

## Virtual Mentor

American Medical Association Journal of Ethics  
February 2013, Volume 15, Number 2: 104-106.

### ETHICS CASE

#### Is the Standard of Care Always Worth the Cost?

Commentary by Susan Dorr Goold, MD, MHSA, MA

Mrs. Howard was writhing in pain on the paper-covered bed in the emergency room. She clutched her abdomen. “Yes, I’ve had this pain in the past,” she said to Dr. Murphy, the resident taking her history. “I know I have gallstones. My right side usually aches after I eat greasy foods, but it’s never been this bad before.”

“Okay,” said Dr. Murphy, after performing the physical exam. “I’m almost certain that you have cholecystitis, but we’ll order an ultrasound just to confirm. Most likely, we’ll start you on some antibiotics and fluids until the inflammation goes down, and then we’ll take the gallbladder out with surgery.”

“Wait a minute,” said Mrs. Howard, sitting up in bed. “I’m on a health savings account, and I haven’t spent my deductible yet. Can we just go ahead with the antibiotics and fluids and skip the ultrasound? We already know I have gallstones, so this test is just taking money out of my pocket.”

When Dr. Murphy went to discuss Mrs. Howard’s case with his attending, he asked whether they could skip the ultrasound due to Mrs. Howard’s finances.

His attending wasn’t pleased. “The standard of care in this hospital is to get a confirmatory ultrasound,” she said, “regardless of the patient’s preference to not spend \$200 out of her HSA. If you start changing the way you treat patients based on their payment preferences, you’re in dangerous territory.”

“We’re not denying her care or skipping a crucial step because she’s unable to pay, or because we’re trying to cut costs for the emergency room,” Dr. Murphy argued. “We’re just trying to save her money. We could see it as part of acting her best interests.”

The attending fired back, “You know, failing to meet the standard of care feels better when it’s to directly benefit a patient, but the bottom line is, you need to be consistent about the way you practice medicine. The cost of a test shouldn’t enter into your thinking when you’re trying to diagnose a patient—especially not when there’s a standard of care to be followed. You’re a doctor, not her accountant.”

### Commentary

“The standard of care.” That phrase, used often in medicine, warrants a close inspection.

*The standard of care.* Use of “the” rather than “a,” “our,” or “my” provides a sense of absolutism, an implicit claim that there is only one. Certainly there are some clinical situations in which the evidence of benefit from a particular intervention is so overwhelming (aspirin after heart attack, say) that exceptions should be few and far between and for very good reasons (aspirin-sensitive asthma, say). And there are many medical situations in which evidence favors a particular course of action for the usual patient, but exceptions are easier to justify because the evidence is more questionable (perhaps an intervention studied in adults younger than 65 being applied to a 66-, or 76-, or 86-year-old). There are other medical situations in which the benefit, even if well established, is small enough to readily justify exceptions to “the standard.” In the case described, to assert that an ultrasound is the (only) standard of care, one would have to claim not only that unquestionable evidence confirms that ultrasounds are needed to diagnose acute cholecystitis but also that, even in a patient with known gallstones and a history and physical exam consistent with “almost certain” cholecystitis, an ultrasound provides essential and substantial benefit.

*The standard of care.* There is a suggestion of fairness in the idea of standardization, of treating like cases alike. When treating individual patients, however, doctors need to individualize care recommendations based on a unique history, personality, and, yes, economic context. This patient may differ from the usual patient presenting to the emergency department with suspicion for cholecystitis, since she has known gallstones and typical symptoms and signs. As for considering cost, most doctors have cared for uninsured, a.k.a. “self-pay,” patients and have faced requests for cheaper medications, more limited testing, and less frequent doctor visits. Likewise we have seen patients with ample resources who request unnecessary services (e.g., antibiotics for viral sore throat, unnecessary x-rays).

When the benefit of a recommendation is well proven and substantial, doctors try to persuade reluctant payers that an intervention is worth the cost. Sometimes that payer is the patient (e.g., my uninsured patient with chest pain who did not want to incur an emergency room bill), sometimes it is an insurer (e.g., for coverage of a nonformulary medication when formulary options don’t work), and sometimes someone else faces the cost (a hospital with an uninsured inpatient, a colleague asked to consult). We make judgments about the need, about the anticipated benefit, all for individual, not standardized, patients.

There are few situations in which the standard of care is so clear-cut as to preclude any judgment by the physician. We decide all the time how urgent something is—does this patient need an ambulance or just a ride to the ER; can this one wait for a routine appointment or does he need to be seen today, this week, this minute? These are judgments about need—and the willingness to consider the degree of need (not just the standard of care) when asking a patient (or someone else) to spend money requires the same sort of judgment.

Standards also refer to integrity, to a moral and ethical code. Physicians' primary ethical obligation is to protect and promote the well being of individual patients [1]. At times that may entail persuading a patient to dip into his or her health savings account or wallet to enable him or her to receive the needed care. At other times it may mean recognizing that patients' preferences and values include nonmedical considerations; not just out-of-pocket cost but timing of an intervention, location, or other features. This has the added benefit of strengthening the patient-physician relationship: by taking into account patients' nonmedical preferences, we indicate to patients that we recognize them as something other than their conditions, and that we will treat them as individuals.

The standard of *care*. Without talking to this patient, putting my hands on her abdomen, and seeing her previous diagnostic evaluation, I couldn't say whether the physician should persuade her that an ultrasound is worth the cost. I can say, to quote Francis Peabody, "the secret of the care of the patient is in caring for the patient" [2], words as true today as they were in the early twentieth century, before ultrasounds became the standard of care for diagnosing acute cholecystitis.

### References

1. American Medical Association. Principle VI. Principles of Medical Ethics. <https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page>. Accessed January 10, 2013.
2. Peabody FW. The care of the patient. *JAMA*. 1927;88(12):877-882.

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