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Ethics and high-value care

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ABSTRACT

High-value care (HVC) is en vogue, but the ethics of physicians' roles in the growing number of HVC recommendations demands further attention. In this brief report, we argue that, from the standpoint of individual physicians' primary commitments and duties to individual patients, not all HVC is ethically equal. Our analysis suggests that the ethical case for HVC may be both stronger and weaker than is ordinarily supposed. In some cases, HVC is not merely a 'good thing to do' but is actually ethically obligatory. In others, it is merely permissible—or even ethically suspect. More importantly, we suggest further that understanding HVC as ethically 'obligatory, permissible, or suspect' has implications for the design and implementation of strategies that promote HVC. For example, it questions the use of adherence to certain HVC recommendations as a physician performance metric, which may already be occurring in some contexts. Properly construed, ethics does not threaten HVC but can instead help shape HVC in ways that preserve the fundamental values of the medical profession.

Efforts to encourage high-value care (HVC) are increasing throughout medicine, largely via value-based clinical guidelines, recommendations and educational curricula.^{1–4} HVC, at its core, emphasises evaluating the benefits of healthcare interventions relative to their cost.⁵ HVC as a term of art arguably originated in the USA, where introducing the concept of value to clinical practice, healthcare organisations and payment reform was seen as a way to curb unsustainable health spending and reduce wasteful care while maintaining quality.⁶ In the USA, value-based healthcare initiatives now animate countless efforts within medical education, professional societies, health systems and payment reforms that encourage physicians to practice HVC. Similar efforts are also occurring outside the USA.^{4,7}

HVC is intuitively appealing. Who wants to give or receive low-value care? However, system barriers, physician training and misaligned incentives may hamper its practice integration.^{8,9} Beyond these operational concerns, ethical confusion may impede HVC implementation.

For individual physicians, whose primary commitments are to individual patients,^{10–12} not all HVC may be ethically equal. If HVC initiatives lump all value-based recommendations under a single positive moniker of 'high-value', physicians with reservations about some recommendations¹³ may extend their reservations to other less problematic ones. As value-based recommendations rapidly proliferate (eg, the popular *Choosing Wisely* campaign in the USA now includes hundreds of recommendations), this confusion may contribute

to lacklustre HVC implementation. We propose an ethical typology of HVC to help physicians achieve value while upholding their primary commitment and to guide HVC initiatives.

NOT ETHICALLY EQUAL

Several distinct reasons support the idea that not all HVC is ethically equal. Conceptually, value in healthcare can be increased by limiting harmful services, promoting beneficial and inexpensive ones, favouring clinically equivalent and lower cost options, restricting beneficial but expensive care and so on. Physicians and patients may perceive ethical differences among these. For instance, not ordering an unnecessary, potentially harmful test (such as imaging in non-specific low back pain) may be perceived differently by physicians and patients compared with restricting access to beneficial but expensive care (such as life-extending chemotherapy).¹⁴ Both could be considered HVC,¹⁵ but the latter, rightly or wrongly, could be perceived as more ethically problematic. Friction, real or perceived, between HVC and physicians' primary ethical commitments could prompt lacklustre HVC implementation generally.

Complicating matters, the evidence behind value-based recommendations varies¹⁵ and may be inconsistent or incomplete. For instance, the evidence establishing appropriate age and screening interval for routine mammography¹⁶ is uncertain, complicating the value assessment; the evidence supporting specific blood pressure targets appears to be in near constant flux.¹⁷ For other value-based recommendations, there may simply be insufficient evidence. Assuming physicians are aware of the actual evidence, recommendations accompanied by weak or insufficient evidence carry less ethical weight for individual physician–patient decisions.

Physicians may also question the process used to create value-based recommendations. For example, some analyses of the *Choosing Wisely* lists created by specialty societies suggest that individual societies are reluctant to single out their own revenue generating services as 'low value'.¹⁸ If physicians perceive value-based recommendations as self-serving, they will question their ethical legitimacy and resist following them.

Finally, HVC efforts may also languish from a lack of patient engagement. The importance of engaging patients in clinical guideline development is already recognised.¹⁹ Engagement is particularly important when decisions compare values (health, financial or otherwise) between individual patients and society.²⁰ Yet, existing efforts at engaging patients in HVC appear mainly aimed at disseminating and translating recommendations created by professional societies to patients.²¹ Procedurally,



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this is significantly different than substantively involving patients *in* defining value itself. Absent robust patient engagement, physicians might doubt HVC's public (ethical) legitimacy and therefore question whether or how it should guide action. Moreover, if patient engagement is necessary for defining value from the outset, then patient engagement is also necessary for determining the content of a recommendation (not just as part of fair processes).

AN ETHICAL TYPOLOGY

These complexities suggest a need for further ethical clarity for physicians to meet their individual obligations to patients and HVC.²² We propose three basic ethical categories to help physicians attain this clarity: obligatory, permissible and suspect.

Obligatory

When the pursuit of value, based on strong and sound evidence, promotes delivering equivalent or greater clinical benefit at lower cost to the patient (or to the patient and society), it is clearly in the patient's best interest and should be seen as *ethically obligatory*. For instance, reducing unnecessary or duplicative services can harm patients (eg, via unnecessary radiation exposure or risks of adverse events) and increases healthcare spending to no good end. The same could be said for choosing less expensive, therapeutically equivalent options, such as generic medications. In these circumstances, increasing value is not merely a 'good idea'. For physicians to fulfil their duties of beneficence and fidelity to patients, they must abide by such value-based recommendations. Failure to do so may be a breach of professional duties.

Permissible

Other HVC recommendations are *ethically permissible*. Consider a recommendation to avoid an expensive cancer drug which provides a short average gain in life expectancy. When care is marginally beneficial, expensive or based on weak or inconsistent evidence but still potentially in a patient's best interest, physicians' fiduciary obligation is not to categorically prevent access to it simply because it is expensive for society. Yet following that recommendation can be ethically permissible. Here physicians' primary obligation is to engage in shared decision making regarding the risks, benefits, costs (patient and societal level) and the patient's values. In these circumstances, the ethics of HVC is determined not by the outcome (ie, whether the drug was prescribed) but by the decision-making process. Notably, the *Choosing Wisely* campaign implies this: its lists intend to motivate conversations, not fully determine outcomes for individuals.¹

Suspect

Occasionally HVC could be *ethically suspect* at the individual physician level. Asking physicians to withhold effective treatments simply because they are expensive or low value for society jeopardises physicians' fiduciary commitments to patients. For example, until drug prices declined, treatments for hepatitis C were considered 'low value' despite their remarkable safety and efficacy (and clinical practice guidelines that recommended treating all patients²³). Asking individual physicians not to prescribe such treatments, when available, would be suspect from the standpoint of physicians' primary ethical commitment.

In other circumstances, a physician's rationale for following value-based recommendations might be suspect. Controlling healthcare costs may be necessary to preserve longer term population health or other socially important goods, such as

education.²⁴ However, encouraging physicians to dissuade individual patients from expensive interventions for the sole purpose of preserving these societal goods may be suspect. When the budgetary processes determining these (re)allocations may be complex, uncertain or unknown, basing decisions on these processes could disrupt physician-patient trust. Restrictions on expensive or low-value interventions may sometimes be necessary and licit. But, individual physicians should not carry that burden alone. Ethics instead requires that physicians participate as collective stakeholders in fair processes that make organisational and/or societal resource allocation decisions, not make them on a case-by-case basis at the bedside.^{10 11}

CONCLUSION

So understood, the ethical case for HVC may be both stronger and weaker than ordinarily assumed. It is stronger because, when ethically obligatory, HVC is more than a good idea; rather, failure to abide by obligatory HVC may breach professionalism. Thus, some *Choosing Wisely* recommendations ought to go further than they presently do. Instead of motivating conversations, those that qualify as ethically obligatory should truly guide, if not determine, action. It is weaker because, when only permissible, adherence to HVC recommendations is not ethically required. In some rare circumstances, HVC may even be suspect for an individual physician.

From the standpoint of ethics, it is not enough to show that following a particular value-based recommendation is good for both patients and society.³ Because individual patients and society can benefit in different ways and to different degrees, only in cases where all ethically relevant factors align should a particular action become obligatory. These factors include, but may not be limited to, the ones presented: that is, attention to the HVC evidence base, the effect on individual patient well-being, the impact of recommendations on population health and costs, and the decision-making processes behind determinations of 'value'. At present, most HVC recommendations would fall in the permissible category. Being merely permissible does not make their pursuit unimportant. It simply suggests that other values rightfully take priority (notably, the individual patient's best interest and values).

This typology also intersects contemporary efforts related to performance measurement, incentives and value-based payments. When following particular HVC recommendations is ethically permissible but not obligatory, overemphasis on HVC metrics as outcomes for individual physician performance measurement or determinants of compensation may be rightly questioned. Emphasis should more properly rest on the physician-patient shared decision-making process related to value, not its outcome. Again, being permissible does not make these recommendations unimportant. It implies that incentives (whether financial, such as performance bonuses, or non-financial, such as praise among peers) should aim largely at encouraging shared decision making. This could encourage practice changes without the attendant risk of introducing bias towards a singular, predetermined outcome into the physician-patient discussion. When physicians correctly believe that a recommendation is permissible, they should resist biased measurement and incentives towards only that outcome.

On the other hand, incentives relating directly to outcomes may be appropriate for following obligatory HVC recommendations. Fortunately or not, data suggest that compliance with certain HVC recommendations (some of which are arguably obligatory) is far from perfect: in some cases, 50% or less.⁸ This means that significant progress could be made towards achieving

reductions in wasteful, unnecessary and potentially harmful care by focusing efforts on these recommendations.

Finally, boundaries between categories may blur²⁵ and the ethically relevant factors delineating them may require further elaboration. Moreover, if the evidence base were to become stronger, or if enhanced patient engagement efforts were to lend additional legitimacy to value trade-offs inherent in HVC decisions, a given recommendation could move between ethical categories. Nevertheless, this typology provides practicing physicians (and students/trainees, who increasingly learn HVC) a starting point for ethical clarity.

As HVC gains momentum internationally, future efforts should organise the increasing number of value-based recommendations into priority lists, where ‘priority’ includes ease of implementation, cost and other features and recognition of ethically salient differences in value-based care. Properly construed, ethics can help HVC achieve value while preserving values of a different sort: the fundamental ethical values of the medical profession.

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