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Clinical Cases

Splitting the Difference--Patient Preference versus Conservation of Resources

Patients should not be obligated to change a successful prescription routine in order to save money.

Commentary by Robert L. Phillips Jr., MD, MSPH

Dr. Dan Troy is a well-respected, well-liked family physician in a medium-sized urban community. He has been practicing family medicine for more than 20 years in a multispecialty group practice in a small city and enjoys his work very much.

Dr. Troy was put in charge of monitoring the group's expenditures for prescription drugs. After some research, he discovered that in the case of many formularies, it was actually more cost-effective to prescribe a higher dose of the medication and have the patient split each pill rather than prescribing the actual dose the patient needed. For example, the cost of a single 50-mg tablet of Zoloft was $2.40 while the cost of a 100-mg tablet of Zoloft was $2.43. Dr. Troy notes that several insurance companies have begun to consider effective utilization of resources as a measure of quality care, and his group has consistently exceeded the financial limit that many insurance companies place on expenditures for prescription medication. Adopting a policy to prescribe more cost-effective medication when possible would improve the group practice's insurance profile and, at the same time, improve its efficient utilization of limited health care resources.

Two weeks later, one of Dr. Troy's well-established patients, Lucy Starr, came in for a routine check-up and a refill on her medication. Ms Starr is a middle-aged woman with depression who comes in regularly and usually gets a prescription for Zoloft, 50 mg, with instructions to take one tablet a day. Dr. Troy examines her and is about to write out her prescription, when he realizes that if he writes it for 100-mg tablets instead, over a year's time that would be a savings of more than $400. Dr. Troy then suggests to Ms Starr that he will write the prescription for 100-mg tablets. He explains that it is more cost-effective for her to purchase them in that dosage and have the pharmacy split the tablets instead of writing a prescription for the 50-mg pills. Ms Starr thanks Dr. Troy for his concern but tells him that she would rather have the prescription for the 50-mg pills because she is used to taking one pill a day and it is easier for her. "Besides," she remarks, "I pay the same co-pay in either case, so why does it matter?"

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Many physicians share the external pressures on Dr. Troy to practice more efficiently and cost-effectively today. Before attending to the ethical concerns involved in this case, there are a few very practical messages embedded in his conversation with Ms Starr. First, this patient's request for her medication in a specific form may indicate that she is taking her medication. This is no small matter given that patients taking antidepressants are reported to take the medication adequately only 39 percent to 55 percent of the time [1]. If fulfilling Ms Starr's preference for a specific form enables this regularity, it may be well worth more than the cost savings associated with pill-splitting.

The second practical message is that the patient may be offering an opportunity to explore why she is reluctant to have

her pills split. Threatening daily routines with a change in medication may raise sufficient concern or anxiety that Ms Starr is uncomfortable with even a simple change. And, perhaps, it is not such a simple change given that people with depression often have other chronic illnesses and related medications that are difficult to manage. It would be worth asking whether she understands that the split pill would simply replace her current Zoloft dose and would be taken with the same frequency. It is also worth noting, however, that an invitation to split medications may be an invitation to confusion and increased risk of harm. An accidental overdose may be a low risk with Zoloft, particularly since Dr. Troy is proposing that the pharmacy pre-split the pills. With any medication, it is important to assess whether pill-splitting with a higher dose is a *safe* alternative.

A third practical message is that this may become a real cost issue for Ms Starr. She believes that the copay will be the same, and this may be the case for a middle-aged woman with prescription coverage. However, for many patients, particularly for Medicare-eligible patients, splitting pills and their costs may mean that they can afford to take their medications. Studies show that patients in Medicare managed care plans who experience substantial erosion of their pharmaceutical benefits subsequently take their medications differently than prescribed or drop them altogether [2]. Physicians typically do a poor job of assessing this issue. Splitting higher doses to reduce costs may mean the difference in whether patients can afford to take medications or not. Helping Ms Starr understand any personal cost implications, rather than system costs, may affect her decision [3].

The ethical questions become more pure if Ms Starr's preference for the whole, smaller dose is strictly personal—and not related to risk of confusion, increased complexity, or increased cost. In this case, there are at least 2 relevant ethical elements operating. First is the right of the patient to accept or refuse any medical treatment recommendations made by her physician [4]. In addition to this right, patients also have a responsibility to be cognizant of the costs associated with health care and try to use medical resources judiciously [5]. The patient's rights should take precedence, so that, despite being cognizant of the injudicious use of scarce resources in refusing the split, higher dose, Ms Starr has every right to refuse. Dr. Troy treads on this right at the peril of the patient-physician relationship, and $400 per year cannot begin to replace the therapeutic and protective value of that relationship to Ms Starr.

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