# Physicians, Health Care Costs, & Society: Who's Responsible for What?

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# Disclosures/Disclaimers

- Not the views of Mayo Clinic

# Acknowledgements


- Greenwall Foundation

# Case – Ms. S

- Resident & precepting faculty
- 43 medically complicated obese
- Mother of 3
- Sleep apnea, chronic fatigue, CHF
- PTSD
- Public assistance
- State tax revenue down
- State opted out of Medicaid expansion
- Contemplating gastric bypass
- 14,000 Medicaid patients also eligible
- ~$25,000 initial cost of surgery
- Faculty sits on state Medicaid sustainability panel

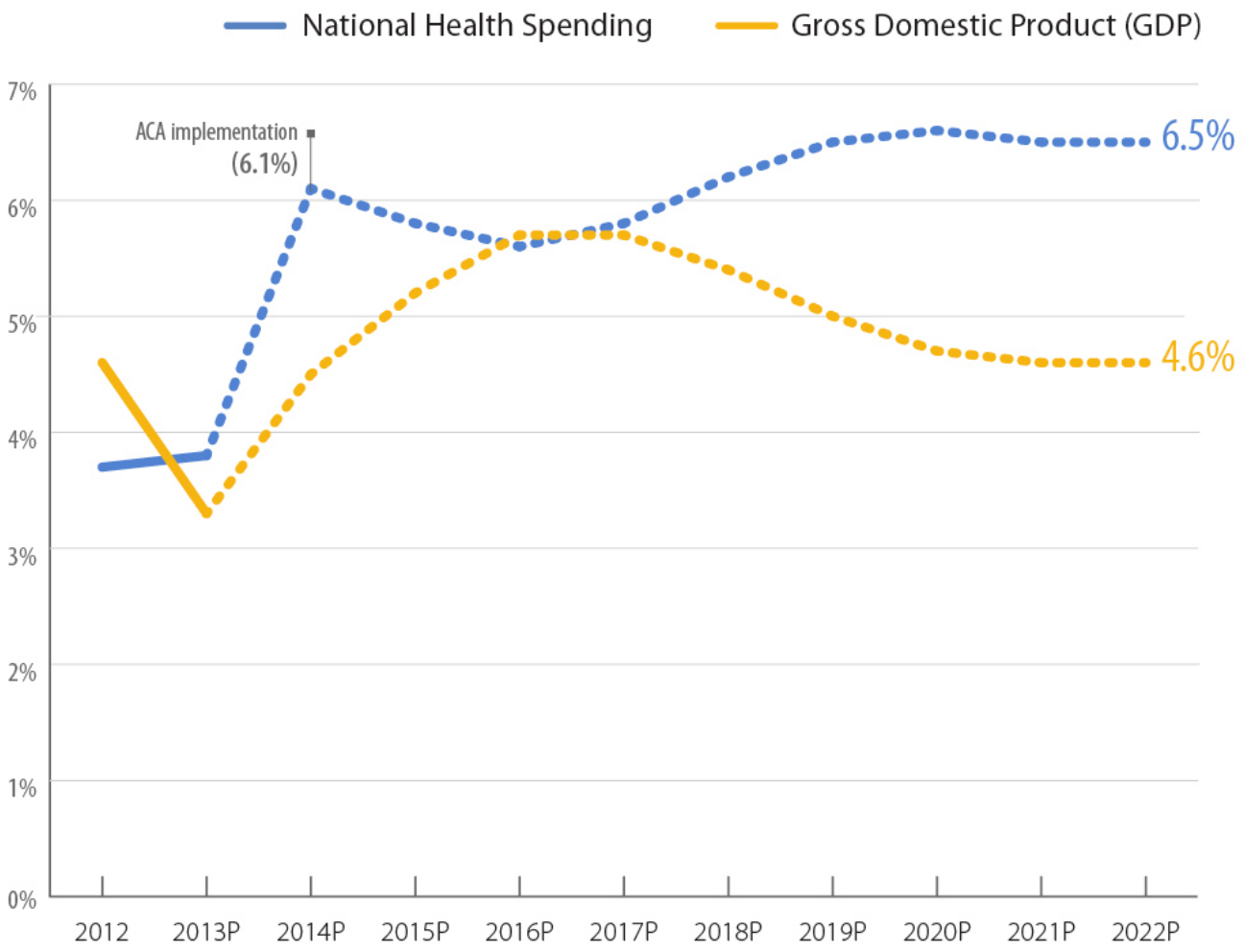
# What should they do?

Should they recommend gastric bypass?

# Rising US Health Care Costs

# Annual Growth Projections, Health Spending vs. the Economy

## United States, 2012 to 2022

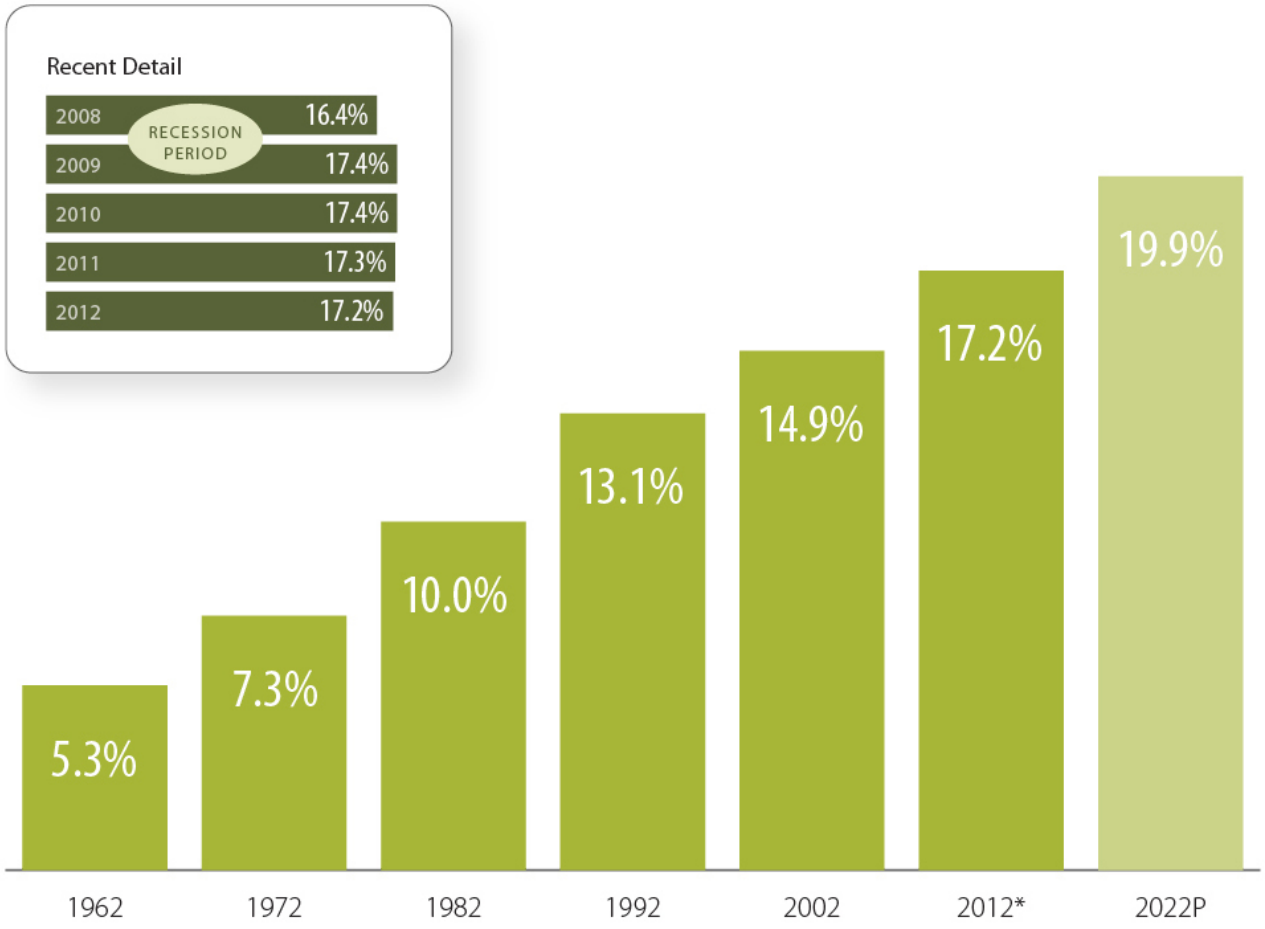



Note: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act, faster economic growth, the aging of the population, and government fiscal policy (end to the sequestration).

Source: Centers for Medicare & Medicaid Services (CMS), National Health Expenditures, 2014 release (historical) and 2013 release (projections), www.cms.gov.

# Health Spending as a Share of GDP

## United States, 1962 to 2022, Selected Years

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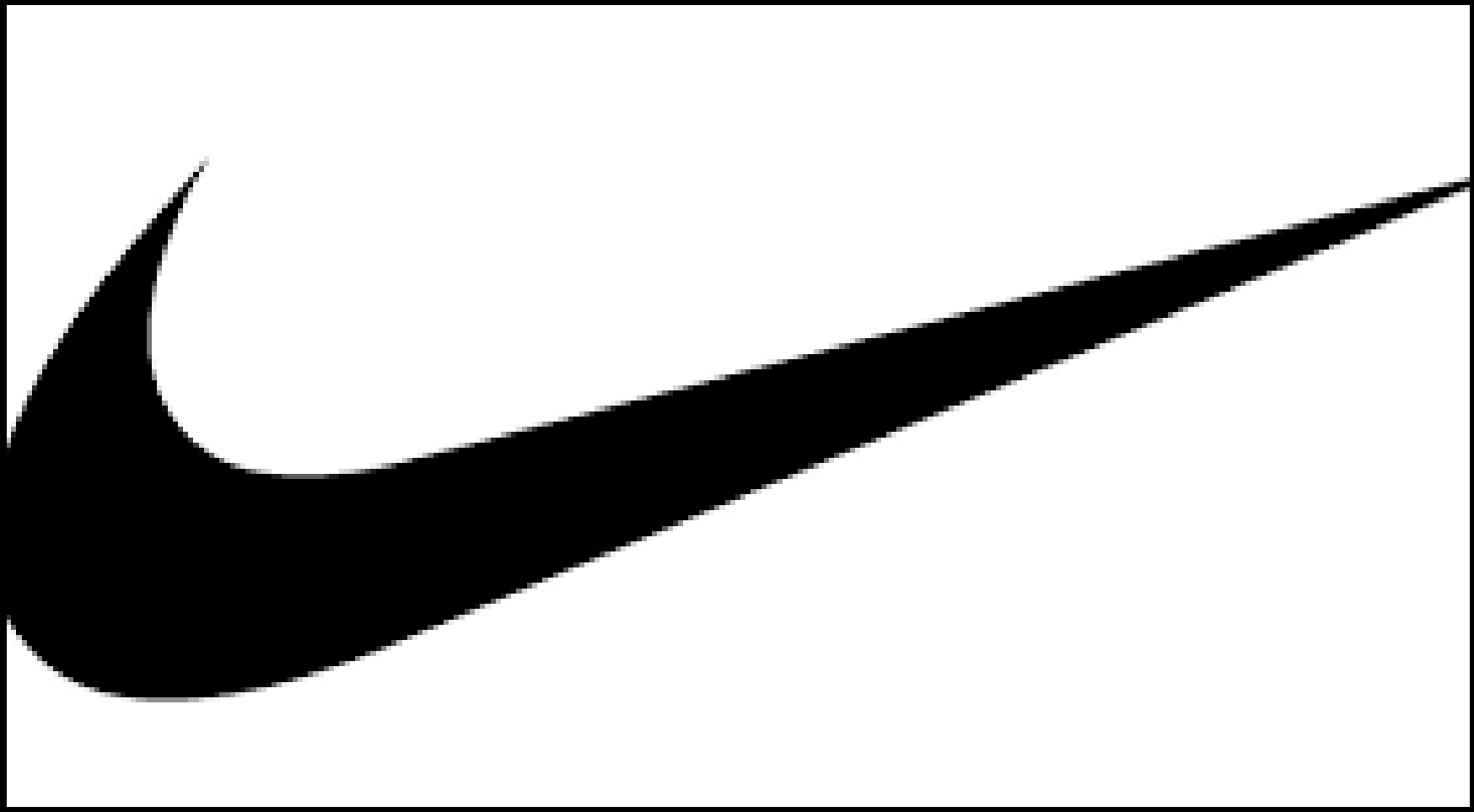
# Costs: A Moral Challenge

- Opportunity cost for other sectors
- Wage stagnation
- Limited opportunity
- Greater inequities
- Scrutiny & bureaucratic overreach

# Whose Responsible?

# Common Sense Logic:

- Healthcare costs are rising
- Physicians direct healthcare spending
- Physicians should help address costs



# Will Physicians Lead on Costs?

"...many physicians would prefer to sit on the sidelines while other actors in the health care system do the real work of reform. This could marginalize and demote physicians. Physicians must commit themselves to act like the captain of the health care ship and take responsibility for leading the United States to a better health care system that provides higher-quality care at lower costs."

Emanuel and Steinmetz. *JAMA.* 2013;310(4):374-375.


CAN'T SOMEONE ELSE
JUST DO IT?

# US Physicians': Perceived Responsibility HC Cost

- >50% said, lawyers, insurers, PHARMA, hospitals/systems, patients

  "major responsibility"
- 36% practicing physicians

  "major responsibility"

+ 59% "some responsibility"

Tilburt et al. JAMA 13;310(4):380-388.

# US Physicians: Crazy or Ambivolent? (n=2400)

- "Trying to contain costs is the responsibility of every physician"

  85% agree.

- "I should be solely devoted to my individual patients' best interests, even if that is expensive"

  78% agree

# Medical Professionalism in the New Millennium: A Physician Charter

Project of the ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine*

*To our readers:* I write briefly to introduce the Medical Professionalism Project and its principal product, the Charter on Medical Professionalism. The charter appears in print for the first time in this issue of *Annals* and simultaneously in *The Lancet*. I hope that we will look back upon its publication as a watershed event in medicine. Everyone who is involved with health care should read the charter and ponder its meaning.

The charter is the product of several years of work by leaders in the ABIM Foundation, the ACP–ASIM Foundation, and the European Federation of Internal Medicine. The charter consists of a brief introduction and rationale, three principles, and 10 commitments. The introduction contains the following premise: Changes in the health care delivery systems in countries throughout the industrialized world threaten the values of professionalism. The document conveys this message with chilling brevity. The authors apparently feel no need to defend this premise, perhaps because they believe that it is a universally held truth. The authors go further, stating that the conditions of medical practice are tempting physicians to abandon their commitment to the primacy of patient welfare. These are very strong words. Whether they are strictly true for the profession as a whole is almost beside the point. Each physician must decide if the circumstances of practice are threatening his or her adherence to the values that the medical profession has held dear for many millennia.

Three Fundamental Principles set the stage for the heart of the charter, a set of commitments. One of the three principles, the principle of primacy of patient welfare, dates from ancient times. Another, the principle of patient autonomy, has a more recent history. Only in the later part of the past century have people begun to view the physician as an advisor, often one of many, to an autonomous patient. According to this view, the center of patient care is not in the physician's office or the hospital. It is where people live their lives, in the home and the workplace. There, patients make the daily choices that determine their health. The principle of social justice is the last of the three principles. It calls upon the profession to promote a fair distribution of health care resources.

There is reason to expect that physicians from every point on the globe will read the charter. Does this document represent the traditions of medicine in cultures other than those in the West, where the authors of the charter have practiced medicine? We hope that readers everywhere will engage in dialogue about the charter, and we offer our pages as a place for that dialogue to take place. If the traditions of medical practice throughout the world are not congruent with one another, at least we may make progress toward understanding how physicians in different cultures understand their commitments to patients and the public.

Many physicians will recognize in the principles and commitments of the charter the ethical underpinning of their professional relationships, individually with their patients and collectively with the public. For them, the challenge will be to live by these precepts and to resist efforts to impose a corporate mentality on a profession of service to others. Forces that are largely beyond our control have brought us to circumstances that require a restatement of professional responsibility. The responsibility for acting on these principles and commitments lies squarely on our shoulders.

*—Harold C. Sox, MD, Editor*

Physicians today are experiencing frustration as changes in the health care delivery systems in virtually all industrialized countries threaten the very nature and values of medical professionalism. Meetings among the European Federation of Internal Medicine, the American College of Physicians–American Society of Internal Medicine (ACP–ASIM), and the American Board of Internal Medicine (ABIM) have confirmed that physician views on professionalism are similar in quite diverse systems of health care delivery. We share the view that medicine's commitment to the patient is being challenged by external forces of change within our societies.

Recently, voices from many countries have begun calling for a renewed sense of professionalism, one that

*Ann Intern Med.* 2002;136:243-246.

# ABIM Physician's Charter

- 3 Principles
- 10 Commitments

http://www.abimfoundation.org/Professionalism/Physician-Charter.aspx

# 3 Principles

- Primacy of Patient Welfare
- Patient Autonomy
- Social Justice

# 10 Commitments

- **Professional competence**
- **Honesty with patients**
- **Patient confidentiality**
- **Maintaining appropriate relations with patients**
- **Improving quality of care**
- **Improving access to care**
- **Just distribution of finite resources**
- **Scientific knowledge**
- **Maintaining trust by managing COI**
- **Professional responsibility**


HOW?

# Objectives

- **Define** the problem of "dual agency"
- **Describe** common strategies
- **Argue** for a solution

*The American Journal of Bioethics*, 14(9): 29–36, 2014

ISSN: 1526-5161 print / 1536-0075 online
DOI: 10.1080/15265161.2014.935878

***Target Article***

# Addressing Dual Agency: Getting Specific About the Expectations of Professionalism

**Jon C. Tilburt,** Mayo Clinic

Professionalism requires that physicians uphold the best interests of patients while simultaneously insuring just use of health care resources. Current articulations of these obligations like the American Board of Internal Medicine (ABIM) Foundation's Physician Charter do not reconcile how these obligations fit together when they conflict. This is the problem of dual agency. The most common ways of dealing with dual agency: "bunkering"—physicians act as though societal cost issues are not their problem; "bailing"—physicians assume that they are merely agents of society and deliver care typically based on a strongly consequentialist public health ethic; or "balancing"—a vaguely specified attempt to uphold both patient welfare and societal need for judicious resource use simultaneously—all fail. Here I propose how the problem of dual agency might begin to be addressed with rigor and consistency. Without dealing with the dual agency problem and getting more specific about how to reconcile its norms when they conflict, the expectations of professionalism risk being written off as cute, nonbinding aphorisms from the medical profession.

**Keywords:** professionalism, role morality, dual agency, professional ethics, physicians, health care

# Argument

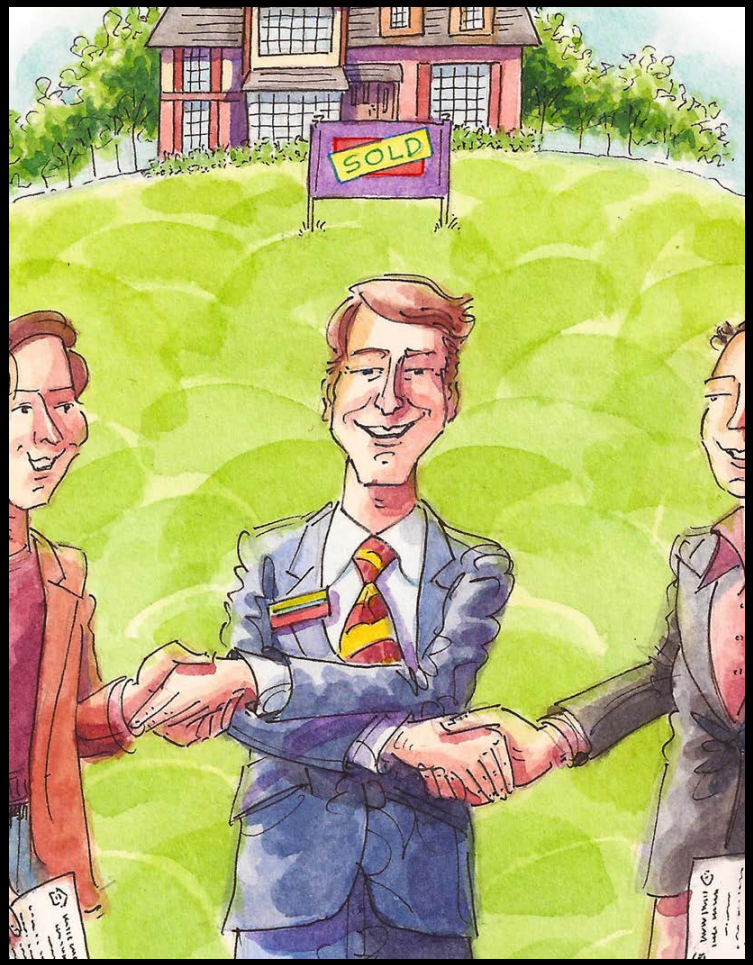
- Professionalism requires competing commitments.
- These competing commitments create the problem of dual agency
- Conventional strategies for coping with dual agency fail (*balancing, bunkering, bailing)*
- We need specifics to meet the expectations of professionalism – *priority, specification, roles/spheres*
- . . .or else professionalism as stated is wrong

# Define

"...[Dual agency is] an avowed requirement to act simultaneously on behalf of two different parties with competing interests."

Tilburt. *AJOB* 2014; 14(9): 29–36.

# Dual Agency



# Trustees, Fiduciaries & Duties

*Keech vs. Sandford (1726)*

- *A child inherits a lease*
- *Mr. Sandford entrusted to look after property*
- *Mr. Sandford acquiesced to landlord*
- *Lease was not renewed for child*
- *Mr. Sandford took the lease*
- *The child (now Mr. Keech) grew up, sued Mr. Sandford*

# Dual Agency in Health Care

- A circumstance in which a health care professional holds obligations to act simultaneously on behalf of two different parties with competing interests, typically individual patients and some other responsibility-compelling entity.

# Dual Agency in Health Care

# Professionalism & Dual Agency

- Commonsense consensus prioritization
- Increasing pressure
- Requires clarity and/prioritization

# Objectives

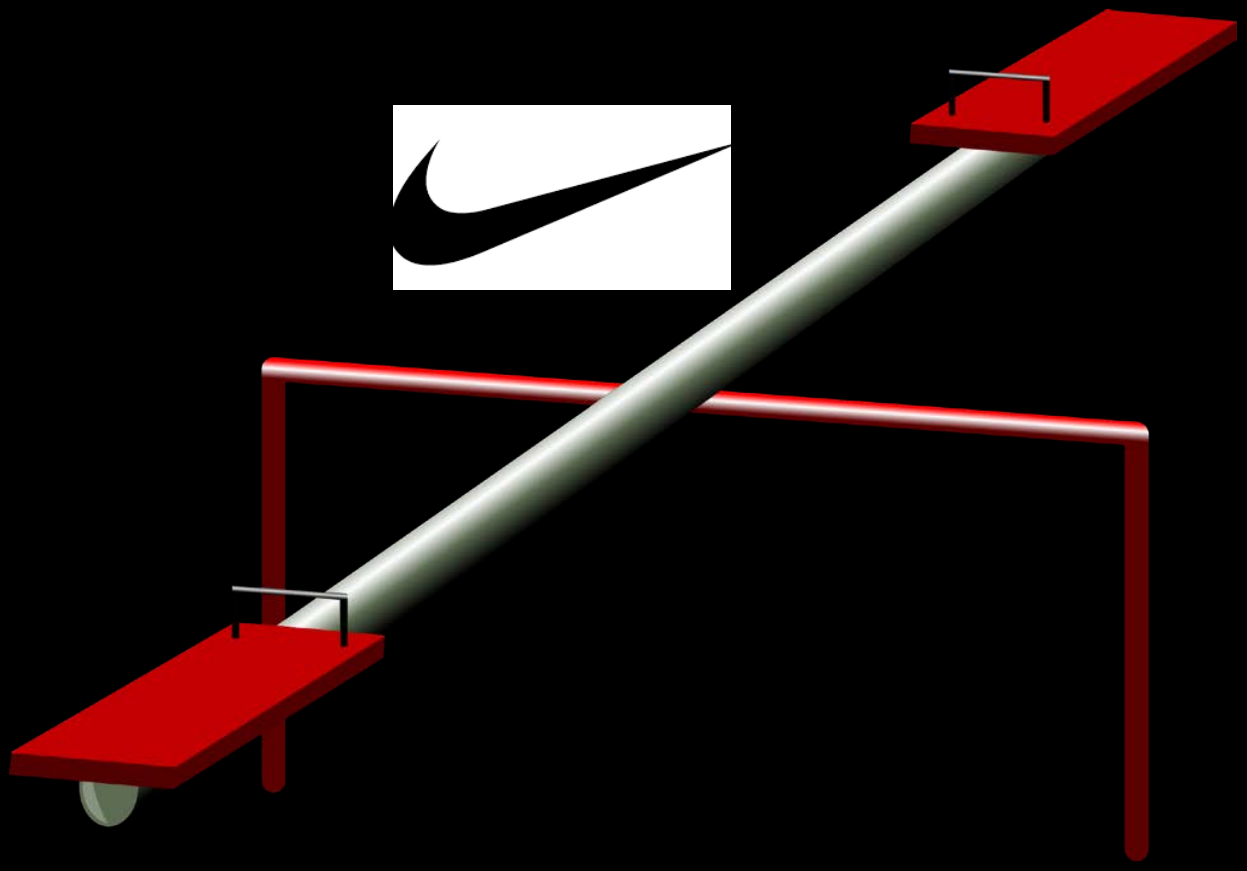
- **Define** the problem of "dual agency"
- **Describe** common strategies
- **Argue** for a solution

# Describe

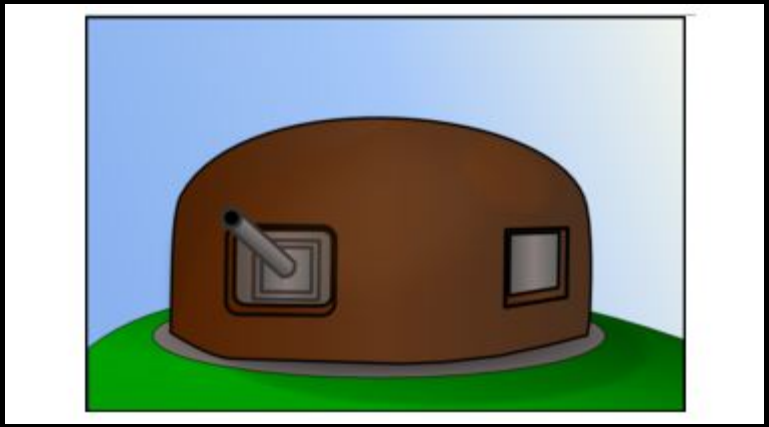
# Strategies

- Balancing
- Bunkering
- Bailing

# Balancing



# Bunkering



# Bailing

# Objectives

- **Define** the problem of "dual agency"
- **Describe** common strategies
- **Argue** for a solution

# Argue

- Prioritize
- Specify
- Delineate Roles & Spheres

# ABIM Physician's Charter

- 3 Principles
- 10 Commitments

http://www.abimfoundation.org/Professionalism/Physician-Charter.aspx

# ABIM Physician's Charter (interpretation guide)

"In circumstances when commitments appear to conflict with principles, principles take priority, and when principles conflict, individual patient welfare takes priority."

# Specify

- Give a rationale
- When, how principles & commitments relate
- Example: Perfect vs. imperfect duties

# Perfect vs. Imperfect Duties

- Perfect: agents holding those obligations are blameworthy and face enforcement of consequences if they fail to conform to the norm
- Imperfect: a duty is real, not optional, but is not universally enforced or does not imply the same amount of blame when violated

# Roles & Spheres

- Roles: care provider, administrator, public health official
- Spheres (contexts): home, institution, government, church

# Physician Role Morality

- Physicians have specific roles in distinct spheres that entail different degrees of obligation

# Role Morality

| Role | Sphere (Context) | Obligation |
|---|---|---|
| Care provider | Clinic | Individual patient good |
| Administrator | Organization | Efficiency and quality |
| Expert citizen | Policy | Just structures |

# Role Morality Limitations

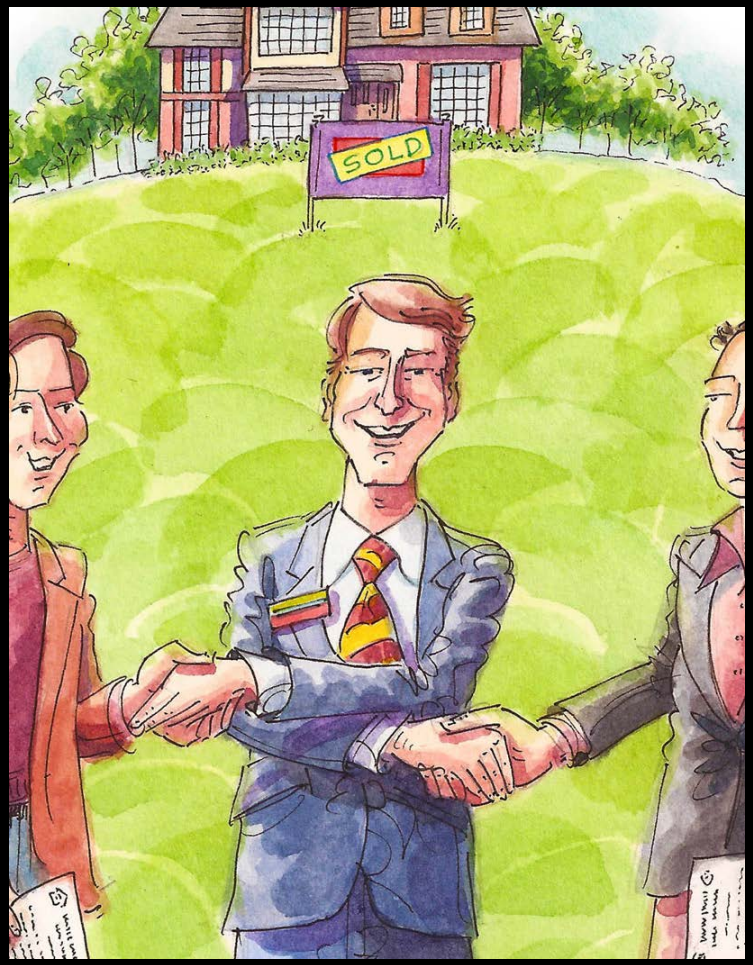
- Functional Bunkering
- Functional Bailing
- Integrity

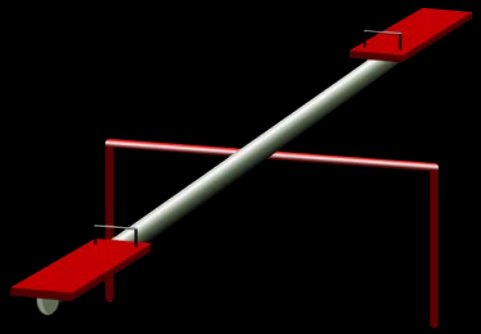
"Integrity entails the imperative to live life with the goal of **being at unity with oneself**, and in support of this goal the word integrity brings to the fore the importance of integration – of **integrating** the constellation of **foundational beliefs, values, commitments, and actions** that constitute our moral identities and guide our choices. Integrity … indicates **the harm we experience when we live a double life . . .**

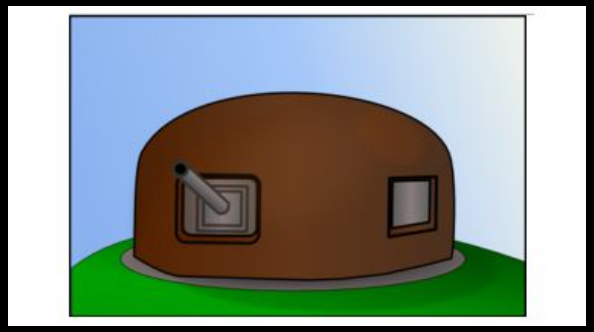
If ethical decision making in medicine is to have genuine personal significance for physicians, those who participate in professional discussions should be ready to engage the **foundational beliefs** that ground a clinicians' ethical judgments and determine the **boundaries** with which his integrity can be sustained." (p235)

Kaldjian LC. Practicing Medicine and Ethics: Integrating Wisdom, Conscience, and Goals of Care. New York. Cambridge Press. 2014.

# Dual Agency







# Case – Ms. S

## Revisited

# What should they do?

Should they recommend gastric bypass?

# Imperfect Solutions, Imperfect World

- In the patient care role in the sphere of clinical care . . .
- Recommend surgery
- In the advocate role in the public health/policy sphere . . .
- Advocate for fair, sustainable limits
- Both roles are required but should not be confused! (

# Thank You

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