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My opinion

In medicine, patientsâ€™ consent for their medical management has evolved as a core ethical principle. One question arises: How responsibly do the patients give consent for their medical management [1-2]? Then the question comes: How can the patients responsibly give consent when they are not fully aware of what costs they are bearing for their medical management until much later after the delivery of their healthcare when they get to know what their dues are and what their medical debts have become [3]? When the third party payers took over, our healthcare management had become a joyride and peace of mind for all of us until now because, just like when families eventually reach their limits and are forced to appropriate their expenditures, the third party payers are already getting on to their edges while pushing their limits to absorb the exorbitantly increasing healthcare expenditures [4-5]. It is understandable that when the core necessity for life is food, the rising healthcare expenditure may be alternatively called the booming healthcare business creating lots of jobs putting food on lots of plates. However, when considering from patientsâ€™ individualistic points-of-view, it is important to recognize that the time has come when the patients should be made aware of the costs of whatever they are consenting to and whatever their consented medical management may evolve into depending on the multiple factors including the iatrogenic factors. Thereafter, the consenting process will become more responsible and accountable. One never knows whether the utopic future of contained healthcare expenditure debts without curtailing healthcare business jobs may dawn when the regulatory power falls upon the patientsâ€™ shoulders and thus lies within their hands wherein they restart learning after all to responsibly consent for their medical management taking into account not only their own socioeconomic limits and their third party payersâ€™ socioeconomic limits but also their societiesâ€™ socioeconomic limits.

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The questions will continue to linger: What is the healthcare cost of patientsâ€™ consents for their medical management to their cost-bearing third party payers? Is separation of consenting party and paying party costing healthcare costs and raising them inadvertently? Who pays for human errors? Who covers the healthcare costs for patientsâ€™ mortality and morbidity [6-10]? What happens to the cost-bearing (or cost-sharing) when patientsâ€™ mortality and morbidity is iatrogenic? Do facilities automatically bear the costs of complications? Or do the third party payers bear the costs of complications? Or do the patients (and their kin in case of patientsâ€™ mortality) bear the costs of complications? What happens if the burden of costs is added to the consenting processes during the decision-making by the patientsâ€™ for their emergency medical management wherein time is the essence even though costs do not lose their essence eventually and completely? Will allowing exceptionsâ€™ rules for emergently consented patient-physician interactions or physician-ordered tests/procedures/prescriptions may instigate slippery slope for inducting exceptionsâ€™ rules in unclear and ill-defined emergencies to eventually revival of currently followed expectations of systems to not even share costsâ€™ data before the consenting processes for elective patient-physician interactions or physician-ordered tests/procedures/prescriptions despite asking for pre-authorizations from the third party payers for the same or similar patient-physician interactions or physician-ordered tests/procedures/prescriptions? Will it be too burdensome as well as cumbersome for the modern digitalized world to generate daily updates of cumulative costs which the patients and their third party payers are incurring during the patientsâ€™ stay in the healthcare facilities? Will these costsâ€™ information become too-much-information overwhelming the patients if they are regularly made aware of the daily costs incurred during their stay in the healthcare facilities? Will personal costs incurred coerce patients against their personal healthcare? Donâ€™t the societal costs coerce societies taking actions against costly healthcare? Isnâ€™t it all about the swinging pendulum aiming at elusive equilibrium wherein the societies initially thought that it was good to take over the cost-bearing responsibilities in order to shield the patients from the costs incurred during their healthcare but eventually the times are forcing them to reconsider and revisit sharing and delegating the economic responsibilities regarding patientsâ€™ healthcare back to the patients themselves so that they can collectively discuss and decide based on what the total costs are and how far they can bear those costs as responsible teams? In a nut-shell, there

will always be ever-lingering questions but that should not deter the bottom line. Â Â Â

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The bottom line should be that the patients should always be told the total costs of the consented patient-physician interactions or physician-ordered tests/procedures/prescriptions. The patients must then presume that X-amounts may be paid on behalf of them by their third party payers while they themselves will have to pay (co-pay) Y-amounts; Z-amounts from the total cost may be forgiven by the facilities/physicians depending on their negotiations with them or their third party payers. Essentially, even though the total costs (X+Y+Z) for the consented patient-physician interactions or physician-ordered tests/procedures/prescriptions may be pre-determined and pre-fixed, the individual components (X, Y, Z) may vary secondary to almost always bilateral negotiations among the three parties (patients, their healthcare facilities/physicians and their third party payers) superseding almost non-existent multilateral negotiations. Some patients may say that this disclosure of costs may coerce them while making their healthcare decisions while some patients may say that this disclosure of costs may make their healthcare decisions more responsible.

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Summarily, healthcare has been, is and will always be self-paid [11-12]. When the patients consent after considering all the costs even when the consenting patients are not the primary healthcare cost-bearing entities, the patients are realizing that even though their third party payers are the primary cost-bearing entities, the patients themselves as integral constituents of their societies are the cost-bearing entities eventually and thus responsible for appropriate appropriations of their healthcare expenditures not only individually as responsible patients but also collectively as responsible societies.

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