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LETTER FROM THE EDITOR

The Era of High-Value Care

High-value care has emerged as a new ethos for practicing medicine, with a greater focus on minimizing waste, containing costs, reducing medical errors, and improving adherence to quality metrics. It emphasizes nonmaleficence, or doing no harm to patients, by reducing overutilization of tests—which may lead to false positives and unnecessary invasive procedures—and unnecessary care. Indeed, high-value care is not only about reducing cost, but also about improving quality and reducing harm. Incentives and curricula are increasingly being designed to focus on maximizing value, which is generally defined as quality divided by cost.

Ethical tensions may arise when practicing high-value care. While value-based care can further the principle of justice by facilitating consideration of how to distribute limited resources fairly, some may argue that it can conflict with the principles of beneficence and respect for autonomy, which have been interpreted as doing the most good and securing the most self-determination for an individual patient without thinking about resource limitations. This issue of the *AMA Journal of Ethics* explores these ethical tensions. We are fortunate to have experts and thought leaders in the field of high-value care contributing to this issue.

Three case commentaries highlight common ethical questions related to high-value care. Often, clinicians must decide whether diagnostic imaging and procedures should occur while a patient is hospitalized or may be deferred to an outpatient setting. In their commentary, Christopher Moriates, MD, and Josué A. Zapata, MD, examine hospital and physician incentives to contain costs within a medical ethics framework. Physicians also are frequently faced with a choice between high-value and low-value care when confronting patient expectations and requests for diagnostic imaging. Bjorg Thorsteinsdottir, MD, Annika Beck, and Jon C. Tilburt, MD, MPH, analyze factors that might influence a physician's recommendation in a case of a patient who expects a screening mammogram when guidelines suggest that it is most likely not indicated. The last case concerns a clinician-educator who obtains extensive laboratory testing for educational and diagnostic purposes and a resident trainee who feels these tests are not indicated. Maggie K. Benson, MD, discusses how they might navigate this disagreement through mutual understanding and compromise.

Two other articles discuss the place of high-value care considerations in medical education. In his piece, Hyung J. Cho, MD, recalls his experiences with clinical conferences in residency, reflecting that consideration of the appropriateness of work-up, costs, and value were often lacking. He also highlights solutions, such as monthly conferences that connect overuse to patient harm by labeling it a medical error. Today, high-value care is increasingly incorporated into medical education and recognized as a core competency of training by professional societies. Aditya Ashok and Brandon Combs, MD, describe novel methods for educating medical students, residents, and attending physicians about high-value care.

The question of how to structure medical payment and care delivery to promote high-value care is also a pressing one. Jeffrey Clemens, PhD, and Stan Veuger, PhD, discuss the implications of the repeal of the Medicare Sustainable Growth Rate (SGR) and its replacement with the merit-based payment incentive system (MIPS), a pay-for-performance model intended to encourage high-value care among provider organizations. Eva Luo, MD, MBA, examines two other approaches to increasing value: the "focused factory" model, in which efficiency is increased to extreme levels to lower the costs per patient, and the "high-touch" model, which focuses on improving outcomes by increasing interaction between the provider organization and the patient.

One of the goals of the high-value care movement is to prevent financial harm not only to the system but also to individual patients by containing costs. Vineet Arora, MD, MAPP, Christopher Moriates, MD, and Neel Shah, MD, MPP, explain the difficulty of identifying the true costs of health care and describe the price transparency movement, which aims to make charges more accessible to both patients and clinicians. Reshma Gupta, MD, MSHPM, Cynthia Tsay, MPhil, and Robert L. Fogerty, MD, MPH, examine the history of costs of care from the nineteenth century to the present day. New standards were adopted over time to improve quality, health expenses rose at a dramatic rate, and price transparency disappeared. The authors conclude by suggesting steps to screen patients for financial harm.

As this month's featured opinion on physician stewardship from the AMA *Code of Medical Ethics* points out, both systemic changes and individual physicians' actions are needed to create a fiscally sustainable health care system. One area in which both are pertinent is end-of-life care for patients with advanced cancer. Ali John Zarrabi, MD, Ran Huo, MD, and Diane Meier, MD, argue that palliative care interventions, supported by increased education and targeted policy, will decrease costs and improve outcomes and quality of life. In the podcast, Wendy Levinson, MD, discusses the challenges to high-value care and Choosing Wisely's efforts to stimulate discussion about overuse of tests and treatments that don't add value or may be harmful.

Practicing medicine responsibly in a complex and rapidly changing era poses challenges to both the patient and clinician. The new paradigm of value-consciousness is being adopted in culture, patient care, and policy; we hope this issue of the *AMA Journal of Ethics* provides a useful lens through which to consider it.

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