THE PRINCIPLES DISCUSSED HERE OFFER A BROAD VIEW OF HOW PHYSICIANS—along with patients, hospitals, health systems, the medical education and training system, medical groups and health policy organizations—can engage in the effort to provide higher-quality care that acknowledges that the resources our society can devote to health care are finite.
PREAMBLE

It has never been more urgent for physicians and other stakeholders to understand the importance of making wise, evidence-based decisions that promote high-quality care while also preserving the health care system’s sustainability. A growing focus on value among health care experts and policymakers has drawn attention to the overuse and misuse of procedures and tests, the perils overuse presents for patients, and the existence of significant variations in care in different regions of the nation. There is also increasing attention to the underuse of preventive services, including those that can promote health while reducing costs.

Meanwhile, the percentage of the nation’s wealth devoted to health care expenditures continues to rise, with cost increases outpacing wage growth by a wide margin year after year, fueling growing budget crises at the state and Federal levels. The aging of the baby boom generation and increases in life expectancy will add to the pressure on health care costs. About 10,000 people turn 65 every day, and the number of Americans 85 and older is projected to grow from 5.8 million in 2010 to 19 million by 2050. It is time for the medical profession to more systematically address the soundness of and public confidence in our nation’s health care system.

PHYSICIANS HAVE A PROFESSIONAL OBLIGATION TO ACT AS RESPONSIBLE STEWARDS OF THEIR PATIENTS’, and the public’s, resources to ensure that health care does not consume an ever-growing proportion of the country’s resources and to assure the appropriate and fair distribution of finite health care resources.
The principles discussed here offer a broad view of how physicians—along with patients, hospitals, health systems, the medical education and training system, medical groups and health policy organizations—can engage in the effort to provide higher-quality care that acknowledges that the resources our society can devote to health care are finite. They were developed through a series of workgroups and meetings convened by the ABIM Foundation:

- A Task Force on Stewardship, which brought together leaders from academic medicine, specialty societies, hospitals, health plans and others to discuss the sustainability of the health care system and what could be done to preserve it;

- An April 2011 meeting of health system leaders in Madison, Wisconsin, which examined how one community was addressing sustainability concerns; and,

- The ABIM Foundation Forum in July-August 2011, where approximately 140 physician leaders, patient advocates and leaders from nursing, health plans, business and quality organizations gathered to discuss how physicians, patients and the rest of the health care community can create a more sustainable system.

Although these principles address many of today’s most severe challenges, all stakeholders in the health care system must continually assess the system’s strengths and weaknesses, and make future adjustments to ensure that care delivery is as efficient and effective as possible.
RESPONSIBILITIES OF PHYSICIANS

Physicians have a professional obligation to act as responsible stewards of their patients’, and the public’s, resources to ensure that health care does not consume an ever-growing proportion of the country’s resources and to assure the appropriate and fair distribution of finite health care resources. Medical Professionalism in the New Millennium: A Physician Charter is a modern code of ethics endorsed by more than 130 medical organizations. It includes three fundamental principles, one of which is the principle of social justice. This principle obligates the medical profession to “promote justice in the health care system, including the fair distribution of health care resources” and a just and fair relationship between the health care system and the rest of society. As health care costs at the individual, employer and societal level continue to increase, physicians must embrace these obligations if they want to ensure the system’s sustainability, the availability of beneficial services to all, and the continued trust of the American people. Indeed, the biggest driver of health care costs is the physician’s pen—from the tests they order to the prescriptions they write, physicians’ decisions account for about 80 percent of health care expenditures.  

Physicians maintain awareness of the most current, evidence-based research about management and treatment options. Physicians have a professional obligation to follow and act upon the best available evidence, evaluating whether a medical intervention is appropriate and necessary for their patients before ordering it. By using research findings to guide their recommendations of which test or procedure is most appropriate—or whether “watchful waiting” may be the best response to the individual case before them—physicians can provide higher-quality care that protects patients and simultaneously conserves resources. Given the volume of information, physicians are challenged in evaluating the quality, integrity and relevance of a constant stream of new studies. Medical societies, independent organizations and government agencies that advise physicians and issue systematic reviews and practice guidelines have a critical role to play in ensuring that this vast body of medical research is translated into clinically relevant information that is useful at the point of care and is widely disseminated, such as through HIT offering real-time clinical decision support. Such decision support systems have proven valuable in limiting the inappropriate use of interventions. Leaders of the profession, along with their physician colleagues, should not hesitate to identify and publicize clearly ineffective or harmful care.

IT HAS NEVER BEEN MORE URGENT FOR PHYSICIANS AND OTHER STAKEHOLDERS to understand the importance of making wise, evidence-based decisions that promote high-quality care while also preserving the health care system’s sustainability.

strategies and take responsibility for reducing their use. Despite the best efforts of the research community, there will always be instances in which the evidence simply does not dictate a particular course of action. At that point, physicians must do their best to integrate the information that does exist about the benefits, risks and costs of potential options, sharing this information with their patients and, in partnership with them, developing an optimal treatment plan, heeding the advice of patient advocates that there should be “no decision about me without me.” Finally, when options are available that are likely to achieve similar results with markedly different costs (such as an initial trial of outpatient treatment with careful follow-up for acute exacerbations of a chronic illness), physicians should seriously consider recommending the lower-cost alternative.

Place a priority on engaging in shared decision-making with patients. Growing evidence suggests that patients who are involved in their care and understand their options tend to make decisions that are more satisfying to them, result in better outcomes, and are less costly.\textsuperscript{5,6,7} Thus, increased use of shared decision-making tools and strategies would more likely deliver patient-centered outcomes, enhance patient satisfaction and optimize resource use. To achieve this goal, physicians should help patients develop the skills they need to engage in shared decision-making. Physicians should develop their communication skills, and familiarize themselves with resources that help patients clarify their values and understand the benefits, risks and costs of possible care management strategies. In communications with patients, physicians and their professional colleagues—nurses, social workers and others on the care team—should solicit needs and preferences, listen carefully, learn about their patients’ values, present options, jointly make clinical and other decisions and collaborate on an individualized management approach. They should ensure that patients understand that more care is not necessarily better care, and that even procedures that can be benign can have a negative and potentially harmful cumulative effect. And, while often difficult, these discussions should also encompass physician-patient counseling regarding patient preferences and values related to end-of-life care. As we increasingly come to realize the importance of care coordination and for physicians working as part of teams, we should also recognize that physicians need not take on the entire responsibility for working with patients. All health care professionals, including nurses and social workers, could be extremely useful in enhancing patients’ understanding and comfort in playing an active role in the course of their care.

Appropriately use diagnostic procedures and imaging, carefully advising patients about their best care options. Even physicians who practice evidence-based medicine and engage in shared decision-making with their patients will be confronted with difficult care decisions,
indeed, the biggest driver of health care costs is the physician’s pen—
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including instances when patients or their families request tests or procedures that may be unnecessary or even harmful. Faced with these circumstances, physicians and their team colleagues should be skilled advocates for and explicators of evidence-based interventions and treatments and should consider alternative approaches (such as a trial of watchful waiting) that may address patient concerns as effectively. They must also be effective advocates for their patients, ensuring that they do get the care that is appropriate for them.

Develop and maintain respectful relationships across disciplines, specialties and delivery systems, and embrace working in teams with others.

Providing appropriate care effectively and efficiently requires collaboration among physicians and other clinicians, the free flow of information among specialists, generalists, home care staff and others, and organized evidence-based transition planning. These steps will enhance quality, increase safety and reduce inefficiencies that drive up costs. For example, research shows that patients often do not receive the attention they need after being released from the hospital, and that efforts to coordinate care post-discharge have been successful in improving health outcomes for those patients and reducing hospital readmissions, a key driver of health care costs. Similarly, patients receive better care when there is effective communication between their primary care physicians and the other specialists who treat them. There is also growing evidence that team-based care in both primary care and acute care settings enhances communication, is valued by patients, their families and providers, and is linked to improved quality and safety of care, as well as improved health and functioning in those who have a chronic illness. Such collaboration will be enhanced in redesigned systems that are truly patient-centered and thus do not silo care or the professionals working within them.

Responsibilities of Patients

Patient engagement in shared decision-making is an essential part of high quality care. Shared decision-making creates the opportunity for patients to participate actively in their own care. To the best of their ability, patients should review information about treatment options, feel empowered and invited to ask questions, and share concerns and express their preferences. (Those providing the care should recognize that the capacity of patients and their families to understand their choices in an informed way will vary due to education, culture and other factors.) Patients are advised to relay all medications and therapies they are taking to provide physicians with a total picture of their care. Patients should be invited to include family members or other trusted loved ones in their conversations with their physicians. Once patients have agreed to a care plan that reflects their values and preferences, they should adhere to it or negotiate changes to it. There is growing evidence that the traditional model of care, in which patients entrust their physicians with all decision-making authority, leads to the provision of elective care that patients do not want to receive.

The best way to prevent this from happening is to ensure an environment in which patients feel confident in expressing their needs and preferences.

Patients should feel comfortable asking for an in-depth explanation from their physicians when a requested intervention is discouraged. The provision of unnecessary or even harmful care can result not only from physician decisions but also from patient requests for tests or procedures that may not be in their best interest. Patients should carefully consider the advice of their physicians—who are familiar with the evidence for and against the use of particular interventions—before insisting on a particular course of action, recognizing that watchful waiting may be the most appropriate path in some circumstances, and that less care is sometimes better care.


Responsibilities of the Medical Education and Accreditation/Certification Systems

Medical schools and residency programs are responsible for teaching their students how they can—and why they should—optimize the use of health care resources. The next generation of physicians will enter a health care system facing severe resource constraints and a growing emphasis on appropriate resource utilization. The institutions that train them must prepare them for this environment, in part by assuring that both systems and faculty model best practices and equip learners with the skills to practice both strong advocacy and conservative management based on the best available clinical evidence. Specific steps these institutions can take include emphasizing the use of clinical evidence databases, providing training in managing the growing complexity of the demographics of the population, sensitizing students and residents to consider both short and long-term costs of different treatment options, and implementing curricula related to shared decision-making that will train physicians about how best to listen to, understand and communicate with their patients. Maintenance of Certification and Maintenance of Licensure programs should then continue to reinforce those elements.

Responsibilities of Government

Government should fund comparative effectiveness research (CER), including information about the cost-effectiveness of alternative courses of action. CER is designed to determine which health care services work best, and it holds enormous potential for improving care decisions. The private market has not produced enough of this information, which physicians and patients need to make intelligent care decisions.

Information about “what works” is a public good, and government should continue to sponsor research that fills the gaps in our knowledge.

Government should assure access to needed services for all Americans. The Physician Charter’s call for social responsibility requires fair access for the entire population to appropriate medical care, and government has a critical role to play in ensuring that access. The physician’s role is also key, both in treating patients who carry government-provided health insurance and by ensuring the careful management of resources so that care for all is a practical possibility.

Responsibilities of Payers

Public and private payers should use the best information, including CER findings, to guide decisions about what to cover and how to price services. It is common for expensive interventions to be introduced in the market without persuasive evidence that they are superior to existing and far less expensive options. Payers should thoroughly review evidence of efficacy, and then consider a number of options, including declining to pay for a service under any circumstances, limiting coverage to only a defined set of patients for whom the intervention is likely to be effective, or agreeing to pay only the amount they would have paid for an equally effective but less costly service.

Public and private payers should adopt payment methods that send appropriate signals about value. Payers can send signals about the importance of high-quality care by employing payment methods that facilitate and reward care coordination, the integration of services and care outcomes. They should also aggressively seek to limit unwarranted price variation among providers offering the same service in the same region. Finally, they should also ensure that the prices they set for individual services reflect the importance of primary care and preventive services.
JOINT RESPONSIBILITIES OF ALL STAKEHOLDERS

All stakeholders in the health care system should act to prevent conflicts of interest, which undermine the public’s trust and increase the system’s cost without improving quality of care. The health care system is replete with examples of conflicts that can distort care decisions and drive spending. Prominent examples that have recently received widespread attention include self-referrals and decisions to implant a device or prescribe a drug that appear to have been influenced by relationships between industry and physicians. Practices and institutions throughout the health care system have a responsibility to adopt and actively enforce policies to ensure that care decisions are made without regard to financial or other inappropriate influence, and care providers have a professional responsibility to accept and adhere to those policies.

All stakeholders in the health care system should actively work to rebuild and support primary care. Primary care physicians are the backbone of an accessible, efficient and high quality health care system. Effective management of our nation’s health care resources—and our nation’s health—requires recruiting and retaining a robust primary care physician workforce, as well as designing a practice model that leverages this workforce for maximum societal benefit. However, the current practice of primary care is plagued by job dissatisfaction. The system—from the medical schools that prepare new physicians to the health plans and public payers whose policies shape primary care physicians’ practices—must encourage and reward choosing and sustaining a primary care career, and work toward greater innovation that will make primary care more vibrant, satisfying, and prepared to meet the future needs of the health care system while sensibly stewarding our resources.

Stakeholders should actively promote a wellness rather than an acute care-focused system. All stakeholders must work collaboratively to improve how the health care system offers preventive services and manages chronic conditions, with care coordinated across conditions and sites of care delivery. Physicians and other clinicians should be rewarded for a patient-centered approach to achieving quality outcomes, not for units of care provided whether or not they are appropriate. Among other things, this should involve a greater emphasis on preventive measures in outpatient settings, with patients themselves taking greater responsibility for lifestyle choices that impair their health. Acute care, of course, is a critical function for our health care system, and one upon which nearly all Americans will rely at some point. Where acute care is needed, however, hospitals, payers and others need to build on recent acute care successes—such as efforts to reduce emergency room visits or reduce the number of hospital-acquired infections—and demonstrate their commitment to ensuring high-quality patient care and avoiding waste, preventable complications and unnecessary treatments.

Stakeholders should work collaboratively to help physicians understand their resource use. Physicians would be more likely to make wise choices about resource use if they understood their actual use if they understood their actual practice patterns, how those compare with their peers, and the costs of key therapies and tests. Research has shown significant variation in medical practice and resource use but limited information is available to allow physicians to evaluate their own practices and reduce unwarranted variation. To fill this gap, third parties—government, foundations, payers, certifying organizations or others—should develop tools that doctors can use to measure and optimize their own resource usage.

All stakeholders should take advantage of opportunities to eliminate waste in clinical and administrative processes. Evidence from diverse clinical settings has shown that it is possible to reduce the cost of providing a given clinical service through the effective redesign of care. Examples include identifying and eliminating extra steps in care processes, choosing supplies wisely and making sure that tasks are carried out by those with the most appropriate training (i.e., by clinicians practicing at the “top of their license”). In addition, administrative waste in both clinical practices and health insurance programs abounds. All participants in the health care system have a responsibility to identify and eliminate waste.

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