"Doctor, I Can't Afford That!"

Humanism, Cost, and the Prescribing Encounter | Module #1

Faculty Reading Guide *to accompany the book "Rethinking Medications."*
Prepared by Nora Jones, PhD, and Jerry Avorn, MD.

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Small group with faculty facilitator, or self-directed
Suggested time: up to 60 minutes

Faculty Guide Note: *This document combines the student-facing reading guide along with faculty facilitation notes. Student-facing content appears in regular text, and faculty notes appear in italics within gray boxes. Faculty notes should not be shared with students in advance.*

The medicine rotation scenario in the opening is drawn from an actual clinical education experience. It is presented without resolution to generate discussion, not to assign blame. Faculty should present it neutrally and resist signaling the "correct" answer before the students have grappled with the case.

Students should read pages 57-60 and Chapter 15 of "Rethinking Medications" prior to the session.

Our case: Ms. Susan Brown, 42

This case is written with an urban/suburban clinical setting in mind. Facilitators in other settings — rural, safety-net, VA, etc. — can adapt specifics such as the pharmacy look-up exercise, the employment context, the insurance mechanics to match what their students are most likely to encounter. What should stay constant is the core arc from autonomy to agency, the framing concerning coverage, and the affordability conversation toolkit. The setting-specific texture can be swapped out while retaining the underlying lesson.

A fourth-year medical student is troubled by something she hears on her in-patient medicine rotation. During rounds, the team had been caring for Susan Brown, a patient with Crohn's Disease; she had been admitted for intractable abdominal pain and diarrhea. The attending physician recommended restarting the biologic Humira (adalimumab) that a gastroenterologist had prescribed for her several months earlier. It is an effective and well-studied first-line medication for her condition though it is costly: Its list price is about $8,000 per month, though patients with health insurance pay less.

The student had spent time with Ms. Brown the day before. She knew that the patient was temporarily employed as a cleaning lady for a janitorial services company, with an unpredictable schedule. She had learned, almost in passing, that the patient had stopped her medication, not because it hadn't worked — it reduced her symptoms markedly — but because she couldn't reliably keep affording and taking it. That gap likely helped to explain why she was back in the hospital now.

The student wondered whether a different, more affordable medication might be a better choice for her situation.

The attending physician's response was measured but clear: "I have been using Humira for years and know how effective it is. We shouldn't compromise our clinical standards because of a patient's circumstances. Our job is to prescribe the best medicine."

The student didn't say anything at the time, but she couldn't stop thinking about it.

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Was the attending right?

Don't answer that question yet — we'll come back to it.

Note: throughout the rest of this case you are Ms. Brown's primary care doctor. She comes to your clinic for a post-discharge follow-up.

You have reviewed Ms. Brown's refill record at the pharmacy and found that prior to her hospital admission, she had filled her monthly prescription for Humira only three times over the past 6 months, instead of all six. You ask her how she's been doing with her medication.

She pauses, and then replies, "I take it when I remember."

Discussion Question 1

What would you do next? What are you thinking, and what do you say to Ms. Brown?

Take five minutes to write down, in the actual words you would use, your response.

Then share with the group.

Faculty Guide: *This first question is intentionally open. Students will likely cluster into a few camps: those who immediately take the clinical perspective ("I need to counsel them on adherence"), those who start with the relational aspects of her care ("I want to understand what's getting in the way"), and those whose initial approach is somewhere in between. Note which instinct dominates — it's useful information for the discussion ahead.*

Don't intervene yet. The goal is to hear the students' default responses before introducing any new framework. If there is little reaction, prompt: "What's the first thing that comes to mind?" rather than "What's the right answer?"
Pay particular attention to whether anyone asks about cost or logistics unprompted. If not, notice that such an absence is itself a teaching moment.

One dynamic worth anticipating: students will tend to speak in generalities. "I would make sure she felt heard" is not the same as "Ms. Brown, I'm really glad you told me that — can we figure this out together?" If responses stay abstract, redirect them with a single constraint: "Can you give me the first sentence of what you'd say?" That almost always breaks the abstraction and helps get to the real skills.

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Reveal 1

Ms. Brown's answer to your first question didn't give you much to go on, so you decide to try a different kind of question: "How has it been getting and taking this medication regularly?"

There's a pause — longer than you'd expect. Then:

"Honestly, doctor? It's the cost. My insurance covers part of it but my deductible resets every January. For the first few months of the year I have to pay hundreds of dollars for it. Even after the deductible period ends, my co-pay every month is often more than I can handle. I have a mortgage, two kids in college. Some months I just have to stretch it. And if I get laid off, I'll lose my health insurance."

She looks slightly embarrassed and adds: "I didn't think that was something you could help with."

Discussion Question 2

Did anything about Mrs. Brown's answer surprise you? Looking back at your response to Discussion Question 1 — did you ask about cost or logistics? If not, what did you ask about, and what does that tell you?

What do you say next? What would you ask about to move this encounter forward?

Again — write down the actual words, not a description of them.

A note on time: You may be thinking: I don't have time for this kind of conversation. But research suggests otherwise. When patients are left to tell their story without interruption, they finish in about two minutes on average — yet studies show doctors interrupt within 11 seconds, often assuming they already know what the patient needs (Singh Ospina et al., Journal of General Internal Medicine, 2018). The two minutes you think you don't have may be exactly what this encounter requires.

Faculty Guide: *The line "I didn't think it was something you could help with" is the emotional center of this module. Let it land before moving on.*

Students who didn't ask about cost or logistics in Discussion Question 1 should be invited to reflect on why - without shame. Clinical training often orients us toward considering biological and behavioral aspects over the more social aspects of care. Logistical barriers such as cost, pharmacy access, transportation, work schedules, and the structural realities of getting a medication before even taking it are as clinically relevant as biological ones.

This is the moment to introduce the 'ALICE' framework explicitly. The patient is employed, insured, and still falling through the cracks: she is what researchers call an ALICE patient: Asset Limited, Income Constrained, Employed. These are people who live above the poverty line and above the threshold for most assistance programs, but below the actual cost of managing their health. They are far more common in clinical practice than students typically expect, and naming the framework here disrupts the tendency to associate affordability problems with a narrower or more stereotyped patient population.

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Faculty Guide: *The time objection will likely come up. The note in the student-facing text gives you an opening to ask students if they have seen non-adherence lead to additional visits, complications, or emergency care. The time "saved" by not having the cost conversation at that point rarely stays saved, particularly when viewed from the perspective of the total experience of the patient or of the health care system as a whole.*

Watch again for generalities in Discussion Question 2. The move from "I would explore what's getting in the way" to "Ms. Brown, I'm really glad you told me that — can we figure this out together?" is where the skill lives. If students stay abstract, use the same redirect: "Can you give me the first sentence?"

Reveal 2

Mrs. Brown is looking at you. She seems relieved just to have said something out loud.

You have four options for Ms. Brown:

Option A: Switch to an older medication that's more affordable, but is not the recommended standard of care.

Option B: Keep her on Humira and try to help her navigate the cost gap through a manufacturer's patient assistance program. You look it up. She doesn't qualify — her modest income puts her just above the eligibility threshold.

Option C: Try and find whether a less costly version of Humira is available – a biosimilar version of adalimumab – which insurers would pay for which product, what the co-pay would cost your patient, how her coverage might be changed.

Option D: Say to the patient, "I'm sorry you can't afford the medication we're prescribing for you, and I know that's not your fault. But all I can do as your doctor is recommend the most appropriate drug I can; that's what I've been trained to do. I don't have the skills or the time to try and fix these economic problems."

You tell her you're glad she said something — that this is exactly the kind of thing you need to know to take good care of her. You say: "Let's look at this together now."

She nods.

You pull up CostPlusDrugs.com on your computer. You type in Humira; in under a minute you can see that a biosimilar version of adalimumab is available at a fraction of the list price, even if she loses her health insurance. You turn the screen toward her.

Her expression shifts.

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A two-minute exercise — Do this now:

Pull out your phone. Go to to CostPlusDrugs.com. Look up the prices for Humira biosimilars, and compare them with the list price of brand-name Humira. Note the price range.

What did you find? Does anything surprise you?

You write the new prescription together and ask Ms. Brown to come back in three months.

Before she leaves, you ask one more question:

"Is there anything else about your medications or about your care that you've been managing on your own because you didn't think I could help?"

She thinks for a moment. Then she says softly, "It's just that a lot of the time I don't think I have the strength to go on. Things have really started getting the best of me." This possibility of untreated major depression is beyond the scope of this module. But her response illustrates that once you've opened the door to this kind of humanistic communication it tends to stay open, and your patients can benefit from that.

Discussion Question 3

What just happened in this encounter — and what made it possible?

Reflect individually for two minutes, then discuss:

What did the doctor do differently from the default clinical encounter?

What did it require — in terms of knowledge, skill, and disposition?

What do you think Ms. Brown will remember about this visit?

What do you think you will remember about it, when you are five years into practice?

And finally: Go back to the opening story. The attending said, "We shouldn't compromise our clinical standards because of a patient's circumstances; our job is to prescribe the best medicine." Having worked through this case — how do you think about that statement now?

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Faculty Guide: *Possible threads to pull on:*

Note that the option of a manufacturer's assistance program fails here for two reasons: her income is just above the threshold, and her plan's benefit design wouldn't let manufacturer funds count toward meeting her annual deductible even if she qualified. Students who reach for manufacturer's assistance programs as the automatic solution to affordability problems should be invited to consider this; the same applies to the solution of "get her onto Medicaid," especially at a time of sharp cutbacks in that program. The systems designed to help Ms. Brown don't reach her; recognizing that structural problem is part of humanistic practice.

The return to the opening hook should land differently now. Students should resist declaring the attending simply wrong — the team didn't, in the end, compromise on the medication at all; considerable evidence documents that the biosimilar is clinically equivalent. What the attending was missing wasn't a willingness to use a lesser drug; it was the assumption that switching to a less expensive option would be the end of the affordability conversation. It wasn't. Prescribing a medication that isn't reliably taken because of a patient's insurance plan status is not clinically excellent care, regardless of how effective or affordable the drug looks on paper. Clinical standards, fully understood, include whether the patient can actually act on the prescription month after month.

A related question worth raising, if it doesn't come up on its own: Why did the attending recommend Humira by name in the first place, rather than the biosimilar version of the same biologic adalimumab? There's no clinical reason to prefer one over the other — they are equivalent in efficacy and safety. The answer may be habit: Biosimilar versions of this drug have existed only since 2023, after years of patent-related delay that prevented Humira biosimilars from coming market (see the Go Deeper reading, pp. 204–205). A clinician who has prescribed Humira by name for years may reach for that name reflexively, without pausing to ask whether it's still the best way to get the same medical result. This isn't a story about a doctor making a bad clinical call — it's a story about how unexamined defaults, not malice or even conscious cost-blindness, are often what stand between a patient and the more affordable, equally good option. It connects directly to Chapter 14's discussion of how industry messaging shapes prescribing habits, including the pull toward brand names.

The CostPlusDrugs exercise is worth doing even if it feels disruptive to the flow, because learning how to use such tools fluently in exam settings is a clinical skill. It can take under two minutes and it signals to patients that their financial reality is part of your clinical picture, and seeing the price difference directly on a screen is more powerful than being told about it.

The gesture of turning the screen toward Ms. Brown is worth naming if it doesn't come up organically. It's a small physical act that shifts the dynamic from "I will manage this for you" to "Let's look at this together." Ask students what the gesture communicated. What would it have communicated to keep the screen facing you?

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Closing Reflection

Take five minutes to write individually before discussing with the group.

The attending in the opening story wasn't wrong that his job is to prescribe the best medicine. He was just working with an incomplete definition of "best."

How would you complete that definition? In one or two sentences, write down what "the best medicine" means to you now, having worked through this case.

For the Long Run

Medical training is long, and the habits and instincts you are forming now will shape how you practice for decades. Research on physician behavior suggests that the dispositions formed early, including whether cost, logistics, and the patient's experience are part of the clinical picture, tend to be durable.

What do you want to make sure you don't lose? And what if anything do you want to start practicing now, before it happens for the first time in an exam room?

Faculty Guide: *The first question asks students to do something constructive with the attending's position rather than simply reject it. The goal is not to produce the "right" definition of best medical practice but to explore students' range of possible definitions, and to notice whether humanistic considerations appear naturally or have to be prompted.*

The second question is the one that we hope will stay with them longest. It names directly what medicine can often do to the humanism instincts students bring into training. Invite students to be specific: not "I want to stay compassionate" but "I want to keep asking how the patient has been getting and taking the medication." Specificity is what makes an intention into a practice.

If time allows, close by asking the group to share one phrase from the toolkit they intend to use before the end of their next clinical rotation. Making a public small commitment is more predictive of follow-through than private intention. It also ends the session on a forward-looking note about what they are now equipped to do.

Faculty should direct students to the following sections of "Rethinking Medications":

- *Appendix A: Resources for Consumers (pages 424-428). It was written for patients navigating the real-world challenges of accessing and affording their medications. Consider bookmarking it as a clinical resource, along with www.alosahealth.org/clinical-topics/biosimilars/*
- *Pages 204-205, on how the Humira brand of adalimumab remained protected by patents and very costly for so many years after its original patients would normally have expired.*
- *Chapter 11, on why Americans pay twice what citizens of other wealthy countries pay for the same medications.*
- *Chapter 15, on specific policy proposals to make medications more affordable.*