

Editorial

Patient care and population health: goals, roles and costs

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Strong voices today are calling on the health professions to expand the goals that clinicians should pursue in the course of patient care. It is an expansion that promotes population health through the enhanced integration of patient care and public health¹ with a focus on three interrelated aims: i) improving care for individual patients, ii) improving health of populations, and iii) reducing per capita costs.² These aims seek to address population-level challenges of access, quality, disparities, and cost, while still satisfying patient-level needs. Because cost control is a key element, the economic burdens of health care are routinely discussed as part of population health, resulting in current efforts to teach physicians to weigh the costs of care and become better stewards of medical resources.³

Much of the current emphasis on cost control is appropriately directed at avoiding tests and treatments that do not improve health. Attention is also given to standards for assessing the degree of benefit of tests and treatments that do improve health, such as quality-adjusted life years (QALYs).^{3,4} Some cost-concerned voices go even further, suggesting that health care which provides only minimal benefits should be avoided since it harms population health by reducing access to more beneficial care.⁵ In the midst of these efforts to merge the interests of patients and populations, we need to be clear about the professional implications of population health, and we need practical wisdom to decide what means are best suited to achieve the well-intentioned ends the advocates of population health propose.

Practical wisdom is an ancient virtue that is as relevant today as it was in the days of Aristotle or Aquinas. It is a character trait that involves the ability to know, and deliberate about, ends or goals that are worth pursuing and the means most likely to accomplish those ends or goals. Historically, practical wisdom was foremost among the virtues because it allows us to respond realistically to challenging situations by perceiving and engaging their objective features as well as their relevant moral values. In short, practical wisdom can be understood as deliberation and action that integrates i) pursuit of worthwhile ends or goals, ii) accurate perception of specific practical situations, and iii) commitment to moral virtues and principles that form an integrated moral framework.⁶

Goals are a key determinant of practical wisdom, and they are of pressing concern in health care both with respect to the goals of public health in society at large and the goals of care in clinical decision making for individual patients. Goals of public health concern broad social goods, such as prevention of disease, promotion of health, relief of pain, treatment of disease, or avoidance of premature death. Goals of care concern individual patient needs such as clarifying a diagnosis or prognosis, curing disease, living longer, improving function, being comfortable, achieving life goals, or providing support for family. The moral framework that surrounds and guides the pursuit of goals in public health and patient care will involve a variety of virtues and principles, ranging from compassion and honesty to beneficence, non-maleficence, respect for autonomy, justice, and utility.

The merging of the goals of public health and patient care under the banner of population health draws attention to some important tensions between ethical principles. A patient-centered approach to health care promotes benefits (beneficence), avoids harms (non-

maleficence), and respects self-determination (autonomy). A public health approach focuses more on distributing healthcare resources effectively (utility) and fairly (distributive justice). At a time when population needs are increasingly highlighted, we should note the paradox that contemporary clinical practice is already pervaded by the paradigm of shared decision making with its emphasis on individual patients' needs, values, and preferences.⁷ This paradigm is grounded in respect for patient autonomy⁸ and may be difficult to reconcile with priorities of population health that are grounded in utility and distributive justice.

Sometimes the ethical tension between patient-centred and population-centred considerations may be passed over, even when contrasting ethical principles relevant to the tension are defined.⁹ At other times the tension is explicitly addressed and may be seen as potentially irresolvable.⁴ The tension presents dilemmas for ethicists and problems for administrators. But it is particularly challenging for clinicians whose sensibilities have been formed by an overriding sense of responsibility to meet the needs of the individual patients they see, hear, and touch. An awareness of the stressful nature of this tension can be found in other special clinical contexts, such as pandemic emergencies where it is acknowledged that crisis protocols shift outcome priorities from the individual to the population, creating ethical tension for health professionals who are educated to care for individuals rather than populations.¹⁰ Shifting priorities from individuals to populations may be more acceptable to clinicians when they can see with their own eyes the circumstances that justify triaging patients or allocating scarce resources. But the non-emergency conditions of population health are more challenging, because a clinician cannot directly see the advantages to future patients derived from cost controlling decisions involving current, identifiable patients.

We should welcome efforts that encourage clinicians to avoid tests and treatments that do not improve health and thereby waste valuable resources. We may also find valuable information for shared decision making from analyses based on health benefits measured in QALYs. But we should critically evaluate proposals that assign clinicians the direct double responsibility of meeting the medical needs of patients while simultaneously meeting the economic needs of populations. Instead, we should favour proposals that assign the responsibility of cost control to persons not directly involved in a given patient's care who can attend to the important goals of equity and cost control across a population without conflicting obligations. And we should be sceptical if it is suggested that clinicians can navigate a way through the tension posed by patients and populations by relying on *skillful improvisation coupled with mastery of a few decision-making principles*.⁴

Why should we be sceptical? For two reasons. First, shared decision making between a clinician and patient is a unique process between two human beings who come to the clinical encounter with their individual beliefs, values, and expectations. Clinical decision making is therefore always an individualized process based on specific patient and clinician characteristics. It is not a standardized process, which means it is all the more susceptible to variation for clinical and non-clinical reasons. Second, if clinicians are expected to control costs for populations, they should be expected to do so justly, without favouring

or disfavoured care on the basis of anything but a valid medical reason, ethical imperative, or patient preference. We should ask ourselves whether history, health disparities research, and our beliefs about the human capacity for justice plausibly support such an expectation. We should consider whether the adoption of population health, no matter how well intended, might invite an ethic of cost control that facilitates a shift in attitudes, especially among the emerging generation of clinicians. Such a shift might not only result in the systematic reduction of wasteful or minimally beneficial care; it might also result in a non-systematic reduction of care for some patients because of biases in the individual applications of a general economic imperative.

Population health envisions an expansion of the role of clinicians that is inspired by a desire to improve quality, distribute benefits equitably, and constrain costs. We need not doubt the value of these clinical, ethical, and economic objectives. But we should ask if there is a better alternative to a role-expansion that recasts the clinician as a steward of society's resources. I would suggest that a better approach is to sustain *role-fidelity* among clinicians and administrators as a means of promoting their respective fiduciary responsibilities to patients and populations.

Apart from uniquely challenging clinical settings where resources are limited and must be immediately allocated, role-fidelity implies that cost-controlling strategies in health care should be developed within a division of labour that separates administrative decisions about access to resources from clinical decisions about the need for those resources. This division of labour holds that clinicians should not attempt to serve simultaneously as advocates for the health of individual patients and as stewards for the economic health of society. It maintains that clinicians should be care providers, not resource allocators – even as it acknowledges that policy decisions based on economic constraints will necessarily limit what forms and amounts of health care patients will be able to receive. Role-fidelity resists inclinations to shift from a primary professional focus on the *patient-clinician dyad* to what might be called a *patient-clinician-population triad*.

We ought to support systems of care that encourage clinicians to practice quality-driven, evidence-based, patient-centred, and cost-effective medicine. But we ought to do so without placing on clinicians' shoulders a responsibility for controlling health care costs in ways that may decrease their advocacy for individual patients as they increase their advocacy for the *greater good* of populations. A division of labour allows individual patients to have advocates in physicians, and populations to have advocates in administrators and legislators. Such a separation of roles would likely preserve more trust in patient-clinician relationships as there would be less cause for patients to question what is motivating clinicians' recommendations. As arguments for population health are increasingly promoted and accepted, we should be clear about its goals and the roles it expects clinicians to adopt. And the need for cost control should not by itself be seen as a justification for a role-expansion that would make clinicians directly responsible for controlling costs through resource allocation at the level of individual patients.

If society imposes on clinicians the expectation of the dual responsibility to serve simultaneously as advocates of patient care and overall cost control, we should watch for an attitudinal shift. In terms of ethics, this shift would represent a movement from the principle of beneficence (focused on the benefit of the patient) to the principle of utility (focused on the maximization of benefits across a population). In terms of goals,

this shift would assimilate the economic goal of cost-containment into the set of clinical goals of care that have traditionally guided clinicians' decision making. We should think carefully about the possible unintended consequences that can come with such a shift in attitudes and goals, realizing that what might be measurable as an economic gain could be accompanied by a far-reaching professional loss.

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