

Finally, there are objections from the medical community. In a 2003 study of AMA members, 69% objected to physician-assisted suicide,<sup>1</sup> a position officially held by various national and state medical associations. Even with allowances for conscientious objection, some physicians believe it's inappropriate or wrong for a physician to play an active role in ending a patient's life. We believe there is a compelling case for legalizing assisted dying, but assisted dying need not be physician-assisted.

Under the DWDA, the patient's physician prescribes lethal medication after confirming the prognosis and elucidating the alternatives for treatment and palliative care. In theory, however, the prescription need not come from the physician. Prognosis and treatment options are part of standard clinical discussions, so if a physician certifies that information in writing, patients could conceivably go to an independent authority to obtain the prescription. We envision the development of a central state or federal mechanism to confirm the authenticity and eligibility of patients' requests, dispense medication, and monitor demand and

use. This process would have to be transparent, with strict oversight. Such a mechanism would not only obviate physician involvement beyond usual care but would also reduce gaps in care coordination: in Oregon and Washington, patients whose doctors don't wish to participate in assisted dying must find another provider to acquire a prescription. Physicians who strongly object to the practice could potentially refuse to provide certification or could even alter their prognosis, but these possibilities yield the same outcome as permitting conscientious objection. Patients could also provide an independent authority with their medical record as proof of their prognosis.

Such a mechanism would make it essential for physicians to offer high-quality palliative care. The availability of assisted suicide in Oregon seems to have galvanized efforts to ensure that it is truly a last resort, and the same should hold true regardless of who writes the prescription. Usual care for terminally ill patients should include a discussion of life-preserving and palliative options so that all patients receive care consistent with their own vision of a good death.

Momentum is building for assisted dying. With an independent dispensation mechanism, terminally ill patients who wished to exercise their autonomy in the dying process would have that option, and physicians would not be required to take actions that aren't already part of their commitment to providing high-quality care.

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## Cents and Sensitivity — Teaching Physicians to Think about Costs

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Imagine your first medicine rotation. You present a patient admitted overnight with cough, fever, and an infiltrate on chest x-ray. After detailing a history and physical, you conclude, "This is a 70-year-old man with community-acquired pneumonia."

Dead silence.

"Perhaps," the attending finally says. "But what else could this be?"

Your face reddens. "Pulmonary embolism," you say. The resident nods. "Heart failure." Now you're talking. "Churg–Strauss," you add.

"The patient does have a history of asthma."

The attending smiles. "How might you investigate these other possibilities?" he asks. Next thing you know, the patient's lined up for a chest CT, lower extremity Dopplers, echo, and a

rheum panel. You get honors. And so it begins.

Our profession has traditionally rewarded the broadest differential diagnosis and a patient care approach that uses resources as though they were unlimited. Good care, we believe, cannot be codified in dollar signs. But with health care costs threatening to bankrupt our country, the financial implications of medical decision making have become part of the national conversation.

Terms like “value-based purchasing” and “pay for performance” have entered the language of the health care system.

***Some physicians now believe that considering cost serves not only the equitable distribution of finite services, but also the real interests of individual patients. Medical bills, after all, are among the leading causes of personal bankruptcy in the United States.***

Moreover, physician organizations have joined the dialogue, most recently with the American Board of Internal Medicine Foundation’s Choosing Wisely campaign, shaped partly in response to Howard Brody’s call for “Top Five Lists” of expensive but non-beneficial tests and treatments in each specialty.<sup>1,2</sup> But this evolving conversation has yet to change the way we’re trained to practice medicine. The fact that we can no longer ignore the financial implications of our decisions leaves the medical profession in a quandary. Is there a place for principles of cost-effectiveness in medical education? Or does introducing cost into our discussions threaten

to destroy what remains of the patient–physician relationship?

Many who have been in practice for decades argue that at no point, no matter the economic environment, should cost factor into physicians’ decisions. After all, this is not the first time in history when recession has loomed. Each generation, notes Martin Samuels, chair of the Department of Neurology at Boston’s Brigham and Women’s Hospital, has been led to believe it’s on the precipice of doom and that unless it considers the greater good, society will unravel. But Samuels cautions that when phy-

society, they must abandon their Hippocratic commitment.”<sup>3</sup>

Art Caplan, a bioethicist at New York University, frames the dilemma in terms of advocacy rather than costs: Can a physician remain a patient advocate while serving as a “steward” of society’s resources? Sometimes these dual impulses are compatible; for example, patients are often delighted to learn that their statin is now generic and their costs will decrease. Everyone wins. But even when patient and societal interests don’t appear to align — for example, when a patient insists on yearly mammograms starting at age 40 — cost may not really be the pivotal concern. “The fight about cost is a smokescreen,” says Caplan. “What’s really at issue is the definition of ethical physician advocacy.” When interests don’t overlap, “people get nervous because they think it’s going to undermine the obligation and duty to put patients’ interests first.”

Yet some physicians now believe that considering cost serves not only the equitable distribution of finite services, but also the real interests of individual patients. Medical bills, after all, are among the leading causes of personal bankruptcy in the United States. When Neel Shah was doing his surgery rotation in medical school, an uninsured patient in the hospital slipped and fell on her way to the bathroom. She was not presyncopal, did not hit her head, and explained that she had tripped. Because the fall was unwitnessed, the resident ordered a head CT. When Shah suggested that the test was expensive and medically unnecessary, he was chided by the nurse and house staff, who

physicians start weighing society’s needs as well as those of individual patients, they begin to lose the essence of what it means to be a doctor. When we lose our personal responsibility to individual patients, he says, “We are in deep trouble.”

Samuels is not alone. Many physicians have long endorsed the understanding encapsulated by ethicist Robert Veatch: “The ethics of the Hippocratic physician makes yes or no decisions on the basis of benefit to a single individual without taking into account what economists call alternative costs. . . . If physicians are asked to reject such care for their patients in order to serve

retorted that cost was irrelevant. Shah realized that those around him seldom considered that their clinical decisions would translate into bills for their patients. He sees such consideration as ethically imperative.

Increasingly, others agree that thinking about cost can actually improve care. Chris Moriates, a resident at the University of California, San Francisco, has implemented a curriculum for internal medicine residents that teaches them how to do both. Through modules detailing common admission diagnoses, he emphasizes the principles of evidence-based medicine and provides information about associated costs.

In one module, a pulmonary embolism develops in a patient. House staff review the tests the patient receives, focusing on incremental benefits and associated costs. She first undergoes CT angiography at a cost of \$3,500. Though the CT shows a pulmonary embolism, house staff subsequently order a D-dimer (\$410), fibrinogen (\$100), lower-extremity Dopplers (\$1,397), and a full hypercoagulability workup (\$2,864). The hospital bill eventually comes to \$155,698.

The focus is not on limiting expensive care, but rather on the principles of evidence-based medicine. These principles, however, are not new to medical education and have yet to change our approach to resource use. So Shah proposes an ethical framework, arguing that caring about the individual patient requires us to think about cost. That's the central theme of his nonprofit organization, Costs of Care, which has collected essays about instanc-

es in which inattention to costs has harmed patients — emulating the patient-safety movement's fruitful deployment of anecdotes about sponges left in abdomens or amputations of the wrong limb. In one essay, for example, a patient describes how a CT her physician ordered for musculoskeletal neck pain suddenly branded her with a "preexisting condition" and caused her insurance premiums to "skyrocket."

In 2010, Molly Cooke made a compelling argument for the profession to change its ways, asking, "How should we deal with [the] forces that have resulted in a failure of medical education to address the urgent issue of costs?"<sup>4</sup> Some educators have apparently responded, and efforts at teaching cost-consciousness are gradually spreading. Cynthia D. Smith, M.D., American College of Physicians (ACP) staff, has worked with volunteers from the Alliance for Academic Internal Medicine and ACP to create a curriculum that is partially based on Moriates' modules. The impact of the curriculum will be measured by surveys and a subscore of the national in-training exam. And some educational leaders are pushing to make proficiency in "cost-consciousness and stewardship of resources" a core competency overseen by the Accreditation Council for Graduate Medical Education.<sup>5</sup>

Emphasizing cost consciousness, of course, could incite a backlash from both patients and physicians. Admittedly, we, too, initially had a visceral aversion to the notion of putting price tags on our recommendations to patients. Punching numbers at a checkout counter comes to mind.

"That Crestor's going to cost \$250, the lisinopril \$20, the insulin \$30, and with your insurance it looks like the insulin syringes come to \$110. Sound good?" What's the patient going to say? "I'll take the insulin but wait for the syringes to go on sale?"

On some level, the conflict between a traditional medical education and one that teaches resource-savvy care may be a matter of semantics. The real goal is not "cost consciousness" per se, but better use of evidence-based medicine and Bayesian principles. Whether it's lack of time, fear of "missing something," or simple ignorance, the incentives to do more often overwhelm our impulse to use resources wisely. Now some educational reformers are offering us an added ethical incentive. Put simply, helping a patient become well enough to climb the stairs to his apartment is meaningless if our care leaves him unable to afford that apartment. Protecting our patients from financial ruin is fundamental to doing no harm.

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