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It has been estimated that perhaps one-fourth to one-third of U.S. health care dollars buy care that has only marginal benefit, if any. To lower this figure, some medical professionals have placed their hope in the increasing use of practice guidelines, in conjunction with other efforts aimed at fostering greater efficiency in the American health care system. This interest has come about despite the challenge that practice guidelines pose to the traditional autonomy that physicians have enjoyed in determining what procedures are medically necessary or effective, and that patients have had in receiving whatever treatment they desire. Guideline proponents argue that while the lessening of physician and patient autonomy might be regrettable, the larger good of providing at least basic health care to more people is the greater consideration.

Of eight organizations participating in a survey on practice guidelines, all indicated that they developed guidelines primarily to improve “clinical effectiveness” and “quality of care,” but six stated that cost control was a secondary goal. Studies show that in some circumstances the adoption of guidelines can indeed lead to cost savings. For example, the institution of guidelines at the Yale-New Haven Hospital reduced the number of emergency room x-rays by 15 percent without compromising quality of care.

Most proponents of practice guidelines, particularly in Congress, have argued that reducing costs might be a byproduct of the adoption of guidelines based upon medical effectiveness (through the elimination of unnecessary or marginally beneficial diagnostic procedures and treatments). To date, financial factors typically have not been incorporated explicitly into practice guidelines. RAND, for example, specifically rules out any consideration of cost in its approach to guideline development, and government agencies traditionally have taken a similar path. An Institute of Medicine (IOM) committee, in preparing a report on practice guidelines for the Agency for Health Care Policy and Research (AHCPR), decided not to take a position for or against the incorporation of cost into the definition of practice guidelines or appropriate care (although several members of the committee were strongly in favor of such an inclusion).

It is unlikely, however, that savings accrued incidentally as a result of the application of practice guidelines, even if they are widespread, will obviate the need for consideration of additional cost control measures such as global budgeting. These savings likely will be outweighed by factors such as a growing and aging population, rising input costs, and increased use of advanced and expensive medical technology. Even if the Clinton administration is successful in introducing proposals to reduce the 7 percent rate of medical care inflation, its efforts to increase access to health care for uninsured Americans will create new financial strains on the U.S. health care system.

It seems inevitable that economic considerations, whether adopted voluntarily by the medical profession or imposed by government or private payers, will increasingly become a part of medical decision making. This might be accomplished most easily and least painfully through practice guidelines that incorporate economic considerations. Such a move would perhaps provide the best combination of meeting the needs of all patients, present and future, while retaining treatment-decision authority within the medical community.

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community continues to take a hands-off approach to reform and does not assume the lead in constructing practice guidelines that reflect current and expected future monetary realities, the public and its elected and appointed officials likely will do the job themselves. In that event, fiscal considerations that otherwise might become a part of suggested practice guidelines-leaving room for the physician to exercise his or her judgment in individual cases—are likely to be incorporated into third-party (government or private) standards that the physician could be required to follow with little allowance for clinical “extenuating circumstances.” A first step toward this has already been taken through legislation authorizing Medicare reviewers to weigh costs explicitly in making coverage decisions; more recently, AHCPR received a mandate to include cost-effectiveness analyses in technology evaluations whenever “cost information is available and reliable.”

It is commonly argued that decisions about funding for medical procedures should not be laid at the feet of physicians, for doing so contradicts the “traditional” role of the physician in looking exclusively after the interests of the patient. This view of clinical practice has not always predominated, however:

Not so long ago, before government entered the health care financing arena, physicians routinely balanced clinical and economic judgment in consultation with patients and their families. Should the family farm be jeopardized to buy three more months of life? Who will care for this man if we somehow succeed in prolonging his bedridden life a little longer?

Given the fortuitous coincidence of the post-World War II economic boom and the growth of the private health insurance industry, the medical community has been able to afford an ethic under which referring to the cost of treatment is considered undesirable or even gauche. That era is now coming to a close.

The explicit inclusion of economics in practice guidelines would mean recognizing that the needs of the many (society) might sometimes outweigh the needs of the individual (the patient). American medicine soon will have to come to grips with systemwide choices that the rest of the world has already made concerning whom to treat and when, with the realization that not all treatable patients can receive any treatment at any cost. We ask this question: Would most practitioners choose to make these decisions themselves, even if it does mean a radical change in the profession’s self-conception, or would they prefer to have the new rules handed to them by fiat?

Medical practice is too complex to be governed by coverage or treatment guidelines created at a distance from the actual practice of medicine and that do not allow for judicious clinical decision making. Conversely, the individual physician in his or her busy daily clinical routine should not be expected to operate without support in deciding among various diagnostic and treatment options. In between the government and the practitioner are the medical societies; practice guidelines-instructive but not inviolable-developed at this level should consider all pertinent factors, including medical effectiveness and efficiency with particular groups or classifications of patients, patient evaluations and preferences, and costs and benefits. If medical societies are to assume this responsibility, there are two stipulations: (1) adherence to established principles for developing practice guidelines (as enunciated, for example, in the IOM report); and (2) a process structured to minimize the bias of vested interest.

It might be argued that inclusion of economic considerations in practice guidelines could be less effective than depending upon an unstructured cost containment method. This is true, but we contend that increasing structure and regulation are coming to medical practice in one form or another. For example, Blue Cross/Blue Shield of Illinois, as of 1 January 1994, requires participating cardiologists, oncologists, and some surgeons to agree to follow guidelines.” Such a structure should be instigated from within the profession rather than imposed from
Physician And Patient Autonomy

A common complaint about practice guidelines is that they reduce physician autonomy. However, physician autonomy will become increasingly compromised in the future by the simple fact that there will not be enough money for all patients to receive all treatments of possible benefit. As Morreim has noted, “To allow physicians the necessary clinical freedom means, however, that physicians will be key agents of allocation if costs are to be constrained. . . . The power to say ‘yes’ in one instance requires that [the physician] say ‘no’ elsewhere.”* If physicians insist on autonomy in practice, they must accept all of the responsibilities of that freedom. Williams points out that it might be easier to accept the need for responsibility and fiscal constraint in care for the individual patient if the physician realizes that, in deciding to forgo the provision of some treatment, one is not just “saving money” but also providing a real chance for others to benefit from medical care.”

Practice guidelines also might be said to impinge upon patient autonomy, in that traditionally patients have had (at least theoretically) the option of seeking whatever treatment they desire. That autonomy, however, is often more apparent than real and is in any event diminishing. This was recognized in 1983 by a presidential commission, which noted that the U.S. health care system “places some limitations on individual choice. . . . Thus, the issue is what kinds of limitations on choice are most consistent with fulfilling society’s moral obligation to provide equitable access to health care for all. . . . [S]ince an adequate level is something less than all care that might be beneficial, patients’ choices will be limited to that range unless they are able to pay for care that exceeds adequacy.”

Incorporating economics into practice guidelines can help to preserve patient autonomy. Donabedian has suggested that it should be “the practitioner’s responsibility to fully inform each patient of the available alternatives in care, of the costs and benefits of each, and of the precise nature of obstacles to choice,” even, or perhaps especially, if those obstacles are fiscal in nature.¹⁵ As physicians begin to discuss this “delicate” matter with their patients, they might find to their surprise that many of them are more willing to talk dollars than has often been supposed. A well-informed patient might be more likely to reject questionable and possibly expensive care.¹⁶ Eddy has argued that the treatment choices patients would make under varying combinations of effectiveness, invasiveness, and cost should be the focus of extensive research during the formation of practice guidelines.¹⁷ For example, surveys in the United Kingdom have indicated that in times of shortage of available services (or of financing for those services), the general population strongly favors care for the young over the old—and that this preference also is manifested by senior citizens as a group, often with the expressed opinion that they have had a long, full life and that others deserve a chance for the same.¹⁸ Another study showed that when people are given a hypothetical situation in which they are incapable of caring for themselves and have a poor prognosis, 70 percent would choose to forgo life-sustaining treatment.¹⁹

Social Responsibility

As part of a recent study on the circumstances under which life support should be administered or withdrawn, the Stanford University Medical Center Committee on Ethics noted six basic principles of medical ethics, among which is the “concept of justice, exemplified by the effort to ensure that medical resources are allocated fairly.”²⁰ The American Medical Association’s (AMA’s) Principles of Medical Ethics states that “a physician must recognize responsibility not only to patients, but also to society.”²¹ Many physicians acknowledge this responsibility and agree that, at least at a general level, they must be concerned with the cost to society of runaway medical expenditures and should
work to constrain that cost.

At the same time, however, it is often argued that it is difficult to see how such concerns relate to individual patient care. Even if a physician were to decide to recommend against some treatment on the grounds that it is not cost-efficient or perhaps is futile, there is no way of knowing that the savings will indeed be passed on to other patients with greater needs especially in the highly fragmented U.S. health care system, in which there is no central authority to dole out the dollars. Our response is that practice guidelines, if developed as we propose, would be detailed and specific in providing a basis for less vigorous and more appropriate medical management of certain patients. An additional and critical task then facing the medical community would be to ensure that the savings do indeed remain within the health care system and are used for patient care. Resisting pressure to siphon funds freed by a more cost-effective system away from patient care will be a challenge for the next several decades, no matter what reforms are instituted.

Although no one knows what will emerge from the current health care reform debate, there can be no consensus until physicians as a community recognize and address the limitations in the health care system. The alternative is that persons focused on containing the costs of health care, but with little understanding of its complexities and of the sensitive nature of physician/patient relationships, will set the rules.

We would add that the consideration of economics in practice guidelines provides an opportunity for physicians to face the current health care fiscal crisis responsibly while retaining decision-making autonomy as a profession. The downside to inclusion of economic factors in practice guidelines is that such a move requires a drastic reevaluation and restatement of the “traditional” concept of the physician’s role—a concept that, while admirable, unfortunately is becoming increasingly unrealistic. The upside is that it offers a first step in helping our nation to resolve the long-term issue of providing adequate health care in a fair manner to all of its citizens. The medical community should lead the nation in striving to achieve this goal.

NOTES

3. Audet et al., “Medical Practice Guidelines.”
13. A. Williams, “Health Economics: The End of


