

Teaching About Costs in Training Programs: A Complex Topic

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The nation's health care system is being strained by spiraling costs due to a variety of factors: the overuse and misuse of tests and procedures, a dysfunctional payment system, the lack of systems to assure care coordination and clinical information exchange, and inefficiencies that cause waste with little value to the patient. According to the Centers for Medicare & Medicaid Services, national health care expenditures are projected to increase from 17.3% of the nation's GDP in 2011 to 19.3% in 2019. Although physician decisions account for most health care spending, only a small proportion of the nation's physicians historically have received information about their use of health care resources. And many do not consider the cost issue to be their direct responsibility.

That perception is expected to change. The Accountable Care Act will change how Medicare pays for health care, including physician services, by moving toward value-based purchasing arrangements at both the organizational and individual physician levels. To succeed within these new arrangements, physicians will need an awareness of the cost as well as the quality and effectiveness of services that they provide and prescribe, and they will need the skills to effectively engage with patients in shared decision making that is informed by all of these dimensions of medical care. Are our medical education and training programs adequately preparing aspiring physicians for the challenge of practicing effectively within the new "value" paradigm?

Decades before the Accountable Care Act, concerns about health care costs were prompting calls for better training of residents about the cost and effectiveness of care options.¹ The Accreditation Council for Graduate Medical Education (ACGME) competencies, which apply to all specialties, now include the expectation that residents "incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate." Even so, we suspect that in most graduate medical education programs, trainees still do not receive formal training in cost-effective medical practice.

The Sehgal and Gorman article in this issue, "Internal Medicine Physicians' Knowledge of Health Care Charges," adds to the documentation that physicians generally are naive about the costs of medical care, but suggests there is

an appetite among both students and faculty for training in this area. The authors conducted a survey of residents and faculty in one residency program, measuring their knowledge about and attitude toward the charges for specific diagnostic tests. The authors concluded that "physicians have very poor knowledge of the charges for diagnostic tests, as less than a quarter of total charge estimations [by both residents and faculty] were within 25% of the true charge." Yet both residents and faculty had a "significant desire (agreeing more strongly than to any other statement) to know more about the charges of diagnostic tests and felt that improved access to charge information would affect their ordering behavior." The authors argue that improving transparency of charges at the point of order is a straightforward way to sensitize trainees to the cost implications of their diagnostic and treatment decisions.

This proposition has some support in the literature, but it is clear that the availability of charge information is unlikely by itself to inculcate trainees with the attitude of cost-consciousness as a positive professional attribute. Rather, we also need to see changes to the culture of the physician and the environment in which physicians practice. Many physicians, and most likely faculty members, are uneasy thinking about the cost of health care. Many feel uncomfortable with the principles in the Physician Charter (created in 2002 by the American Board of Internal Medicine Foundation, where the authors are employed; the American College of Physicians Foundation; and the European Federation of Internal Medicine) that call for both the primacy of the patient and of social justice, including a just distribution of finite health care resources. For cost information to shape the behavior of residents or faculty, they must believe that health care costs are as much the responsibility of the physician and the medical profession as of other stakeholders, including patients, payers, and purchasers. Prominent voices are increasingly making this argument: in a recent article, physician leaders in integrated delivery systems pointedly called on the profession to reduce overuse and misuse, reduce hospital complications, and reduce inefficiencies in operations.² But recognition of the physicians' role in driving costs will not be sufficient to engage physicians. Ultimately, physicians will engage on this issue only if it is about better medical decision making—reducing the risk of harm, removing waste, and enhancing care outcomes for their patients.

The impact of teaching residents how much services cost might not trump the effect of the practice environments in their training programs. Indeed, a number of factors threaten to outweigh the benefits of including cost-effective

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care in the curriculum. For example, will training programs that feature a higher intensity of services help perpetuate higher usage of services by graduates later in practice? Does the fee-for-service reimbursement system encountered by most of these residents swamp sensitivities to the costs of care to the complex patient? Will hospitals' imperative to fill beds override the conservation of resources?

These are daunting challenges, but the fiscal realities are such that training programs need to systematically teach the ACGME-mandated knowledge, skills, and attitudes that lead to cost-effective care. From a curricular perspective, the importance of cost-effectiveness should be conveyed to trainees from day one. If trainees are not taught to evaluate the costs and benefits of their decisions early, the result can be costly practice habits that persist throughout their careers. This training must also provide residents with an understanding of the cumulative costs of episodes of care—the information likely to be most valued by patients, payers, and purchasers—rather than simply informing them about à la carte charges. From a developmental perspective, cost-effective care delivery is not just about knowledge. It

requires a set of complex skills that require development—for example, how to manage a conversation with a patient whose expectations may not be realistic given the medical evidence. Training programs need to build in explicit opportunities for faculty to observe and provide feedback to trainees about their performance in these competencies. Faculty in many specialties can turn to work performed under the ACGME Outcome Project, which provides a framework for assessing trainee performance against developmental milestones.

Residents should be made aware of the cost of interventions, but in the context of improving the quality, effectiveness, and patient-centeredness of the care they provide. This step can be only one part of a much larger effort.

References

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