to sound so pessimistic. I am dismayed that the son has hijacked the consultations. When we first met, the patient had exuded calm acceptance. Having seen the ravages of chemotherapy, he knew his mind. But now his son was steering him away on a dangerous tide of misplaced optimism.

I turn to the patient. “There is no urgency to chemotherapy. Think it over during Christmas.” He is looking forward to hosting

There are obvious benefits to autonomous decision making. But sometimes people who passionately believe they are advocating for patients end up submitting them to inappropriate — and sometimes harmful — care.

“Yeah, Dad,” says the son, “but they’ve discovered new drugs since your sister died.” The patient’s eyes cloud with the recollection.

Reluctant to be cast as the naysayer, I add, “True, we have better drugs now.” The son responds approvingly. The father consents to a second biopsy.

The next week, he appears subtly worse. The diagnosis is metastatic bladder cancer.

“What’s the treatment?” The son readies his pen to conduct business.

I explain that I don’t believe chemotherapy will benefit his father and could prove hazardous, and I emphasize supportive care. The patient nods sagely.

“But there must be that small chance of success,” presses the son.

I feel uneasy. I’ve indicated my sense of the futility of treatment,

the traditional family lunch.

The patient likes the idea, but the son objects. “It’s best to go straight in, isn’t it? These things multiply pretty fast.”

Suppressing my irritation, I address the patient. “You are the one having chemotherapy. I’d like you to be sure.”

He pauses briefly then exclaims, “You know what, doc? I’ll just go for it! I’ll have the chemo!”

The son shrugs. “And you can always stop it, Dad. No harm trying.”

Deaf to my counsel, the son wants to root out his father’s problem, acting as decisively and quickly as he does in his job. But the human body is not governed by his simplistic rules, and he cannot imagine that his solution could become the problem. The patient chooses to be guided by his trusted son rather than an

unknown doctor. His son is educated, informed, intelligent — surely he knows best.

The patient signs the consent form with his son as the witness.

And when I see him in the chemotherapy chair, the patient looks robust enough to convince me to temporarily dismiss my solicitude. But 2 days later, I am called to the emergency room.

“Doctor, I haven’t left my bed since chemo. My head spins.” He looks uncharacteristically vulnerable.

I point to the bag of blood on the IV pole. “You are quite anemic, but this will help.”

He cheers up. His son seems unconcerned. “Hear that, Dad? The blood will fix you.”

The patient determinedly shows up for further chemotherapy. Days later, I am summoned again. This time, lying limply in bed, blood trickling into his vein, he looks ghoulish, insensate. My heart sinks.

“His counts have crashed; it’s DIC,” the resident reports.

“I am so sorry you’re back,” I sympathize.

He flutters his eyelids weakly.

“We will do whatever we can to make you feel better.”

“Everything hurts,” he whispers through parched, ulcerated lips.

“We can fix that,” I console, charting morphine.

His son calls repeatedly. “How is Dad?”

“Unwell. His organs are failing.”

“The hematologist says the chemotherapy did it,” he reports. “Can you reverse it?”

“We are treating him as best we can.”

The son demands full resuscitation and a second opinion.

I’m torn between sadness and frustration.

The next day, I’m relieved to find the patient alone in his room. “How do you feel?” I ask.

Tears roll down his face.

“How can I help?” I wait to be blamed for all this — perhaps it would make us both feel better.

“No more,” he pleads.

His plummet toward death is frightening. Two days before Christmas, I call the son. “I would suggest bringing the family in to say goodbye,” I say.

“How can you be sure?” This time, his tone carries more chagrin than challenge.

“I honestly hope I’m wrong, but I had to let you know.”

The patient dies, inadequately palliated because the family held out for a miraculous recovery. It’s Christmas Eve. My thoughts keep returning to his planned celebration, now replaced by a funeral. Should I have flatly refused to prescribe chemotherapy or insisted on a “cooling off” period? I could not have foreseen that he would die of such a tragic complication. I am confident that making the decision alone, he would have forgone chemotherapy. Should I have insisted on seeing him alone? At the time, it seemed like an antagonistic move designed to fracture trust between father and son. But now, I feel complicit in his untimely death.

Increasingly, I notice a technological but also a mind-set gap between geriatric oncology patients and their escorts, often their children. The patients are used to trusting the doctor’s word. The escorts Google the disease and the doctor. They ask more prob-

ing questions, expect more concrete answers, and are much less accepting of medicine’s limitations. The patient says, “I understand.” The escort objects, “It’s not good enough.”

There are obvious benefits to autonomous decision making. But sometimes people who passionately believe they are advocating for patients end up submitting them to inappropriate — and sometimes harmful — care.

Informed consent is a cornerstone of medicine, something that ethics committees and hospital lawyers spend hours mulling over. My patient’s consent was valid. But there was no checkbox for consent based on misplaced enthusiasm — nor anywhere to indicate the physician’s gut instinct.

Not feeling morally absolved, I call the son. He says, “I am glad you didn’t give him a placebo because you were against chemo.”

Confounded by the suggestion, I simply express my regrets and tell him I appreciated his father.

“He should have celebrated Christmas,” the son reflects.

He would have, I think wryly, if not for the chemotherapy he never truly desired.

“It must have been a sad day for your family.”

“At the end of the day,” he finally declares, “this is what he wanted. After all, he signed the consent.”

The statement takes my breath away — it tells a literal truth but sidesteps critical details. Yet the son’s nonchalance masks a heavy heart. It seems a further abnegation of my duty to agree with him, but he’s looking for redemp-

tion. I remind myself that he loved his father, was unsettled by his impending loss, and thought he was doing the right thing. I know the patient had chemotherapy to please his son, but I also recall how proudly he spoke of him. And I tell myself that I need to

find ways of reconciling my own perspective with the needs of patients in order to uphold a practice faithful to my principles.

“You’re right,” I finally concede. “He did sign the consent.”

His relieved response is immediate: “Thank you, doctor. You

could not have done any more for Dad.”

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