UNDER MY SKIN

Mistakes

Jenna wanted to show me something on her lip before she and her young family moved to Berlin in 5 days. "This has been here for a year," she said. "I think it may have grown."

BY ALAN ROCKOFF, M.D.

I stared at it in bright light, with high magnification. "It looks like a large pore," I said. "It's small and perfectly round. I don't think it's a problem." I suggested she e-mail me if she had any concerns while she got settled.

Two months later, Jenna did just that, telling me that the lip spot had grown. I sent her the names of AAD-affiliated dermatologists in Berlin. Shortly afterward, she wrote again. "What you said was a 'pore' is actually a basal cell skin cancer. I'm disappointed that it wasn't diagnosed earlier."

You would think that, after 30 years, I would recognize a basal cell.

Everyone knows that humans make mistakes, but it's hard to admit that we are that human. This is true even if the mistake isn't likely to result in a lawsuit. Admitting fallibility is hard, especially for doctors. So often patients put us on a pedestal, whether we deserve to be up there or not, and it's tough to climb off.

In our professional role, we are calm and competent. People come to us when they're in trouble and count on us to get things right. If we let them down, can they trust us next time around? Can we trust ourselves?

The answer to whether they can trust us again is often no. Even after a warm clinical relationship spanning years, a missed diagnosis may be followed by a signed request to "Forward my records to …" It doesn't matter how many correct diagnoses came before, how many ultraprecautionary biopsies were negative; sometimes one strike and you're out. This may seem unfair but is really no more than the flip side of all that unmerited adulation.

Anyone in practice long enough gets his or her share of letters expressing anger or disappointment. Sending a response that aims at self-justification is usually unhelpful, if not useless. But who among us is courageous—or foolish—enough to say, "Sorry, but you're right—I blew it"?

We dermatologists can make relatively few errors that have dire or irreversible consequences. Missing a melanoma is, of course, such a mistake. Yet despite hypervigilance, careful examination, and frequent biopsy, there will always be that funny lesion that doesn't look the way a melanoma should, about which the patient, or attorney, will demand, "Why didn't you test that, Doctor?"

We might respond to this circumstance with frustration or a guilty conscience. Either way, it's embarrassing to admit we came up short. Now and then, a patient or relative will rub in our shortcoming with particular relish.

Last year, I diagnosed and treated a basal cell on the forehead of an elderly Russian woman. She returned a few months later to show me another spot on her upper lip. "You said it was okay," she said, "but my daughter is worried." I could barely see the lesion, but the biopsy confirmed that it too was a basal cell.

Her daughter, who turned out to be a family practitioner, called soon after. "Tell me," she said, her voice heavy with sarcasm, "when you look at the forehead, do you also look a few centimeters down to the lip, or is that too much trouble?"

Taken aback, I offered no response. "My mother has a daughter who is a physician," she went on. "What happens to your patients who don't have that luxury?"

I could have responded by hoping that if she herself ever makes an error, her patients might be more forbearing. But I said only that I understood her point.

As for Jenna, I answered by saying that her lip lesion had not looked to me like a basal cell and that I tried to avoid biopsies on the faces of young people if I couldn't justify them. I added that I was sure she would be well taken care of.

Hippocrates had it right: Life is short, the art long, opportunity fleeting, experience misleading, judgment difficult. We just have to keep trying. ■

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COMMENTARY

Ingenix Settlements: Don't Drop Your Guard

The recent Ingenix settlements have been hailed as "an enormous step toward pricing transparency and consumerism in health care," but given the insurance industry's track record in sidestepping similar agreements, physicians have little cause to celebrate, or to lower their guard.

BY JOSEPH S. EASTERN, M.D.

If you haven't been following this issue, the controversy centers around UnitedHealth Group and its wholly owned subsidiary, Ingenix, which for the last decade has controlled the insurance industry's pay rates for out-of-network care. In 2000, the American Medical Association sued UnitedHealth and Ingenix, charging they were routinely low-balling "usual, customary, and reasonable" (UCR) rates, thereby shortchanging both patients and their physicians. New York State Attorney General Andrew Cuomo subsequently launched his own investigation and filed a separate legal action.

In a typical scenario, according to the complaints, an out-of-network doctor might charge $200 for an office visit. The insurer would claim, based on Ingenix data, that the "usual and customary" fee was, say, $77, of which the insurer would pay 80%, leaving the patient responsible for the difference of $138.

Mr. Cuomo and the AMA charged that the UCR numbers, derived from claims data created and maintained by Ingenix and sold to other insurers, were fundamentally skewed in favor of the insurers themselves. It was a "closed loop," he said, tainted by an inherent conflict of interest: United and other insurers (notably Aetna) allegedly entered lower payments in the database and omitted higher ones, which lowered the resulting UCR rate by as much as 28%, Cuomo's office found.

Over a 10-year period, this cost patients and their physicians hundreds of millions of dollars. Patients were saddled with unfairly high balances, despite the fact that they had paid extra for access to out-of-network care; and physicians often did not collect those balances, because many patients assumed they were being overcharged and refused to pay them.

In January, Cuomo's office reached a settlement with UnitedHealth that requires Ingenix to scrap its database and contribute $50 million to help establish a new, independent database to be overseen by a nonprofit (and presumably impartial) third party. Two days later, United settled the AMA's class action suit, agreeing to pay $350 million to shortchanged patients and physicians. Aetna has also agreed to stop using Ingenix data and to contribute $20 million to the nonprofit entity holding the independent data (possibly Syracuse University).

The new database will be viewable by patients and doctors alike on a public Web site, theoretically allowing fast and easy determination of the "usual and customary" payment for a given service in a given area.

Many observers on the provider side have been quick to praise the agreement as a major watershed. AMA President Nancy H. Nielsen said that new, reliable data will eliminate "that wedge driven between patient and doctor." Patients will be more comfortable going out of network, she maintained, because they will have a reasonable idea of what they will have to pay out of pocket. Physicians will stand to receive fairer out-of-network compensation. There were even predictions that the balance of power in physician/health plan negotiations would shift in physicians' favor.

Physicians would certainly welcome an end to insurance companies' unilateral and secretive determination of what is fair and reasonable, but it is not at all clear that this, or any of the other promised reforms, will be realized, or that physicians' practices will be affected in any meaningful way.

Although details of the agreements have not been released, it would appear that there is little motivation for other insurers to change their ways. United and Aetna, after all, did not even have to admit to any wrongdoing.

The new nonprofit database is meant to be used industrywide, but insurance companies not bound by the Cuomo and AMA agreements will be under no obligation to do so. And while United and Aetna will be barred for 5 years from developing a competing database, the rest of the industry will have no such restriction.

Cuomo said that his office intends to pursue agreements from other insurers to use the new database, but whether that will come about, especially outside of New York State, is far from certain.

The settlements are undoubtedly a step in the right direction, but it will be months, maybe years, before we know if the new database is truly transparent or differs significantly from the old one, and even longer before we know whether anyone, patients or physicians, will see any lasting benefit.

In the meantime, given the insurance industry's long history of finding creative detours around any and all obstacles put in their path, physicians cannot afford to relax and assume that the out-of-network problem has been solved. ■

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LETTERS

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