THE JOURNAL OF FAMILY PRACTICE

ONLINE EXCLUSIVE

Professional obligations when patients pay out of pocket

Here's what the ethics literature—and real-world experience—teaches us about helping patients make better cost-conscious choices.

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The authors report no potential conflict of interest relevant to this article.

During a long-overdue routine check-up with a 65-year-old Caucasian patient we'll call Dan, you discover his blood pressure is 150/90—this, despite the prescription you wrote for him nearly a year ago. When you recommend that he increase the daily dose and suggest he may want to try a newer drug, he tells you he never filled the original prescription. Soon it's apparent that he and his wife, who has diabetes, hypercholesterolemia, and severe arthritis, have been deciding which medicines to take and how often to schedule visits based on their monthly budget.

This is one of countless common scenarios playing out as a result of consumer-directed health care (CDHC), the latest movement in the constant struggle to control the costs and improve the quality of health care. CDHC uses mechanisms like steeply tiered co-payments, high deductibles coupled with health savings accounts, and reduced coverage (such as the infamous "donut hole" in Medicare Part D) to compel patients to spend their own money, not insurance money. This approach is intended to give patients more "skin in the game" so that they look harder for thriftier options and accept only treatments they really think are worth the money.[1,2]

CDHC may be wise; it may be foolish. But many patients must use it, and they urgently need their doctors' help. This asks a lot of you, but the medical profession has a long and honorable tradition of pursuing what is best for patients, not just what is most cost-effective.[3] Patients' modest understanding of health insurance, providers, and medicine rarely equips them to make medically and financially prudent decisions. For sound information and sage guidance, your patients must rely on you, their physician. In other words, under CDHC, patients present not just with medical symptoms and a social history, but also with a financial condition.

So what kinds of practical and ethical problems does this create? Official oracles of medical ethics are virtually silent, yet patients have paid their own costs from time immemorial, and much can be learned from the collective wisdom of doctors' accumulated experience.[4]

With this in mind, we interviewed a convenience sample of 7 primary care physicians in North Carolina who treat lower-income patients (3 in family practice, 2 in geriatrics, 1 in internal medicine, and 1 in pediatrics), and we reviewed the relevant professional ethics literature.[5–10] From this body of practical and professional knowledge, we synthesized the following principles and strategies.

Talking about money is fraught with difficulty

If you are to help patients in the new consumerist health care world, you need to know to what extent money is an issue for a patient. But both doctors and patients often dislike discussing money.[11,12] In 1 study, women were more uncomfortable talking about their in-

come than their abortion.[13] Many patients hesitate to broach the topic for fear of offending their doctor, who recommends services and may be selling them.[11,14] And many doctors fear that mentioning costs during examination and treatment will alienate patients who take offense at, or misunderstand the motives behind, discussions of money.[11,15]

Medical anthropologist Howard Stein even suggests there is a "taboo in official American health culture: namely, a prohibition upon allowing the physician to appear concerned with financial matters" because introducing money violates "the sacred by the profane."[16] Nevertheless, the purpose of CDHC is precisely to place cost in the front of patients' minds. So patients may be grateful for help in acknowledging the elephant in the room.

Approach finances as forthrightly as you would a potentially embarrassing clinical problem. You can work to help patients feel comfortable discussing costs by treating financial issues in the same matter-of-fact way you address sexual concerns.[17] One doctor we interviewed at a low-income clinic said that his patients may be ashamed or embarrassed to acknowledge their financial problems. So he normalizes cost concerns by routinely asking patients if insurance coverage will be an issue—gracefully putting the discussion more in terms of third party rules than the patient's ability to pay.

One doctor says he normalizes cost discussions by routinely asking patients if insurance coverage will be an issue.

Other doctors we interviewed recommend watching for clues patients give when they are concerned about costs, just as doctors attend to patients' clues about clinical problems.[18] Patients may, for example, delay scheduling visits or neglect to fill prescriptions. As a fine doctor said a century ago, "Just remember that people generally care little how you collect your facts. They want to help you to help them, and are ready to accept your methods, especially if tactfully applied."[19]

Patients often feel relieved to address cost problems, but finding out exactly what financial obligations a patient faces can be challenging. Different health plans allocate costs between patient and insurer in dismayingly different ways. Furthermore, those allocations fluctuate depending on each policy's annual cycle of deductibles and out-of-pocket limits, which in turn depend on each patient's renewal date. Patients are better situated than doctors to know the particulars of their own plans, but most people find their insurance baffling. Advances in information systems someday will prune this thicket, but today insurance coverage must often be added to the list of concerns about which doctors need better information.

Share your knowledge of treatment costs. If patients who pay out of pocket really are to make wise economic and medical choices, they need to know what tests and treatments cost.[20] This information, too, may be elusive. For instance, physicians often are unfamiliar with, or mistaken about, the plethora of drug prices. One literature review reports, "With... the median [physician's] estimate 243% away from the true cost, many of the estimates appear to be wild guesses."[21] And hospital charge masters are impossible to master. They can list more than 40,000 items whose prices are negotiated by insurance companies in a tumultuous market that regards prices as trade secrets.[22]

Precision may be unachievable, but there is room at least for a better understanding of large-magnitude cost differences. For instance, physicians we interviewed said that their computers or handheld devices provide basic information about the costs of prescription drugs, and some states and leading insurers are starting to post comparative provider and procedure prices online.[23] Without these aids, doctors still appear very able and practiced in discussing the costs of different options in general qualitative terms, even if they lack exact price information.

How to factor cost into your discussions of treatment

The law of malpractice enforces the medical profession's minimum standards for treatments, and the culture of medicine expects doctors to provide the best care available—to apply the gold standard of treatment. Patients (and perhaps juries) share that preference. But CDHC gives patients reasons to seek something less than the gold standard.

So once approximate costs are known, how should you factor them into discussions about treatments? When care is needed, do you merely inform the patient of less expensive op-

tions but always recommend the optimal one? When might you press a more effective option on a reluctant patient? Once again, these questions raise dilemmas doctors know all too well.[24,25] You face them every day when patients assert other reasons to refuse treatment, like discomfort or inconvenience, or when their reticence amounts to little more than caprice. Here are 3 situations to consider:

When some treatment is better than none at all. The easiest situation arises when a more expensive option would be superior in an ideal world, but not in the real world. Sometimes, the best can be the enemy of the good. For example, if a patient who is offered only the medically optimal treatment leans toward forgoing treatment altogether, doctors often recommend a suboptimal but still useful alternative.[26] Based on examples we heard, a physician might order a generic medication to control blood pressure when much costlier options are only moderately more effective, or an x-ray rather than a computed tomography scan, or 1 return visit rather than 2.

But what about malpractice liability for suboptimal care? Within reasonable ranges of professional judgment, the liability threat is not serious, since there are 2 legal defenses:[27]

1. If a less expensive treatment, or no treatment at all, is within the broad prevailing standard of care or a recognized alternative school of thought, then doctors may recommend this, even if it is not the course they normally counsel.
2. Even substandard options are defensible if reasonably well-informed patients understand their options and reject the doctor's first recommendation.

When medical consequences of refusing a treatment are not dire. A second situation is also comparatively easy, at least in theory. Where the long-term medical outcomes are not dire and patients experience the health consequences directly, patients can reasonably be left to make suboptimal choices. Examples we were given include physical therapy or pain control. When a patient is considering direct-impact, lower-stakes treatments, a doctor should not feel great ethical or liability qualms in acceding to the patient's wish to sacrifice health for wealth.

When a patient's decision and your opinion are at odds. In the third category, physicians' role as healers conflicts with their role as patients' agents.[28,29] If you suspect that a cost-reluctant patient can afford the gold standard and the patient chooses the pyrite standard, what should—or may—you do? This, too, is a variant of a familiar problem: Even well-informed patients may make bad decisions. To cope, doctors have developed an array of techniques (from soft to firm) that can be applied when decisions seem "penny wise and pound foolish."[30]

First, and most coercively, doctors can simply refuse to treat a noncompliant patient. Except in emergencies, this is professionally and legally permissible; however, it is hardly ideal. When patients flatly cannot afford decent care, doctors often help by discounting fees or by arranging financial assistance.[31]

When patients are simply penurious rather than penniless, doctors can try arguing a patient into a wise choice. This tactic is not necessarily impermissible paternalism; it can be an act of respect and friendship. In our interviews, for instance, 1 doctor told a woman who balked at a mammogram that he was scheduling it anyway. Another called a taxi to drive a patient directly to the hospital out of concern that she might just go home. Yet another doctor enlisted family members in convincing recalcitrant patients. In sum, doctors dance a delicate dance to accommodate patients' ambivalent wants and ambiguous needs.

Finding a new balance

You can accommodate the theory and policy of CDHC by acceding to a patient's desire to pay less and get less.[32] Professional obligations can be met by recommending the same care to each patient with a given condition, but informing patients of the costs and consequences of alternatives. Properly documented, these economically impartial conversations should protect physicians from malpractice liability. However, you need not go as far as having patients sign "Against Medical Advice" forms in order to continue seeing those who refuse optimal care. Doctors we interviewed thought it would be excessive to do this routinely and would threaten good relationships with their patients.

Watch for clues to cost concerns, such as patients neglecting to schedule expected appointments or refill prescriptions.

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Unavoidably, solving consumerism's problems will require conversations between you and your patients that take time—time that is already maddeningly limited. "Current practice guidelines for only 10 chronic illnesses require more time than primary care physicians have available for patient care overall."[33] For preventive care alone, providing all recommended services "to a panel of 2500 patients could require up to 7½ hours a day of physician time."[34]

Furthermore, some doctors may feel that expecting patients to pay more out of pocket is an unwise policy. That may be right; even well-intentioned social reforms sometimes make ill-conceived demands of professionals. But rightly or wrongly, our political economy, having resisted managed care (at the urging of doctors and patients), has accepted consumerism as another means to restrain unsustainable spending. In public policy forums, doctors may argue against government or market initiatives, but in clinical forums, there is a professional obligation to cooperate with prevailing social policy—especially when the policy forges the interests that patients bring to the examination room. JFP

ACKNOWLEDGEMENT
This work was supported by a Robert Wood Johnson Foundation Investigator Award in Health Policy Research. The views expressed imply no endorsement by that foundation.

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Identify the best option, while disclosing the costs and consequences of alternatives.

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