REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

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Subject: Physician Stewardship of Health Care Resources

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US health care spending reached 17.6 percent of gross domestic product (GDP) in 2009,[1] almost double that of other industrialized countries.[2] This level of spending presents an enormous burden for federal and state governments, businesses, families, and individuals.[2] The high cost of health care imperils access to care,[3,4] and access is likely to worsen if costs continue to outpace incomes.[5]

This report by the Council on Ethical and Judicial Affairs (CEJA) examines the role physician treatment decisions play in overall health care costs and analyzes physicians' obligation to manage health care resources wisely. It provides ethical guidance to support physicians in making fair, prudent, cost-conscious decisions for care that meet the needs of individual patients and help to ensure availability of health care for others.

The focus of the report is on physicians' recommendations and decisions in everyday situations that are often overlooked, in which physicians' choice of one among several reasonable alternatives can affect the availability of resources across the community of patients or the aggregate cost of care in the community. (For example, ordering a serum pregnancy test instead of a urine pregnancy test, which costs substantially more but for the majority of patients does not provide significant additional benefit.)

These everyday decisions are distinct from triage decisions, in which multiple patients compete for a clearly defined set of limited resources—e.g., in a pandemic or natural disaster. Decision making under such conditions has been discussed at some length in the literature and is addressed in Opinion E-9.067, "Physician Obligation in Disaster Preparedness and Response" (AMA Policy Database). Everyday choices are also distinct from "high stakes" decisions about interventions that can mean life or death for patients or forestall extremely poor outcomes, such as decisions to initiate mechanical ventilation in emergent circumstances when the patient's prognosis is uncertain. Arguably, in situations when there is significant risk of harm, cost considerations, if they play a role at all, are better addressed through collectively designed policy than left to individual decisions physicians must grapple with at the bedside.

TREATMENT DECISIONS, HEALTH CARE SPENDING & BENEFIT TO PATIENTS

Numerous factors drive the overall cost of health care, many of which are beyond the control of individual physicians. These include high administrative costs;[2,7] population trends (such as aging or obesity[2]); malpractice liability costs; patient expectations and demands; and high prices of drugs, devices, and hospital and professional services.[2,7] Other cost drivers, however, such as extensive use

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of new technologies[8] and high intensity of services provided at each patient encounter,[2,7] are influenced by physician choices.

Physician orders and recommendations play a significant role in determining which services and how many services patients receive; without a physician's assent clinical orders or policies generally cannot be implemented.[9] To this extent, physicians have an opportunity to affect health care spending overall. Documented regional variations in Medicare spending are explained in part by variations in physician practice patterns.[10,11] Higher spending regions and institutions have been shown to have higher intensity care, greater use of hospitals and intensive care units, and more utilization of specialists, tests, and minor procedures.[12-14] Practice differences seem to be less for interventions for which there are established guidelines, and more for the "discretionary" interventions that physicians recommend.[11]

More intensive and/or costlier services do not necessarily lead to better health outcomes.[12-17] In fact, lower spending regions appear to have better outcomes on certain measures, such as those developed by the Medicare Quality Improvement Organization.[8,10,15,17,18] In many domains, the services that yield the greatest benefits to health are not the factors that drive up costs, and the services that tend to drive up costs are not the ones that yield the greatest benefits to health, at least when measured at the population level.[18]

STEWARDSHIP AS AN OBLIGATION OF PROFESSIONAL ETHICS

Stewardship refers to the obligation to provide effective medical care through prudent management of the public and private health care resources with which physicians are entrusted.[6] This obligation flows both from the influence that physician decisions and recommendations have on health care costs and from core ethical obligations of physicians as professionals.

Physicians' primary ethical obligation, of course, is to protect and promote the well-being of individual patients (Principle VI, AMA Principles of Medical Ethics). However, it has long been recognized that physicians also have a responsibility to patients in general to promote the public health (Principle VII) and access to care for all patients (Principle IX).

Historically, medicine as a learned profession has been understood to have a social responsibility to use knowledge and skills to enhance the common good,[21-23,24] including obligations to protect public health and safety, even if this might require restricting the liberties of individual patients (Opinion E-2.25, "The Use of Quarantine and Isolation as Public Health Measures"; Opinion E-2.24, "Impaired Drivers and Their Physicians"). Similarly, the *Code of Medical Ethics* recognizes that without compromising their primary obligation, physicians should be conscious of the costs of care (Opinion E-2.09, "Costs"); that they should consider the needs of broader patient populations (Opinion E-8.054, "Financial Incentives and the Practice of Medicine"); and that they should not provide treatment that is "willfully excessive" (Opinion E-4.04, "Economic Incentives and Levels of Care"). The profession's authority rests on fulfillment of these commitments.[25]

Arguments that physicians should never allow considerations other than the welfare of the patient before them to influence their professional recommendations and treatment[19,20] do not mesh with the reality of clinical practice. Physicians regularly work with a variety of limits on care: clinical practice guidelines, patient preferences, availability of certain services, the benefits covered by a patient's insurance plan, and the time physicians and nurses can spend caring for a patient all influence what interventions physicians recommend and what care they provide.

Physicians also regularly confront the effects of uneven or unfair distribution of health care resources in their day-to-day practice. They express moral distress about having to provide different levels of care

for those who are uninsured or grossly underinsured than they provide for patients with adequate insurance coverage. They witness the adverse consequences for their patients when needed resources (e.g., particular specialists, hospital beds, imaging equipment) are too scarce.[27] As frontline providers, physicians are in a position to identify unacceptably restricted resources in their community.

MAKING COST-CONSCIOUS DECISIONS

There is broad consensus that physicians should first take medical need into consideration when making recommendations and providing care. Physicians are expected to refrain from offering or acceding to patients' requests for interventions or diagnostic tests that are medically unnecessary (E-2.19, "Unnecessary Medical Services") or that cannot reasonably be expected to benefit the patient (E-2.035, "Futile Care"). Physicians are likewise expected to provide—or advocate vigorously for—interventions that will clearly benefit the patient or clearly avert significant harm. However, between these two ends of the spectrum, physicians face decisions about whether to recommend or provide interventions that offer some increment of benefit, but which perhaps pose additional risks or substantial additional financial cost.[29] It is in this grey zone of marginal benefit that principles for wise stewardship should help shape decisions about care.

Making cost-conscious decisions is not far removed from the professional judgments physicians already make. Physicians routinely decide whether interventions with small benefits are worthwhile, whether diagnostic tests need to be STAT or routine, whether a patient needs to be seen urgently or routinely, whether the public health impact of a broad spectrum antibiotic is justified for a certain infection, and whether patient requests for expensive interventions are justified.[30-31] Reasonable criteria to guide cost-conscious decisions in routine care include the likelihood of benefit for the patient and the anticipated degree and duration of benefit, including change in quality of life (E-2.03, "Allocation of Limited Medical Resources").

Physicians should be aware of the relative strength of the evidence for anticipated benefits. Well-designed clinical practice guidelines, such as those available through the National Guideline Clearinghouse,[32] or quality measures, such as those developed by the AMA-convened Physician Consortium for Performance Improvement® (PCPI™),[33] should provide a baseline for treatment recommendations.

But guidelines should never simply supplant professional judgment. Physicians have a responsibility to argue for the course of care they judge most appropriate for the individual patient based on the patient's unique clinical circumstances (e.g., E-8.13, "Managed Care"; E-8.135, "Cost Containment Involving Prescription Drugs in Health Care Plans"). Even the most evidence-based guidelines cannot take into account the tremendous variety physicians encounter caring for individual patients.[28] A guideline that suggests a particular service is not "needed" may be well justified for most patients, but physicians will inevitably care for patients who qualify as legitimate, justifiable exceptions, clinically and ethically.

Similarly, for a specific patient, guidelines or standards of care might describe services that are unnecessary because of individual patient details. For example, current quality measures stipulate the frequency of lipid testing and use of lipid-lowering medication for diabetics. However, as is often mentioned in guidelines, co-morbid conditions (e.g., a life-limiting disease not related to diabetes or heart disease) can justify less testing or discontinuation of medication. Conversely, younger diabetics, who have more years in which to develop end-organ damage, might be treated more aggressively in many ways than older ones, sometimes more aggressively than guidelines (or quality measures) describe for the "average" diabetic. Likewise, screening that may be generally recommended for various cancers (especially slowly developing cancers) may have less clinical value for patients of advanced age or who have significant co-morbidities than for younger or healthier patients, for whom

earlier detection and intervention may offer greater clinical benefit or may be better able to bear the burdens of treatment.[29]

When guidelines are not available, determining whether a particular intervention is worthwhile for an individual patient necessarily rests heavily on physicians' professional judgment. Such determinations may differ from patient to patient and for an individual patient as his or her clinical situation changes. To the extent that physicians' primary task at each patient encounter is to heal, physicians should judge the necessity of an intervention based on its ability to cure, to relieve suffering, or to cultivate health—but always to care.[34]

While the default presumption is that physicians should honor patients' wishes with respect to treatment (E-10.01, "Fundamental Elements of the Patient-Physician Relationship"), patient values and preferences should be balanced against considerations of stewardship. Patients with health care insurance rarely face the entire cost of their care, and in any individual situation they may not recognize or value the need to restrain spending. When patients or their families argue for an intervention the physician deems to offer marginal benefit, physicians should strive to help them articulate goals for care and to help them form realistic expectations about whether the intervention is likely to achieve those goals.

For example, a particular patient or family might request off-label use of an expensive chemotherapeutic agent as an adjunct to standard therapy.[35] Physicians should be mindful that patient expectations for particular treatments or procedures can be shaped by many influences, including the advice of family and friends, online information, direct-to-consumer advertising,[36,37] and, of course, a wish to do "something" that might increase their overall survival. Many of these influences are not tailored to the patient's immediate clinical needs, and naturally most are not sensitive to considerations of cost or fairness.

Physicians' knowledge of what care their patients need (and how urgently they may need it), along with their firsthand experience with the consequences for patients when those needs are not met, means physicians can well appreciate the importance of allocating health care resources responsibly. In making treatment recommendations for individual patients, physicians should be aware of and consider the level of resources needed to achieve the patient's goals. When alternative courses of action offer similar likelihood and degree of benefit but require different levels of resources, choosing the less costly course of action can help preserve resources for the benefit of patients overall (E-8.135; E-8.054, "Financial Incentives and the Practice of Medicine").

Physicians should take the time to be transparent and honest in counseling patients about alternatives—including less costly care—instead of deferring to patients' requests for care that are not consistent with the physician's considered professional judgment. Honesty and transparency are critical to maintaining patient trust; patients are vulnerable and rely heavily on the physician's competence and good will.[38] In today's busy practice environment, it may be expedient for physicians simply to provide what a patient asks for regardless of medical need. Yet such expediency does not serve patient interests well, because it often does not lead to more efficient or higher quality care.

Physicians should make all reasonable efforts to resolve persistent disagreements about whether a particular treatment or procedure is cost worthy in the patient's situation. Physicians should consider consulting with a colleague or seeking an ethics consultation, for instance. If all efforts to resolve the disagreement fail, the patient may wish to seek care elsewhere. While it may be justifiable to terminate the patient-physician relationship, this should be a last resort and appropriate measures should be taken to ensure continuity of care (Opinions E-8.115, "Termination of the Patient-Physician Relationship"; E-8.11, "Neglect of Patient"; E-10.01, "Fundamental Elements of the Patient-Physician

Relationship").[39-41] Physicians are under no obligation to provide interventions simply because patients request them (E-2.035).

OBSTACLES TO PHYSICIAN STEWARDSHIP: A ROLE FOR THE PROFESSION

Many physicians generally recognize an obligation to distribute limited resources responsibly, but struggle with when and how to take this into account when considering individual treatment decisions.[42] They face a variety of obstacles in trying to fulfill the ethical obligation to be prudent stewards, including lack of knowledge about the costs of interventions and the impact of their individual recommendations and decisions, the complexity of the systems in which health care is delivered, and concerns about potential medical liability if they fail to order a test or intervention.[43] Individual physicians cannot and should not be expected to resolve the challenges of wisely managing health care resources and rising health care costs solely "at the bedside." Medicine as a profession has an equal obligation to help create conditions for practice that make it feasible for physicians to be prudent and trustworthy stewards.

Physicians need to be knowledgeable about health care costs and how their individual decisions can affect overall health care spending (Policy H-155.998, "Voluntary Cost Containment"). Education for medical students and practicing physicians alike should include discussion of costs. Physicians also need to understand how their individual decisions affect institutional resources in the aggregate. Health care administrators and organizations should make costs transparent to participating physicians to enable them to make well-informed decisions as stewards.

Other systemic factors, such as the perceived need to practice "defensive medicine," also work to undermine stewardship. The professional responsibility and ethical duty to practice medicine in a manner that is respectful of the finite nature of health care resources does not confer a legal duty to withhold or administer any particular treatment or diagnostic procedure. Rather, responsible stewardship upholds the principle that clinical expertise should be integrated with the best information from scientifically based, systematic research and applied in light of the patient's values and circumstances.[26] Medicine as a profession has an important role to play in advocating for policies that address concerns about medical liability and other systemic factors that impede responsible stewardship.

Every physician must be able to trust that the colleagues to whom he or she refers patients will exercise prudent stewardship in making recommendations about a patient's care. Given the complex structures in which health care is now delivered, responsible stewardship by one will have little overall effect if responsible stewardship is not practiced by all. Medicine must commit itself to nurturing a culture of accountability, in which health care expenditures are directed toward providing high quality care to meet the needs of individual patients in ways that preserve resources to enable physicians to better meet the needs of all.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

> 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.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

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

(b) Use scientifically grounded evidence to inform professional decisions when available;

(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals;

(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 for the individual patient, but require different levels of resources;

(f) Be transparent about alternatives, including disclosing 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, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship;

(i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending; and

(j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500 to implement.

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