TO THE EDITOR: The Accreditation Council for Graduate Medical Education’s system-based practice competency, discussed in Weinberger’s article (1), is more than teaching quality improvement and being a team player. “... Residents must be able to utilize resources within the system to provide excellent patient care by... demonstrating cost effective resource allocation and prescribing patterns that uphold quality...” (2).

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Potential Conflicts of Interest: None disclosed.

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TO THE EDITOR: Weinberger’s commentary (1) boldly and eloquently advocates for a new competency that would ensure that residents receive formal training and evaluation focused on the avoidance of overuse and misuse of tests and procedures, with an aim of reducing health care costs and improving patient outcomes. Although many stakeholders share the responsibility for building a sustainable health care system, physicians will increasingly be held accountable for practicing on the basis of wise decision making about the tests and procedures they order. The Charter on Medical Professionalism (2), published nearly a decade ago by the American Board of Internal Medicine Foundation, American College of Physicians Foundation, and the European Federation of Internal Medicine—and endorsed by more than 130 organizations—states:

The physician’s professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one’s patients to avoidable harm and expense but also diminishes the resources available for others.

There is growing evidence that reducing unnecessary tests and procedures will not only lower health care costs but will improve patient outcomes. According to research published in a recent issue of Newsweek (3), although advances in medicine have improved outcomes for many patients, many more receive no benefit from these advances and in some cases may have even been harmed because of them. An investigation by Consumer Reports on heart health found that patients were often over-treated with newer and more expensive tests and procedures that did not lead to better outcomes and sometimes resulted in worse outcomes when compared with established and cheaper options (4).

Physicians practicing in an environment that is increasingly focused on reducing costs and improving care will need training to help them make wise decisions about the resources they use. I ap-
plaud Weinberger’s proposed competency for residency training and believe it will help physicians in advancing a sustainable health care system and improving care for all.

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Potential Conflicts of Interest: None disclosed.

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TO THE EDITOR: By proposing “cost-conscious care and the stewardship of resources” as a seventh core competency for training in internal medicine, Weinberger (1) underscores the need to better prepare physicians to reduce overuse or misuse of health care services and contribute to the economic sustainability of health care in the United States. We concur and wish to report lessons learned at one Program of All-Inclusive Care for the Elderly (PACE) site: Hopkins ElderPlus.

Like all PACE programs, Hopkins ElderPlus is a comprehensive health care delivery model designed for patients eligible for nursing-home care who still live in the community despite high morbidity and functional impairments. Operating under full financial risk, these capitated programs use a well-coordinated interdisciplinary team to achieve desirable outcomes while controlling costs. Although the organization of more than 70 programs in 29 states substantially varies (2), the solvency of every PACE program depends on cost-conscious care because each program is responsible for all health care costs of its participants.

As with other PACE sites, our main financial challenge lies with overall hospital costs associated with acute illness. We strive to avoid redundant testing and to smoothly and efficiently transition care to a nonhospital setting.

When a PACE patient is hospitalized, members of the Hopkins ElderPlus interdisciplinary team communicate with hospital physicians in writing through a standardized packet, which includes information that patients cannot usually remember, such as active and recent medications, allergies, plans for life-sustaining treatment, and recent medical assessments. The interdisciplinary team notifies hospital physicians that the care team, including the primary care physician and social worker, wishes to be involved in important patient and family discussions of major procedures or changes in the care plan. It also performs active retrieval of all test information obtained during hospitalization and participates in hospital discharge planning.

These steps have not been subjected to a controlled experiment; rather, they have been developed as a result of continuous, real-time monitoring of patient care and financial outcomes. These efforts have improved efficiency in the coordination of care between the inpatient and outpatient settings, which aligns the goals of improving patient care while controlling costs. Indeed, a valuable and necessary core competency.

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Potential Conflicts of Interest: Ms. Holden and Dr. McNabney are employed by Johns Hopkins University and work primarily for Hopkins ElderPlus (PACE). Dr. Weiss was formerly employed in the same manner. Hopkins ElderPlus is a nonprofit health plan receiving capitated funds from Medicare and Medicaid as well as funds from patients.

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TO THE EDITOR: The proposal by Weinberger (1) for a seventh competency for physicians is deeply flawed. While it is true that “the U.S. economy cannot sustain the staggering economic burden imposed by the current and projected costs of health care,” the key to driving down costs is not “cost-consciousness” but “appropriateness-consciousness.”

It is certainly important—and has always been a part of sound medical practice—for physicians to avoid “unnecessary care that does not benefit patients,” but the imperative to do so is about doing the right thing, not about doing the less expensive thing. It would be important to avoid unnecessary care even if it had no financial cost because all care always comes with some burden or risk for the patient. Even if the burden is light, such as the inconvenience of an office visit during work hours, it cannot be justified if there is no expectation of benefit. In addition, risk is often “invisible,” thus underappreciated, but still real. The “unexpected” (and ultimately meaningless) finding on a “harmless” diagnostic test drives more tests of potentially greater hazard and discomfort, affixes an inappropriate label to a patient, and generates anxiety. Better medicine often costs less, but costing less is not what makes medicine better.

Unfortunately, Weinberger’s proposal also reinforces the false notion that any attempt to reign in inappropriate care is just cost-cutting masquerading as quality improvement, and undercuts the credibility of legitimate and important efforts aimed at improving care. Finally, there is real danger down the path of physicians focusing on goals other than providing the best care for the individual patient in front of them. Such behavior undermines trust and can lead to putting “collective” goals ahead of individual patient needs, a banner under which any number of atrocities have been perpetrated (2).
TO THE EDITOR: I deeply appreciate Weinberger’s point of view (1) on teaching a cost-conscious approach to care. As a generalist, I frequently struggle with uncertainty, balancing my desire for an answer that leaves no doubt with the costs and consequences of excessive diagnostic testing. As an educator, I watch students and residents face the same decisions, and I realize that there are countless opportunities to help them reflect on the costs of their choices. This is a real area of opportunity for medical education that also raises needed questions about professionalism and just allocation of scarce resources.

I’m concerned, however, that the College is missing another opportunity for leadership in this regard. Weinberger focuses on diagnostic testing and hospital readmission, but what about therapeutic choices? For example, the Web page on www.annals.org where I found Weinberger’s abstract contained an advertisement for a new long-acting opiate indicated for “the relief of moderate to severe acute pain in patients 18 years of age or older.” I followed the link (2) and found a chart demonstrating that the new drug was as equally effective as sustained-release oxycodone, which costs 4 times less than the new product (3). I question whether writing a prescription for this new drug would constitute cost-conscious care.

I know that the College does not endorse the use of every product that appears on the Annals Web site, in its journals, or in the exhibit halls of its meetings. However, by accepting funds from advertisers and exhibitors, the College is endorsing the marketing process. The marketing budgets of many medical products are funded by sales, which in turn are paid for by patients and third-party payers. By using advertising revenue to offset the costs of meetings and publications, the College and all of us who use those resources are benefiting from high costs of care. In a small but important way, we have become part of the problem.

It is unrealistic to expect the College to immediately divorce itself from these funding sources. Producing educational materials of the quality of PIER, MKSAP, and the annual Internal Medicine meetings (to name a few) is breathtakingly expensive, and the quality of those products must not suffer. However, this seems like an opportune moment for the College to develop a strategic plan that would lead to a gradual reduction in industry funding of its educational products, with a long-term goal of eliminating it entirely.

Cost-conscious care is not only a competency for trainees, but one with which we all struggle. By demonstrating a leadership role in reducing industry funding of continuing medical education, the College would show a willingness to make difficult choices to reduce costs and would be putting itself in a stronger position from which to advocate for high-value care without apparent conflict of interest.

Potential Conflicts of Interest: None disclosed.

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TO THE EDITOR: Nine years ago, during my third postgraduate year as an internal medicine resident, my attending physician asked me why I had ordered a test. Unsatisfied with my answer, he followed with the question, “Do you know how much that test costs?” I did not know. He then stated, “Well, then you should pay for it.”

At the time I did not know I was being evaluated on the competency of “cost-conscious care and stewardship of resources” recently proposed by Weinberger (1). However, the lesson I learned that day about cost-conscious care—and the mere $100 test—left an indelible mark on my virtual wallet. I never paid for the test, but my patient and the health care system did.

Although I lack the power to deduct the cost of unnecessary tests ordered by residents from their paychecks, I still use the lesson I learned that day to practice and teach cost-conscious care. The reason that the lesson worked is that the attending physician made it personal. If I ordered a test that was unnecessary, then why shouldn’t I pay for it?

Our current health care system does not hold physicians personally accountable for the judicious use of finite resources. In fact, most physicians have never experienced the inability to pay one’s medical bills because they have never lived in poverty. Allopathic medical schools in the United States continue to accept most students from the highest quintile of family income (2). Despite efforts to improve gender and ethnic diversity in medical schools, little has been done to improve the socioeconomic diversity of future physicians.

Because most of us have no personal experience with poverty, and we are not held accountable for ordering unnecessary tests, our ability to effectively teach cost-conscious care to our residents may be limited. Cost-conscious care, unlike the professionalism and communication competencies, is not a “fundamental attribute” of a high-quality physician and thus cannot be adequately implemented as a core competency through role modeling. Focusing on faculty development of this competency will be essential.

Ideally, a poverty curriculum should be started in medical school, which some schools have already developed (3). If we first teach the competency of “cost-conscious care and stewardship of resources” to our medical students and our faculty, and if we also improve the socioeconomic diversity of our medical students, then implementing this new core competency into residency training will be much more effective.

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Potential Conflicts of Interest: None disclosed.

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IN RESPONSE: I appreciate the many thoughtful comments in response to my proposal that cost-consciousness be elevated to the level of a seventh general competency for physicians.

Dr. Pollak appropriately notes, as mentioned in the article, that cost-consciousness currently resides within the general competency of systems-based practice. However, as mentioned by Dr. Graham, Dr. Potyk, and Ms. Raimi, this wording in the training program requirements is very general and does not include sufficient specificity to achieve the intended goal (1). As I argued in my article, the inclusion of cost-consciousness under systems-based practice does not give it sufficient visibility or emphasis, considering the current health care environment and the importance of effecting a substantial reduction in health care costs. I also agree entirely with Dr. Cassel that providing cost-conscious care is part of the professional responsibility of clinicians, as well-stated in her comments and in the professionalism charter (2).

Dr. Graham, Dr. Potyk, and Ms. Raimi additionally stress the importance of addressing other components of the health care system that contribute to high costs, including financial drivers for low-value services, excessive administrative costs, and lack of transparency in pricing of health care services. I agree that price transparency is critical, so that both physicians and patients understand the costs of the services they are either ordering or receiving. Only with such information can all health care stakeholders assess the true value of a service, defined as its benefit relative to its harm, risk, and cost. The PACE model described by Dr. Weiss, Ms. Holden, and Dr. McNabney nicely illustrates how a multifaceted approach can address some of the other issues that contribute to the high cost of care in a specific population of patients.

In response to Dr. Nash’s comment, I agree that our primary goal is improving quality of care through “doing the right thing,” not just reducing costs. However, I would argue that “cost-consciousness” and “appropriateness-consciousness” can be viewed as different ways of describing a largely similar effort. Inappropriate care certainly represents a major, if not the primary, component of the estimated one third of health care costs that are wasted and do not improve patient care. But focusing purely on quality and on the appropriateness of care does not eliminate the need to understand costs because physicians and other providers of health care must often choose between comparably appropriate options for care that differ substantially in their cost. I would also stress that an emphasis on cost-consciousness in the training environment should not put “collective goals ahead of individual patient needs,” but should link the goals of best care for each patient with the societal need to rein in the ever-escalating cost of health care.

Dr. Knight raises an important issue about industry funding and its potential impact on continuing medical education and cost-conscious care. It is indeed essential that there be a strong firewall between revenues that a medical society obtains from industry (for example, through advertising or exhibits) and the development of any educational content or clinical recommendations or guidelines produced by the society. That principle is sacrosanct at the American College of Physicians, which has a strict policy about relationships with industry that assures not only full disclosure of all commercial support but also absence of any industry influence on educational or clinical content developed by the College.

Finally, Dr. Wallace describes the interrelationships among limited societal resources, limited resources of poor patients, and the need for greater socioeconomic diversity among physicians, as well as an understanding of the effect of poverty. The anecdote he provided, where it was suggested that he pay for an unnecessary test, demonstrates how there may be creative ways to get the attention of residents and change the culture about cost-conscious care in the training environment.

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Potential Conflicts of Interest: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M11-1081.

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Correction: Whole-Body Vibration

On page 669 in the first full paragraph, a recent article (1) contained an error. The second sentence of that paragraph should read: “Most of these RCTs had sample sizes of less than 100 (6, 12, 13, 14, 15, 16) and 6 to 8 months of follow-up (5, 6, 12, 15, 16), and only 2 provided calcium and vitamin D supplements (5, 15).” This has been corrected in the online version.

Reference
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