Cost Discussions Seldom Occur at Office Visits

Physicians talked about cost or insurance for just 12% of the 243 prescriptions issued to 185 patients.

BY PATRICE WENDLING
Chicago Bureau

TUCSON, ARIZ. — Physicians and their patients seldom discuss new medication costs and other acquisition issues, Dr. Derjung Mimi Tarn and associates reported in a poster presentation at the annual meeting of the North American Primary Care Research Group.

The investigators audiotaped the clinic visits of 185 patients who were receiving 243 new medication prescriptions and found that discussions about cost occurred in only 28 of the encounters. Patients rarely initiated conversations about cost, doing so for only four new prescriptions.

Physicians talked about cost or insurance for 12% of the 243 prescriptions, mentioned whether the medication was generic or brand name for only 2% of the prescriptions, talked about how to obtain the medication for 19%, about how long the supply would last for 9%, and about refills for 5%.

The analysis was based on the taped clinic visits that were conducted in 1999 at the University of California's Davis Medical Group and Kaiser Permanente, both in Sacramento, Calif., as part of the Physician Patient Communication Project. The project included 15 family physicians, 18 internists, and 11 cardiologists. The patients' mean age was 55 years, 83% were Caucasian, and more than 75% paid less than half of prescription drug costs. Overall, 31% were seen by family physicians, 47% by internists, and 23% by cardiologists (percentages do not total 100 because of rounding).

As patient age increased, the chances of physicians discussing cost decreased, according to a multivariate analysis that adjusted for medication class, over-the-counter and as-needed medication status, patient gender and race, prescription drug coverage, number of continued medications, and number of new medications prescribed. One possible explanation for that finding may be that time constraints and multiple health concerns were a factor, Dr. Tarn said in an interview.

Patients with a yearly income of less than $20,000 had significantly more conversations about medication costs than did those with an annual income of $40,000-$60,000 (odds ratio 8.27 vs. 0.29, respectively).

Family physicians (OR 0.003) and internal medicine physicians (OR 0.02) were less likely to discuss cost than were cardiologists. Cardiologists may encounter more patients with chronic conditions and thus are more aware of cost issues, or perhaps in this setting, they were prescribing more brand name or expensive medications and have had more problems with insurers not covering these drugs, said Dr. Tarn, department of family medicine, David Geffen School of Medicine, University of California, Los Angeles.

The results don't necessarily mean that primary care physicians are really doing that much worse, as the study did not evaluate previous interactions. It may be that primary care physicians have been seeing these patients for years, have a much closer relationship, and have had these types of discussions with their patients in previous visits, she said.

Other study results have also shown that physicians and patients seldom discuss cost because they are uncomfortable about raising the subject. However, both parties need to be more aware of the issue, because high medication costs are strongly associated with medication underutilization and noncompliance, she said.

"Patients really shouldn't be scared to ask if there are cost issues" or to ask if it's the cheapest medication available, Dr. Tarn said. "On the flip side, previous studies have shown that doctors aren't very good at recognizing whether patients are having trouble with costs. A simple exchange can bring out a lot of concerns with patients." ■

Physicians Split Over Ethics of Accepting Sample Medications

BY PATRICE WENDLING
Chicago Bureau

TUCSON, ARIZ. — Physicians are divided over whether it is ethical to use free sample medications in their primary care practices, Nancy Sohler, Ph.D., and Dr. Diane McKee reported at the annual meeting of the North American Primary Care Research Group.

Accepting samples was viewed either as being ethically questionable or as a useful way of helping provide health care to low-income patients, according to findings from a study of 24 family medicine and general internal medicine physicians, nurses, and administrators in practices affiliated with a large urban medical center serving low- and middle-income patients in New York.

For physicians who drew an ethical line, 'it wasn't that they thought giving out samples [to patients] was unethical, but that it wasn't good practice.'

Interactions with pharmaceutical representatives were viewed as a direct conflict of interest, an influence that could be controlled, or a source of useful information that helped keep the practice up to date on new medications. Of the total, 10 respondents felt that they could control the influence of drug firm representatives by keeping them away from residents, by setting limits on what gifts or favors could be accepted, or by always being mindful that representatives are selling a product, Dr. Sohler said in an interview.

For the respondents who drew a hard ethical line, "it wasn't that they thought giving out samples [to patients] was unethical, but that it wasn't good practice," she said. "They understood why others did it, but they worried about conflicts of interest with their interactions with the reps."

Those who accepted samples said inadequacies in the health care system forced them to rely on gifts to care for their most needy patients.

All the respondents evaluated marketing practices from the perspective of protecting and serving their patients, said Dr. Sohler, professor of community health and social medicine, City University of New York, New York. No one was concerned that physicians were ignoring clinical symptoms to prescribe the "right drugs."

The study included in-depth, qualitative interviews and was prompted by an administrative decision at the medical center to ban samples and pharmaceutical representatives from the community practices. That decision left many providers uncertain about how to care for patients without adequate health care coverage. Others suggested that the policy was changed because the administration didn't want physicians taking the time to talk to sales representatives, didn't trust that staff would avoid entering into agreements with pharmaceutical firms, and did want a single policy, because teaching sites had a "no-rep" policy and other sites didn't need samples.

Dr. Sohler said further study would be needed to determine whether samples help poor patients more than they harm them, and whether representatives influence prescribing practices in mostly helpful or harmful ways.

"The empirical, quantitative evidence isn't good on whether free medications help or harm our patients," Dr. Sohler said. "We realize that all marketing has an influence, but we don't know if it harms our patients.

"People are drawing on their different values and perspectives to make a decision. We need hard evidence to make a policy, but in the meantime, we should keep these perspectives in mind as the data come in." ■

Beware of Liability Pitfalls Of Electronic Health Records

BY NELLIE BRISTOL
Contributing Writer

WASHINGTON — From a liability perspective, health information technology remains a double-edged sword whose parameters still need to be spelled out, experts said at a meeting sponsored by eHealth Initiative and Bridges to Excellence.

"It's going to provide protection in some places and increase liability in others," said attorney Marcy Wilder, a partner with Hogan & Hartson.

When it comes to electronic clinical decision support (CDS) tools, Jud DeLoss, vice chair of the HIT Practice Group at the American Health Lawyers Association, recommended that physicians document their reasoning when they disregard the tool's suggestion.

Although it would be "difficult to pull off," attorneys could create a class of victims for whom they argue that clinical decision support was not followed, leading to detrimental results, he said. Conversely, attorneys could charge that a physician overly relied on the tool "and did not actually engage in the care they said they did."

Ms. Wilder pointed out another gray area created by HIT: delineating who contributed what sections to a patient's electronic health record.

"Look at the paper system," Ms. Wilder said. "We have handwriting and signatures, which are simple tools to identify who's responsible for which clinical applications, which provider made the diagnosis, who authorized the medication change. It is both easier and more difficult to do that with electronic health records."

The simplicity and efficacy of identity authentication "is going to depend upon the extent to which the vendors that are building the systems get this right," she added.

Although systems are in place to address identity authentication in health care institutions, problems may arise when data from shared information warehouses such as a regional health information organization are incorporated into an electronic medical record, Ms. Wilder said.

"That's where it's going to be very messy, and I think it will be a long time before we are going to be using shared data warehouses in part because of those kinds of liability issues," she said.

Physicians also are concerned about the validity of the portion of an electronic medical record that they did not make. Mr. DeLoss said the concern is, "I'm not jumping into bed, so to speak, with someone who has a pending malpractice and by signing onto this system thereby becoming a defendant in this case."

Mr. DeLoss and Ms. Wilder added that as use of electronic medical records becomes more prevalent, physicians may have a duty to be familiar with a patient's entire medical record if it is available. They also recommended that physicians spell out with hospitals via contracts which party is liable for problems that arise from software donated to them by hospitals. ■

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