Hands on the Patient with Eyes on the Budget

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INTRODUCTION

In 1993, Marcia Angell wrote an article highlighting the growing trend of doctors being asked to function as "double agents," meaning physicians had to weigh their duty to patient care against the social costs of medical services.[1] This situation of care rationing in the 1990s was a result of the rapidly rising costs of such medical services, and was propagated by the open-ended, fee-for-service nature of the country's health care delivery system. It has been more than 20 years since the publication of Angell's article, but doctors are once again facing the ordeal of having to choose between what is best for their patients and what is most cost-efficient.

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ANALYSIS

Joining the fray are influential medical groups and associations, which recommend that costs become a part of the equation that guides physicians in making their conclusions regarding the best course of treatment. As was the case in the 1990s, the rising cost of health care is driving the push, and strengthening the claim made by many leaders in the medical field that doctors must be "good stewards of our health care resources as well as of the patient in our examination room." Medical societies such as the American Society of Clinical Oncology, the American College of Cardiology, and the American Heart Association are developing new guidelines to make their members more conscious of the economic significance of choosing certain drugs or technology. For example, the American Society of Clinical Oncology is preparing a scorecard – expected to be ready this fall – that will rate drugs based on their cost, value, efficacy, and side effects.

Critics of such cost analyses argue that the practice leads to bedside rationing, and thus doctors face an inherent conflict when trying to be both "providers of patient care and financial overseers." For these critics, the solution seems obvious: uphold the physician's fiduciary duty to the patient. The patient is incapable of influencing or controlling the costs of expensive drugs or medical technology. Therefore, why should the physician place the patient at an increased risk by cutting corners for the sake of the bottom line? This could especially pose a problem for Medicare recipients, who make up a constituency that will continue to grow as baby-boomers continue to age, leaving policy makers with the difficult task of managing how to stretch limited government dollars. In critics' minds, only by ensuring that patients receive the quality of care they deserve – regardless of cost – will the needs of the greater society be met, for stewardship of the patient first and foremost instills overall trust in the medical field.

These are well-crafted an easily defensible arguments, especially with regard to the traditional, ethical role of the physician. However, they fall short in addressing the problem at hand. Continuing as we have for the past couple of decades means that treatments costs will increase unimpeded, and with them, health care expenditures. Where the door is open for change is at the policy level, represented by the various medical societies making the cost evaluations. By coupling with government agencies that have economic expertise in the health care arena, physician-policy makers can make economic decisions that bridge the gap between treatment efficacy and cost. By examining treatment methods and rating them according to their value, which can be quantified based on the cost per quality-adjusted life- year (QALY); medical societies are relieving the individual physicians of having to make the choice at the bedside.

CONCLUSION

The important thing to note is that these guidelines will not govern the physician's decisions, but rather guide. The value determinations of certain drugs and procedures can also have the effect of placing pressure on pharmaceutical or insurance companies to bring down the price of their products, expand coverage, or come to the table with policy makers and work out an agreement for cost-saving measures. This may be hopeful thinking, but it marks a step in realizing that medicine cannot go on ignoring the impact of cost on the system.

REFERENCES

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