can apply for help' . . . and I got help!" One has to wonder whether an earlier discussion of out-of-pocket costs might have prevented the patient from losing her home.

Fourth, a growing body of evidence suggests that including consideration of costs in clinical decision making might reduce costs for patients and society in the long term.

Although we believe that physicians should discuss out-of-pocket costs with their patients, we recognize that such discussions will not always be easy. As previously acknowledged, it is often difficult to determine a patient's out-of-pocket costs for any given intervention. Efforts are under way to address this informational barrier: insurance companies are developing technologies to better estimate patients' costs, and several states have passed price-transparency legislation. But these efforts are imperfect and incomplete, so for now, physicians and patients will often have a difficult time estimating cost differentials between viable treatment options. In addition, patients and physicians face social barriers to discussing costs of care. No doubt, many doctors and patients find discussions of money uncomfortable; they have not been coached in ways of having the conversation. Patients worry that asking about costs will put them at odds with their doctors or result in subpar treatment. And some physicians believe that their duty is to provide the best medical care regardless of cost.

We believe that given the distress created by out-of-pocket costs, it is well within physicians' traditional duties to discuss such matters with our patients. Admittedly, out-of-pocket costs are difficult to predict, but so are many medical outcomes that are nevertheless included in clinical discussions. Policymakers need to continue the push for greater transparency in medical costs, especially those borne by patients. Health care stakeholders should advocate for high-value care that reduces cost while improving outcomes. But that change will not occur overnight, and in the meantime, patients will continue to suffer from treatment-related financial burden. Physicians should discuss what is known about these costs with our patients, so that the personal financial impact of medical care is incorporated into the selection of the best care for any given patient, in the same way that any other potential toxic effect is considered. We can no longer afford to divorce costs from our discussion of patients' treatment alternatives.

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The Thousand-Dollar Pap Smear

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The first time a patient called me to say that she'd been billed more than $600 for her Pap smear, I was sure it was a mistake. The second time, I was less sure, and these days I am no longer surprised to find laboratory charges of $1,000 or more for a test that until recently cost only $20 or $30.

Cervical-cancer screening is one of the 20th century's true public health successes. The incidence of a disease that once caused more deaths among American women than any other form of cancer has decreased dramatically since the introduction of routine Pap smears in the 1970s. In the modern era, most deaths due to cervical cancer occur among women who have never been screened or who have gone decades without screening. One of the main factors in helping to conquer this once-dreaded disease has been the availability of a cheap, effective screening test that can detect disease early, while it's still very treatable. Yet increasingly, in my roles as the chief medical officer of a community health center and as a family

doctor seeing patients in that system, I hear from women who are choosing to skip their screenings because of skyrocketing costs.

Concerned about the astronomical bills that are overwhelming patients, I looked into how these fees are calculated and how we arrived at a system in which a cheap screening test whose cost-effectiveness assumes a price of $20 to $30 could become a four-figure budget item. What I found reveals much about the current operations of the U.S. health care system and the challenges that will need to be overcome if we are ever to reduce our health care costs.

It turns out that the high-ticket screening tests contain multiple items: the Pap test itself, usually in the form of a new liquid-based test rather than the older (and cheaper) slide test; a human papillomavirus (HPV) test, which is recommended only for women 30 to 64 years of age and only once every 5 years; tests for sexually transmitted diseases (recommended routinely only for women 15 to 25 years of age and those with symptoms suggestive of an infection); and sophisticated laboratory tests for a variety of yeasts, the presence or absence of which was once assessed by the physician looking at a slide under a microscope. So how do all these tests come to be ordered for healthy women who come in only for an annual gynecology exam? The answer is that someone, whether the physician or nurse practitioner or the medical assistant processing the specimen, checked off all those boxes on the order form.

When I was in training, our attendings would ask a standard quiz question: "What is the biggest driver of health care costs in the hospital?" Answer: the physician's pen. A mouse or a keyboard, rather than a pen, now drives the spending, but we physicians and our staff are responsible for ordering these unnecessary tests and hence responsible for the huge bills our patients are receiving.

Yet we are not doing this alone. Laboratories have learned that one easy way to increase revenue is to make it easy for clinicians to order more tests. In the past year, I have been visited by multiple laboratory representatives touting "improved" tests, virtually all of which involve combination panels that can be easily ordered and that contain extensive lists of fairly esoteric tests. The single-vial women's health test is being heavily marketed by multiple laboratories. It includes not only the Pap and HPV tests but also tests for multiple infections — including some we would rarely have tested for in the past — for which we often have no evidence of benefit. Costly tests that once would have required physicians to submit multiple collection vials and specimens can now be ordered with the Pap smear simply by clicking a single box in the electronic medical record. Nothing at any point along the way alerts either the clinician or the patient to the high costs of these tests or to the fact that there is little medical evidence to suggest that they are useful for most patients. It seems harmless, even possibly beneficial, to run these additional tests, and for our staff, it eliminates the risk of missing a test the doctor might have wanted to have run. The risk it poses, though — the one I face when a patient calls about a crippling bill — is that more and more women may choose not to undergo screening, afraid of the financial consequences.

The final step in creating these astronomical bills for women without health insurance is that some laboratories charge uninsured women vastly inflated amounts, while offering insurers steep discounts from these "usual fees." Although some laboratories offer discounts to uninsured patients, others do not, leading to the phenomenon well documented in other areas of medicine in which the uninsured pay premium rates, often having to set up multiyear payment plans for services for which a health maintenance organization would have paid a fraction of the charges.

As health care costs grow and laboratories develop savvy marketing tactics resembling those deployed by pharmaceutical companies, it is becoming increasingly clear that physicians have an obligation to be good stewards of limited resources and to understand the financial effects that the orders we write have on our patients. We need to teach medical students and residents to see this as an important aspect of their responsibility to their patients. Furthermore, we need to advocate for a system in which information about the cost and benefit of diagnostic tests is readily available to patients and providers at the point of care. If we fail to do so, we risk not only our patients' pocketbooks but also the gains we have made against cervical cancer and many other conditions. We contribute to spiraling health care costs and are doing real harm.

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