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Physicians' Role in Protecting Patients' Financial Well-Being

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During medical training we learn as much from our patients as we learn from our professors. With rising health care costs and bursting household budgets, patients are teaching us that now, more than ever, physicians have a moral obligation to protect not just patients' physical health but their financial health as well.

Our job routinely requires us to manage expensive resources—one day in a hospital bed can cost the same as a week in the Ritz Carlton. Yet we have minimal training in how to manage resources responsibly. In fact, we may have anti-training.

We are taught to approach patient care with an "everything possible" ethos that seems at odds with cost effectiveness. We are rewarded for discovering the rare zebras among the more common medical condition "horses" and for working up exhaustive differential diagnoses indiscriminately [1]. Although we realize health care is expensive, we often mistakenly assume that our patients' best interests and conserving resources are mutually exclusive goals.

Our patients teach us differently.

Medical bills are the leading cause of personal bankruptcy in the United States, even among the insured [2]. As physicians we decide which tests or treatments go on the bill but have little idea how our decisions impact what patients pay [3]. At the same time, up to a third of the tests and treatments we order do not seem to make anyone healthier [4]. This includes daily lab tests on inpatients that never get followed up, imaging tests in patients with nonspecific low back pain, and countless other practices (45 of which are currently listed on the ABIM Foundation's Choosing Wisely web site as practices that patients and physicians should question [5]).

The consequences affect everyone. In 2008 in Massachusetts, where 98 percent of citizens have insurance coverage, more insured non-elderly adults reported difficulty paying medical bills than ever before [6]. More Americans are on high-deductible plans than ever before, meaning many of us are paying the first couple thousand dollars of medical expenses out of pocket [7]. And the emerging case reports are as powerful as the statistics; the Costs of Care Essay Contest has collected hundreds of stories from all over the country of unnecessary financial harm due to cost-insensitive medical decisions that do not help patients get better [8]. In medical school we are taught that any preventable harm is unacceptable, and these examples are no exception.

Patient demand for physicians to consider costs has never been stronger. In 2013, consumers can make informed purchasing decisions about products, services, and entertainment based on the pricing and quality information on web sites such as Yelp and Travelocity. Government and private industry are both betting that patients have developed similar expectations for information about health care. More than 30 states either have or are pursuing price transparency legislation for patients [9]. I know that more than a dozen companies dedicated to health care price transparency have incorporated to date, with some capturing hundreds of millions of dollars in venture capital funding.

Payers and policy makers are also exerting pressure to stop the waste of health care funds. Reimbursement systems are shifting from fee-for-service models, in which doing more means making more (because each intervention is paid for separately), to capitated models, in which doing too much can mean making less money (because payment is per episode of care). Medicare has begun contracting with accountable care organizations (ACOs)—contractual networks of physicians, clinics, and hospitals committed to delivering quality and cost-effective care by coordinating patient treatment. ACOs that meet benchmarks for quality and cost efficiency share savings with Medicare. In the private sector, shared financial risk contracts between payers and physicians and clinics are becoming increasingly common [10].

With patients, the government, and the private sector lining up against wastefulness, the medical profession has been encouraged to promote resource stewardship as a matter of professional ethics. The ABIM Foundation's widely endorsed Physician Charter on Medical Professionalism states that we are obligated to scrupulously avoid "superfluous tests and procedures" in an effort to provide care that is "based on the wise and cost-effective management of limited clinical resources" [11]. In the last year, professional initiatives such as the ABIM Foundation's Choosing Wisely Campaign added greater visibility to the need for physicians to decrease waste.

As many as 80 percent of practicing physicians currently believe it is their responsibility to help bring health costs under control, and even those who do not share this view believe that costs are increasingly influencing their clinical decisions [12]. At the same time, the IOM recently estimated that $750 billion may be wasted each year in the United States on care that does not make anyone healthier, a figure on a par with the Department of Defense cost estimate for the entire Iraq War.

Nonetheless, professional and ethical standards on overutilization have not yet been widely put into practice. While our responsibility to contain costs is clear, lack of training on how to consider costs while caring for patients muddies the way forward.

A central problem is that most of the conversation about health care costs is abstracted to the population level. We discuss percentages of GDP and other macroeconomic statistics rather than patient-level financial harms. We physicians are trained primarily to take care of the patient in front of us, not to assume responsibility for entire populations. As a result, it is seldom clear how resources

diverted from one patient will help better serve the needs of another. For a physician at the bedside, savings realized from ordering a less expensive test or avoiding a marginally valuable therapy seem to accrue to the profit margins of insurance companies, not necessarily to the sick patient down the hall. Moreover, while we have frameworks for thinking about patient safety and therapeutic efficacy, we have no similar framework for thinking about cost and value. In the absence of such a framework, the only alternative is the understandably disturbing image of individual clinicians making rogue rationing decisions.

A first step to developing a framework for cost-conscious care may be to abandon the mythology that we are able to do everything for every patient without harmful consequences [13]. This will require distinguishing between macroeconomic resource stewardship and the financial well-being of the patient in front of us. By doing this, we may see instances in which the best interests of our patients and the need to conserve societal resources are well aligned. For example, both the patient and society win when we use generic medications, yet we routinely miss these opportunities to pick low-hanging fruit.

The cases in which our patients' interests and societal resource stewardship are less well aligned are more challenging to navigate. Occasionally, patients themselves demand low-value services and we must be prepared to advise them appropriately and recommend cost-conscious alternatives. In the same way we are expected to explain to patients why a narcotic or antibiotic may not be indicated, we should feel comfortable explaining why an unnecessary MRI should not be performed.

In other cases, a patient may truly need an expensive therapy but may struggle to afford it. In these cases, we should devise and teach strategies to decrease patients' out-of-pocket expenses by using alternative diagnostic and therapeutic formulations. If less expensive alternatives do not produce the best or standard care, patients should still have the opportunity to choose them as long as they know full well what the anticipated tradeoff is. Dismissal of these type of therapies (even well-intended dismissal) can lead to greater harms, particularly if more expensive options cause financial burdens or if they cause patients to forgo care altogether [2].

For these types of cost-conscious frameworks to be successful, physicians must have some sense of the financial consequences of their decisions. While precise costs are difficult to obtain at the point of care, physicians should be able to identify the largest resources under their direct discretion (for example hospital beds and MRI scans) and be able to estimate the average costs of their decisions within an order of magnitude (does a CT scan cost $10, $100, or $1,000?). Learning how to evaluate costs and interpret cost-effectiveness studies should also be standard parts of medical school curricula.

The task of considering costs while taking care of patients adds an additional dimension of complexity to an already difficult job. Still, there are many sources of complexity in our profession, ranging from the genomic revolution to the integration

of informatics. Our obligation to consider costs is not exceptional. That is why a group of medical educators formed Costs of Care, a nonprofit organization that helps physicians, nurses, and other caregivers master the complex world of health care costs to protect patients from financial harm. Through our Teaching Value Project [12], an initiative of Costs of Care that was funded by the ABIM Foundation, a group of medical educators and economists have come together to create a series of short, web-based video modules that teach medical students practical strategies such as, for example, decreasing patient medication expenses and avoiding test overutilization. The modules are designed to be widely accessible and allow users to efficiently demonstrate their learning with interactive exercises.

It is apparent that the physicians of tomorrow will be increasingly compelled to consider costs and recognize their role in protecting patients' wallets. It is time we give them the skills, training, and support they need to do so.

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