

Virtual Mentor

American Medical Association Journal of Ethics
November 2008, Volume 10, Number 11: 750-755.

MEDICINE AND SOCIETY

Patients Are Hardly Too Thin or Too Rich: Doctors' Preventive Medicine Duties

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Dorothy Parker, a 20th-century humorist, once famously quipped, “You can never be too thin or too rich.” Her comment comes to me occasionally as I care for patients at a publicly funded, inner-city clinic in San Antonio, Texas—one of the poorest, most obese cities in the country. All my patients are poor, and most suffer obesity-related diseases—especially diabetes, hypertension, and osteoarthritis. One patient I care for is a middle-aged woman with uncontrolled diabetes who is overweight. She recently quit her house-cleaning jobs due to painful foot neuropathies and now lives on her husband’s small Social Security check. Another patient is an intermittently employed used-car salesman who weighs 400 pounds, eats a steady diet of fast foods, and has hypertension. A third patient is a cook who is morbidly obese and has painful, unstable osteoarthritic knees that limit her ability to work. She wants bariatric surgery but cannot afford it.

Obesity and poverty are notoriously intractable problems that often cause doctors and patients to despair. Nonetheless, I find myself spending considerable practice time encouraging patients to lose weight and suggesting how they might get the most health benefit from limited personal finances. Like most doctors I consider weight-loss counseling an important professional duty [1]. Yet many colleagues might not agree with me that counseling about medical finances is also a professional duty. To support that view I rely on the concept of health promotion.

What Is Health Promotion?

Medicine’s purpose throughout history has been to treat established disease (identifiable somatic dysfunction) and illness (a patient’s experience of symptoms). Treatment has long sought to correct functional disability, relieve suffering, and prevent premature death [2-3]. But recent advances in public health have expanded medicine’s purpose to include using preventives and enhancements to promote health even before disease or illness arises. I contrast the two kinds of interventions here and conclude that preventives, but not enhancements, impose valid professional duties on doctors. Then I argue that medical-finances counseling, like weight-loss counseling, is a preventive, not an enhancement. Both types of counseling are professional duties. Thus, I urge doctors to address the medical-finances problems of patients as an essential part of care.

Preventives

Preventives are measures taken to preserve some physical or mental condition considered healthful or “normal.” Examples include sunscreens, influenza vaccine, and postmenopausal calcium and vitamin D supplements. Preventives succeed to the extent that the unwanted diseases or illnesses do not occur. Medical science documents the success of preventives across populations, but patients’ understanding of how well preventives work is often incomplete or inaccurate. Patients know that the zoster vaccine succeeds when they do not incur zoster symptoms and that birth control pills succeed as long as pregnancy does not occur. Yet a doctor may need to help patients understand correctly the success of other preventives with less-obvious aims, such as compression stockings for preventing deep-venous thromboses in legs, or cardiac defibrillators for preventing specific life-threatening arrhythmias.

A doctor may also need to educate patients about the different kinds of “normals” that are prevention targets. Some normals are strictly categorical: the patient’s condition is normal or not, and preventives aimed at these normals succeed completely or not at all. Sunscreens, for example, succeed by keeping the patient free of all sun-induced skin cancers; antibiotic prophylaxis against meningitis succeeds by preventing secondary infection among a patient’s college roommates. Other normals are quantitative, having numerical ranges with upper limits, lower limits, or both. These normals allow for graded success. Interventions aimed at preventing myocardial infarctions by controlling blood pressure or low-density lipoprotein (LDL) cholesterol in diabetics succeed more and less, depending on how close to 130/80 a patient’s high blood pressure comes or how close to 100 mg/dl a patient’s high LDL cholesterol falls.

A doctor may also need to explain the factors that determine the significance or relative importance of different preventive interventions. One factor is how conclusively medical evidence defines normal ranges. Morbidity and mortality data define normal ranges with the greatest conclusiveness; population means and standard deviations define normal ranges with intermediate conclusiveness; and personal opinions of health professionals or others define normal ranges with the least conclusiveness. Glycated hemoglobin and body-mass index (BMI) illustrate the first level of conclusiveness; triglycerides (in nondiabetics) and bone mineral density, the second level; and prostate-specific antigen, the third level.

Another significance factor is health promotion benefit, which is greater with some preventives than others. Naturally, doctors should emphasize the more beneficial interventions over the less beneficial (such as smoking cessation over folate supplements for preventing myocardial infarctions). These significance factors—the conclusiveness of normal ranges and the efficacy of interventions—should help guide doctors in tailoring preventive regimens to individual patient’s needs.

Enhancements

A second type of health promotion is enhancements—measures intended to improve conditions considered healthy but not perfect. Enhancements address no specific

disease and are often marketed to the public as products or services available on demand. Examples include liposuction, hair removal or implants, exogenous growth hormone supplements, and other cosmetic interventions. Unlike preventives, enhancements provide little objective basis for scientific measurement of success. Instead, they are judged solely by how much they satisfy patients' subjective expectations. Still, our health care system permits the provision of enhancement services for people who can pay for them.

Mainstream medicine and society at large remain uneasy about enhancements. They do not fit well under medicine's traditional patient-care objectives. Despite rare exceptions, enhancements typically do not maximize function, relieve much suffering, or prevent premature death; they seem to fall outside standard medical care. Furthermore, providing enhancements (even to people who can pay for them) may have far-reaching, unintended adverse social consequences. It may siphon off precious medical resources from life- or limb-saving care, exaggerate the divide between society's haves and have-nots, and reinforce an unhealthy self-centeredness that undermines social solidarity. If the ideal of physical or mental perfection that people pursue narrows too drastically (say, to strictly the tall, blond, beautiful, athletic, and brilliant), enhancements could promote discrimination against those who do not naturally meet those ideals and cannot afford the medical procedures to attain them. Discrimination of this sort could erode important stabilizing diversities in society.

In sum, several characteristics distinguish preventives from enhancements. Preventives serve medicine's traditional patient-care goals, have objective endpoints, and scientific documentation of efficacy. Enhancements have none of these characteristics. Such differences suggest that preventives impose bona fide medical duties, but enhancements do not.

Weight-Loss Counseling as a Preventive Medicine Duty

Most doctors consider excessive weight a serious health risk. The particular risk for individual patients is gauged by their BMIs, that is, weight in kilograms divided by the square of height in meters. Individuals with BMIs between 20 and 25 are considered normal; those with BMIs from 25 to 30, overweight; and those with BMIs over 30, obese [4]. Doctors appreciate the striking coexistence of excessive weight with such chronic diseases as osteoarthritis, diabetes, and hypertension and with early death. For that reason, they believe combating excessive weight to promote health, not beauty, is one of their most important preventive medicine duties.

Careful analysis supports that belief. As with other preventive medicine duties, medically indicated weight loss has traditional medical goals, objective endpoints, and scientific proof of efficacy. It can provide patients with quick benefits by teaching self-discipline and bolstering self-confidence. But more importantly, it yields long-term benefits by improving function, relieving suffering, and preventing premature death [5-7]. The target range for medically indicated weight loss is

determined by the most conclusive data: mortalities are lowest in the normal BMI range and rise steadily above that [1]. Scientific studies also document the efficacy of diet and exercise in achieving at least short-term, modest weight loss and of even small weight losses (as little as 10 pounds) in reducing risks for hypertension, diabetes, and coronary artery disease [1, 8].

Weight-loss counseling need impose only a modest burden on doctors—to identify overweight patients, encourage them to lose weight, and offer practical suggestions for doing so. Yet because weight loss is difficult to achieve and sustain, patients often backslide, and doctors need to support their patients in maintaining hope.

Doctors might consider the following specific steps in carrying out the duty:

1. Explain at the outset of counseling the great health benefits of even small weight losses and express optimism about the patient's prospects.
2. Caution them that safe weight loss occurs slowly (about 1 to 2 pounds per week).
3. Emphasize that a sensible goal should not be some arbitrary weight or a specific dress size but the modest reduction necessary to improve long-term health [8].
4. Recommend daily weigh-ins on a home scale; simple caloric restriction; brisk walks for 30 to 40 minutes a day; and participation in Weight Watchers, Overeaters Anonymous, or a similar support group.
5. Praise patients who lose weight and encourage them to continue the effort.

Medical-Finances Counseling Is Also a Preventive Medicine Duty

Many doctors who accept weight-loss counseling as an important preventive medicine duty view counseling patients about medical finances as an optional service. But I believe doctors must respond to the financial problems of patients that affect care. Just as medically indicated weight loss aims at good physical health, not excessive thinness, medical-finances counseling aims at good fiscal health, not excessive richness. Ever more patients struggle to pay their medical bills—not only the poor. Thus, doctors should commit to a new preventive medicine duty that addresses patient financial problems before those problems disrupt care.

Although the parallels are not perfect, counseling patients about medical finances shares many characteristics of other preventive medicine duties. Most importantly, when preventing finance-related gaps in care, medical-finances counseling serves medicine's basic patient-care goals—maximizing function, relieving suffering, and preventing early death [9, 10]. Effective counseling might improve the functional recovery of a patient following a stroke by helping him afford bus fare to physical therapy appointments. It might prevent a patient who has used all her allotted monthly Medicaid prescriptions from suffering back pain without analgesics. Effective counseling might also avoid the life-threatening postponement of an emergency-room visit by a patient who has angina and is afraid he cannot afford the copayment. Medical-finances counseling also has a specific, objective, and

measurable goal—adequate funding to meet the patient’s care needs. Scientific studies document that increased access to medical care improves health. To the extent that medical-finances counseling succeeds at increasing access, it should succeed in improving health.

The duty to provide medical-finances counseling need not be burdensome. Doctors can prepare to fulfill the duty by asking new patients about work status and asking established patients about any recent problems with “making ends meet.” Doctors can learn the sliding-scale payment policy of the hospital or clinic. The counseling itself might take various forms, such as coordinating care under patients’ insurance policies, suggesting additional outside resources, or planning ways to cope with potential financial hardships. Doctors might even request notification about patient payment problems and offer to help negotiate solutions. (Obviously, medical-finances counseling should never appear to satisfy mere curiosity or to harass patients for reimbursements.) Doctors should feel free to refer patients to social workers for advice about programs such as food stamps, low-cost exercise programs, and public subsidies for rent or transportation. Some doctors may even want to give general counseling about finances such as urging high school completion, household budgeting, debt counseling, or participation in retirement-savings programs.

Nonetheless, the doctor’s help cannot be open-ended. He or she may rightfully limit help to realistic options, technical input, and available time. For example, the doctor may inform patients about pharmaceutical companies’ payment-assistance programs but can expect applicants to collect the necessary paperwork, complete it as fully as possible, and only then bring it to the doctor’s office for technical details, review, and signature.

Conclusion

Patient-care demands already overwhelm doctors. Why, then, do I suggest medical-finances counseling as yet another patient-care duty? Today’s medicine is shifting care increasingly from hospitals to clinics. The new outpatient care depends heavily on patient follow-through and must be compatible with patients’ life circumstances. Because medical-insurance coverage for many patients is spotty or completely unavailable, their personal finances are more critical than ever for accessing care. If patients cannot afford medical care, they will not seek it. Thus, doctors face a critical choice: either actively address patients’ medical-finance problems or waste much effort at care.

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