Physician Stewardship of Healthcare Resources

Ethics and Evidence

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Acknowledgments

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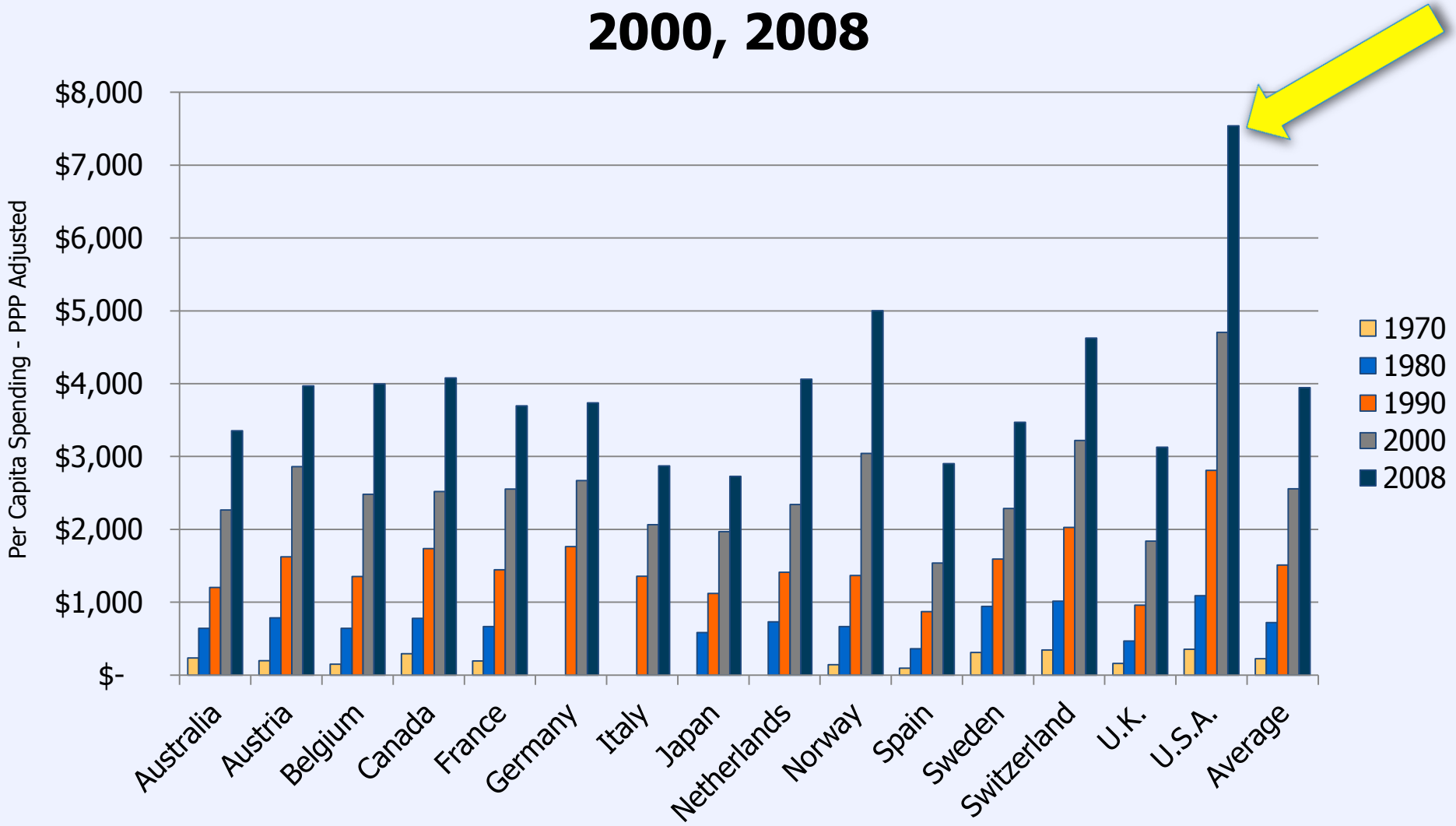
  - M Danis, *National Institutes of Health*
  - S Hurst, *University of Geneva*
  - J Tilburt, *Mayo Clinic*
- Supported by the Greenwall Foundation and the Mayo Clinic Program in Professionalism and Ethics
- Staff supporting the AMA Council on Ethical and Judicial Affairs (B Crigger, D Hahn, V Blake)

Total Health Expenditure Per Capita, U.S. and Selected Countries, 1970, 1980, 1990, 2000, 2008



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011).

Notes: Data from Australia and Japan are 2007 data. 2008 figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. 2000 figured for Belgium are OECD estimates. Numbers are PPP adjusted. Break in Series AUS (1998); AUSTRIA(1990); BEL(2003, 2005); CAN(1995); FRA(1995); GER(1992); JAP(1995); NET(1998, 2003); NOR(1999); SPA(1999, 2003); SWE(1993, 2001); SWI(1995); UK (1997. Starting in 1993 Belgium used a different methodology.

- 2009
  - $8,086 per person, 17.7% of Gross Domestic Product (GDP)
- 2010
  - $8233, 17.6% GDP

Why is health spending growing? Why does the U.S. spend so much more than other countries?

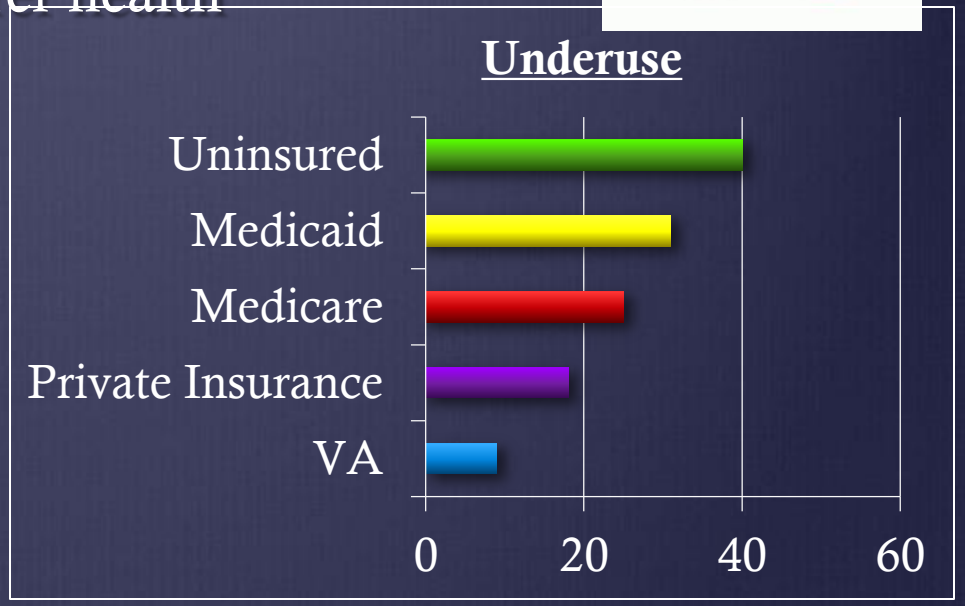
- Aging
- Innovation
- Administrative expenses and less bargaining power due to multiple payers
- Greater intensity (e.g., more MRIs, fewer physicians per capita than in other OECD countries)

Who pays the bills?

- Insurers
  - Public sources
    - Medicare, Medicaid, VA
    - 46% of total (<1/5 of nonelderly total)
  - Private/commercial
  - Uninsured ("self pay")
    - 21% of 19-64 y.o. 10% children in US in 2010-11
    - 31% of 19-64 y.o. 17% children in Texas 2010-11
- Patient/family spending
  - Premium
  - Deductible, Copay, Coinsurance, uncovered services

Underuse of medicine due to cost

- Can affect up to 50%
- Who?
  - Multiple chronic illnesses, poorer health
  - Lack of Rx insurance
  - Higher out of pocket costs
  - Lower income
  - Adult <65
  - Women
  - Racial/ethnic minorities



- Affects health –
  - Diabetics reporting cost-related underuse had worse glucose control, more symptoms, poorer physical and mental functioning

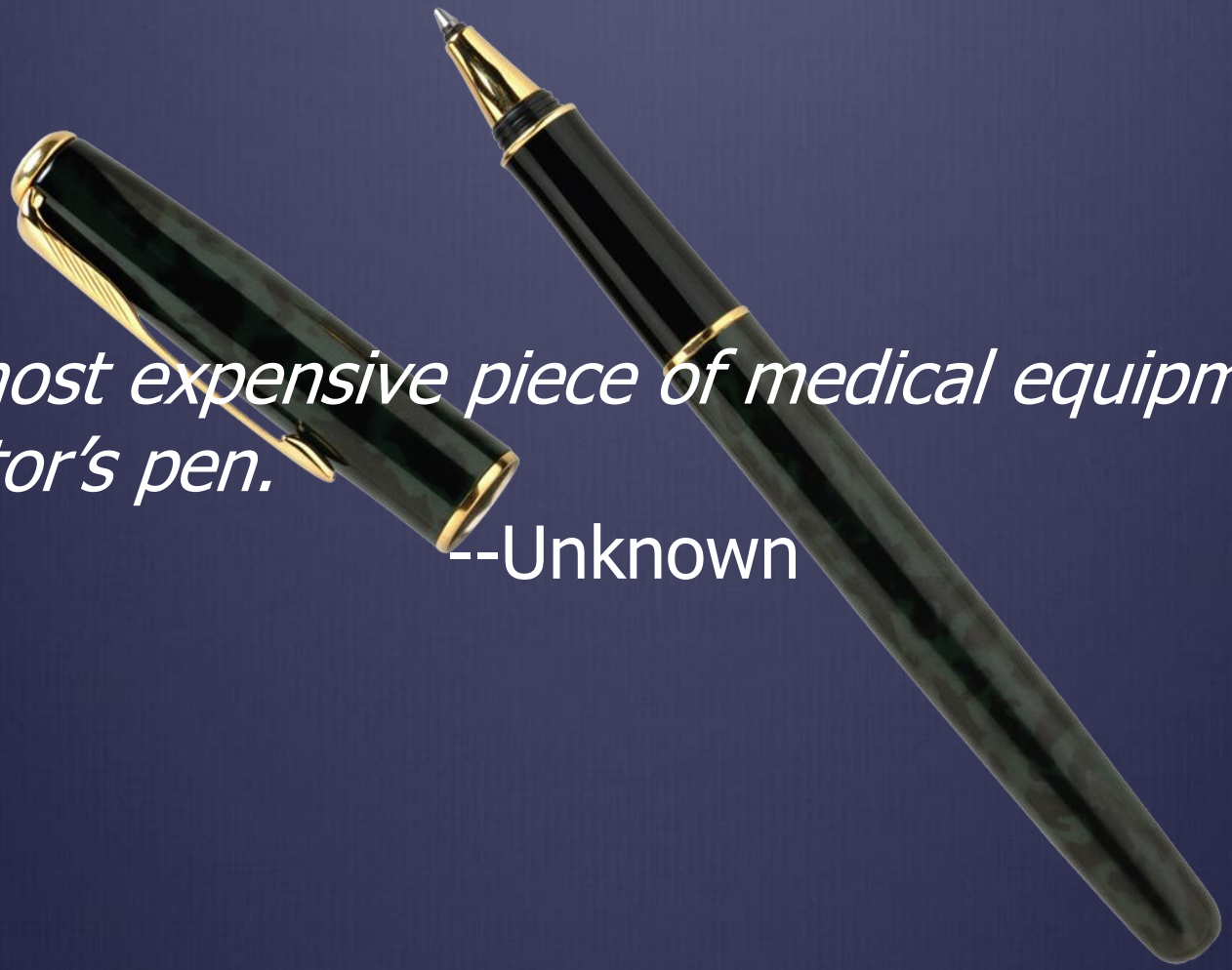
Piette et al, Med Care 2004

Controlling health care costs

- Benefit design (coverage limits)
  - Limit use of health care by type of service, e.g., dental, LTC
- Capital and equipment
  - #MRI scanners, ICU beds
- Workforce
  - Quantity
  - Mix – skill levels, specialization
- Patient cost-sharing – "skin in the game"
- Administrative controls
  - Gatekeeping, preauthorization, formularies, caps by cost or # (e.g., PT, psychotherapy)
- Clinical decision making – stewardship

Stewardship

- derives from old English words for "hallkeeper"
  - "stig" = space
  - "weard"= keeper
- refers to responsibility to watch over and care for a shared, community resource



The most expensive piece of medical equipment is a doctor's pen.

--Unknown

Insurance creates moral hazard

- Neither clinicians nor patients face full cost of decisions they make to "consume" health care
  - May choose service with value << true cost
- Clinicians control much of health care spending
  - Frequency (when admitted, # visits)
  - Time (LOS, time with patient of self and others)
  - Intensity (ICU-ward-ECF-home)
  - Specialization (Referrals to tertiary ctr, specialist)
  - Reducing uncertainty (testing)
  - Supplies and equipment

Money, medicine and ethics

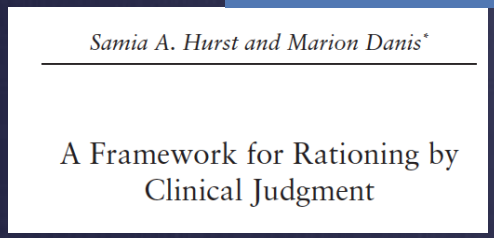
- Financing & organization of health care affect
  - The clinician-patient relationship
  - Decisions and advice for patients
  - Patients' willingness and ability to follow advice
- Relationships between patients and clinicians (e.g., nurses, doctors) are trust-based, and have corresponding responsibilities
- Clinical professionals are expected to abide by professional ethics

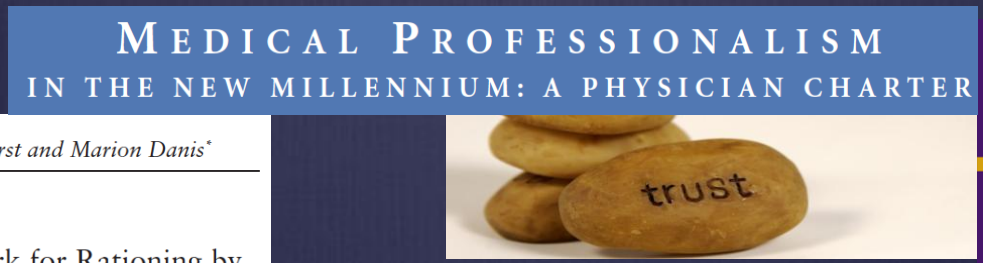
Ethics and Evidence

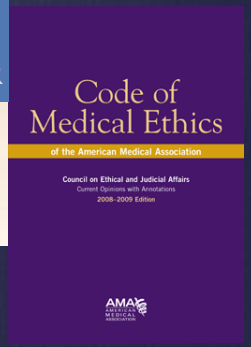
Review evidence about doctors' knowledge, attitudes and behaviours related to stewardship

Analyse evidence using

1) The *Code of Medical Ethics*
2) the Charter on Medical Professionalism
3) the ethical framework of clinical judgment
4) actual and potential impact on trust and trustworthiness.





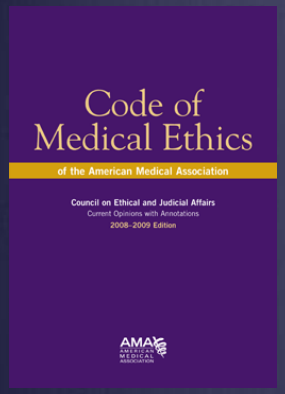


Why these sources?

- AMA *Code of Medical Ethics* - guidance for physicians, medical boards, healthcare organizations and the courts for over 160 years.
- The Charter on Medical Professionalism – 2002 - by the ABIM Foundation in partnership with the American College of Physicians Foundation and the European Federation of Internal Medicine; endorsed by dozens of medical professional organizations.
- Trust and trustworthiness

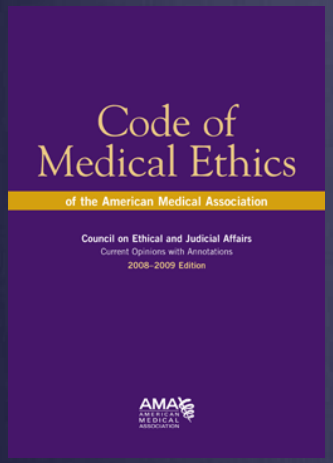
  Central to patient doctor relationship

  To pursue his/her own good, the patient must trust the physician with private information and with his/her body. Trust in the healer is essential to healing itself.
- Danis & Hurst framework for physician "rationing by clinical judgment"
  - Frequently cited criteria for making judgment about value of health service(s)



Opinion E 2.03, Allocation of Resources

"Decisions regarding the allocation of limited medical resources among patients should consider only ethically appropriate criteria relating to medical need. These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment…. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered."



CEJA Report 1-A-12 Physician Stewardship of Health Care Resources

Physicians' primary ethical obligation is to promote the well-being of individual patients.

Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

Medical Professionalism
in the New Millennium: A Physician Charter

- While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost-effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures.

Clinical Judgment

Danis and Hurst

Six elements to facilitate fair rationing:

(1) Reciprocity

(2) General concerns of justice

(3) Respect for individual variations

(4) Consistent process

(5) Explicitness

(6) Review of decisions.

Trust & Trustworthiness

- Trust → Expectations of beneficence, advocacy, honesty, integrity, competence
- Trustworthiness → Commitment to patients, public health, self-regulation, more

Comprehensive Literature Review

1. Initial search terms: resource allocation, scarce resources, rationing, prioritization, cost control, physician rationing, physician attitudes, cost constraints, priority setting, stewards/stewardship, shortage, triage.
2. Crossed with terms for empirical research, e.g., physician practice patterns
3. From relevant articles, identified MeSH terms, string search terms and bibliographies
4. Contacted colleagues internationally to identify projects or reports
5. Searched lay publications
6. Focused search of web-based reports and publications.

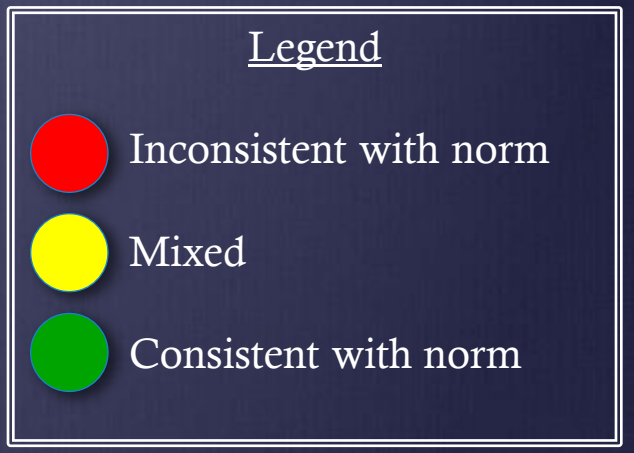
Ethical Analysis

1. Identified professional values/norms found in *The Code of Medical Ethics,* the Charter on Medical Professionalism, the ethical framework for rationing by clinical judgment, and actual and potential impact on trust and trustworthiness.

2. Identified in literature review evidence of physician behaviour, knowledge and/or attitudes related to each norm/value and identified, when possible, whether knowledge, attitudes(s), behaviour consistent with or inconsistent with norm/value.

Preliminary Results

- Place the patient's interest first
- Inform patient of all options
- Physicians should know resources needed
- Consider only morally relevant criteria and respect individuality of patients



Place the patient's interest first

- US primary care physicians: 70% agree responsibility to patient rather than society. (Beach, Meredith et al. 2007)
- Canadian oncologists: unwilling to accept limitations, described moral distress & uncomfortable discussions with patients. (Berry, Hubay et al 2007)
- Norwegian physicians: demanding patients came in conflict with need to be "gatekeeper." Times they just couldn't say no. (Carlsen and Norheim, 2005)
- Community Tracking study: Physicians report routinely considering patients' out of pocket costs when selecting drugs (78%), care settings (51%), and diagnostic tests (40%). Primary care physicians >specialists (Pham, Alexander et al. 2007)
- Calif. Physicians: 59% managing patient drug costs more important than managing total costs.

(Shrank, Joseph et al 2006)

Inform patient of all options

- UK, Switz, Nor, IT internists: 82% reported explaining to at least one patient why an expensive intervention wasn't used; 36% reported sometimes did not inform patient of a more expensive treatment (Hurst, Slowther et al, 2006)
- Nearly all Denmark GPs consider cost-quality relevant to decision, only half would disclose to patients. (Lauridsen, Norup et al, 2008)
- Despite medication changes >1/2 of doctor-patient visits, only 34% of those visits included some discussion of cost; over half of those initiated by the patient. More common when patients white, doctors white, patients income US$20,000-59,999 (vs. >US$60,000) (Beard, Sleath et al. 2010

Physicians should know resources needed

- Systematic review: less than half of doctor's' estimates of medication cost were accurate (Allan et al, 2007)
- Canadian emergency physicians: underestimated cost for imaging (68%), overestimated cost of lab tests (56%) and overestimated cost of drugs (64%). (Innes, Grafstein et al 2000)

Consider only morally relevant criteria & respect individuality of patients

- Allocating ICU beds:

✓ Patients more severely ill, sometimes younger. Mortality and readmission unchanged. (Singer, Carr et al. 1983; Strauss, LoGerfo et al. 1986; Nuckton et al, 1995; Sprung, Geber et al. 1999; Sinuff, Kahnamoui et al. 2004)

✓ Israeli physicians' view of patient's QOL more important than patient's view; not for US physicians. (Einay, Soudry et al 2004)

✓ Most Israeli, European ICU physicians, ~1/2 of US physicians likely to admit patient with survival predicted < few weeks to last bed. (Vincent, 1999)

- Severity, prognosis should affect priority strongly; wealth, poverty, and working status should not. (Finland) (Ryynanen, Myllykangas et al 1999)

- Evidence-based guidance, classifying referrals by urgency, (+/-) waiting lists for elective procedures acceptable (Nor, IT, UK, SW) (Hurst, Forde et al 2007)

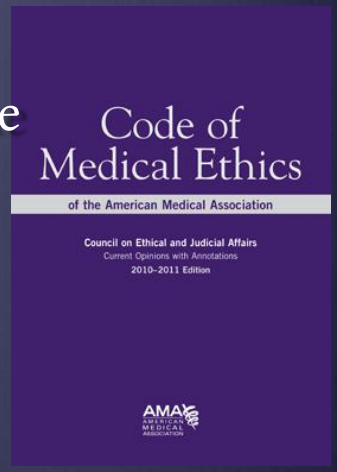
- US nephrologists > weight to pt/family wishes than UK, Canada. (McKenzie et al, 1998)

- Physicians respond to patients' requests. (Campell et al 2007, Carlsen & Norheim 2006)

Conclusions

- Physicians support some amount of responsibility to be cost-conscious, BUT the more tightly this is linked with withholding benefit from patient(s), the less likely they support it.
- Physicians are willing to consider costs faced by patients
- Patients more likely to begin discussion of costs of medication
- Knowledge of costs poor
- Inconsistently disclose influence of cost on recommendation/decision to patient
- Appropriately consider severity, prognosis, sometimes consider age, and what they perceive as patient QOL

Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.... Physicians should:



(a) Base recommendations and decisions on patients' medical needs;

(b) Use scientifically grounded evidence to inform… decisions

(c) Help patients articulate… goals and help patients and their families form realistic expectations….

(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals;

(e) Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm….

(f) Be transparent about… when resource constraints play a role in decision making; and

(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile….

Case

Arm amputees have a number of choices for prostheses, from one with a basic mechanical hand to one that operates on electrical power and is attached to the upper arm muscles to allow quasi-autonomous function. Some low-end prostheses produce a pinch power of 10-15 pounds per inch, while the high-end prostheses can produce a pinch-power of up to 35 pounds per inch. The average human hand normally produces a pinch of 25-30 pounds per inch. In addition, the gloves available to cover the prostheses range from $160 for a basic flesh-colored glove to $10,000 for a glove custom-designed to match the amputee's flesh tone, venous pattern, hair and other features.

- Other than worker's compensation and auto insurance beneficiaries, few insurance companies pay for the most expensive prosthesis, and none of them (save auto insurance and worker's compensation) pay for the custom glove.
-
- *Should every patient be offered the strongest and most life-like prosthesis?*
- *Should every patient be offered the exact same type of prosthesis?*
- *(If not) how do you determine which patients get the more powerful and/or more lifelike prostheses? How might this affect trust in doctors?*

Case

- A woman calls the clinic and asks the doctor to call in prescription refills, and asks for DAW on each so that she can get the brand name drugs. When asked why, she states that her husband's insurance pays for their medicines, and they "just feel more comfortable" with the brand name drugs. She further explains that their insurance premiums are paid by someone else as part of a settlement.

- *Would you agree to her request?*
- *Why or why not?*
- *What would you say to the patient? How might this conversation affect trust?*
- *What if a patient tells you the brand name "works better" after trying a generic version?*

Case

- A young boy with hemophilia might benefit from a new, promising, but costly (>$1million and much larger amounts of limited blood products) treatment regimen. The hematologist's best estimate is that this regimen might lead to 30% fewer bleeding events. Each event has the potential to affect his quality of life permanently. For example, a hemorrhage into his knee can affect his ability to walk.
- *Should the boy's doctor aggressively push to provide this treatment? Why or why not? How much advocacy is enough?*
- *Who should pay for it?*

Case

- T.G. works as a cook at a local restaurant (or two) and is predictably uninsured. He was directed to the Washtenaw Health Plan and qualifies, and comes in to establish care and get treatment for a fungal infection in his toe. He has been trying over the counter topical treatment for weeks without success. WHP only covers griseofulvin, which has a lower cure rate than terbinafine, but terbinafine would cost him over a thousand dollars.
- *How do you talk to patients about expensive, slightly better treatments they might not be able to afford?*