

## *Virtual Mentor*

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Ethics in Family Medicine

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# Virtual Mentor

Ethics Journal of the American Medical Association  
June 2005, Volume 7, Number 6

## Letter from the Editor

### Primary Care in a Specialty Society

A friend of mine found himself attending his partner's son's soccer game, sitting next to his partner's ex-wife. When asked by another soccer parent if they were the boy's parents, my friend paused a moment, and left it with, "Our relationship is a little richer than that."

Increasingly complex family relationships alongside the ever-expanding body of medical knowledge and the unfurling of more accurate and more numerous diagnostics (including genetics) and treatments are perhaps the 3 greatest challenges facing family physicians.

Family physicians are unique because they are trained to treat every member of the family. The demands on their intellectual capabilities and educational devotion are tested as medical knowledge continues to expand. The application of this knowledge is complicated by the sheer number of diagnostics available and the limited time of interaction. Finally, the fragmentation and reconfiguration of households challenge these physicians to appropriately navigate new family dynamics.

The changing family practice environment prompted the American Academy of Family Physicians reports on the *Future of Family Medicine*, mentioned in several essays, and the agreement of the op-eds that the length of family medicine residencies should change, though they disagree about which way. Our medical education essay also argues for a change in family medicine residencies, not in the length but in the location. Concerns about the breadth of family practice are addressed by the case commentaries on dual loyalties (by Stanley Dorst, who was kind enough to give us some early editorial guidance for this issue), intergenerational confidentiality, and clinical depression (which our clinical pearl also addresses head-on). Finally, family practice also faces problems common to the rest of the medical community. The medicine and society essay describes a new model of family practice that addresses financial and administrative concerns in family practice, a clinical case looks at the distinction between physician and friend, and the journal discussion focuses on changes in CME.

As the future of family medicine is charted by the new ranks of family physicians, they face the hazards and puzzles of generalists in a specialists' society.

You'll find the things you should learn listed below.

1. Learn about the "family covenant" as a means for handling medical secrets among family members who are the patients of the same physician.

2. Identify the challenges to respect for confidentiality and patient autonomy when depression interferes with patient decision making, and learn the diagnostic criteria for clinical depression and the principle modes for treating it.
3. Learn how to weigh the harm done by breaking a patient's confidentiality against the harm that patient may inflict on another if you preserve confidentiality.
4. Understand the argument that physicians should discuss with patients only those screening tests that are of proven effectiveness.
5. Understand the arguments for reducing residency training for family medicine to 2 years and for extending it to 4 years, and understand the arguments for locating family medicine residency training in community-based, ambulatory settings.
6. Learn how the "New Model of Practice in Family Medicine" is designed to improve patient care and alleviate financial and administrative pressures on family physicians.

Abe Schwab

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## Clinical Case

### Familial Genetic Risk

Commentary by David John Doukas, MD

Dr Twitchell, the family physician for the Krausers, is scheduled to meet with Andrew, their 18-year-old son this afternoon. “Drew” is an only child and has always looked up to Dr Twitchell as a mentor. Whenever he comes to the office, he asks Dr Twitchell’s advice about something, sometimes medical, sometimes not. Dr Twitchell has consistently gotten the impression that Andrew does not know that his parents are carriers of sickle cell anemia, and Andrew has never been tested. Despite his urgings, Andrew’s parents have never committed to tell him about their status.

As Dr Twitchell enters the exam room, he begins, “How are you doing today, Drew?” Andrew blurts out, “Well, I’m getting married.”

“That’s exciting news, I bet your parents are excited.”

Andrew responds quietly, “Well, they don’t exactly know yet. We’re planning to elope in Vegas. Neither of us has ever been to Vegas before, and Vanessa doesn’t want to make a big deal out of it anyway.”

“Don’t you think your parents would like to know about your wedding, Drew?” Dr Twitchell asks.

Andrew shifts uncomfortably.

“Well, Drew, let’s leave it at that. Just remember that I think you should let your parents know.”

As Dr Twitchell continues the examination, he wonders how to get Drew the information about his parents’ carrier status without telling his parents he plans to elope.

## Commentary

by David John Doukas, MD

Dr Twitchell has a classic “time-forced” dilemma (due to an inability to address a long-term ethical dilemma)—or does he? Both Mr and Mrs Krauser are known carriers of the sickle cell trait. Dr Twitchell has tended to their care and that of their

son, Drew, for years. The case ends with Dr Twitchell considering how he should address the concern he has regarding Drew's genetic risk.

Given Drew's lack of symptoms we can safely assume he does not have sickle cell anemia, but he has a 66 percent probability of being a carrier, like his parents, and a 33 percent probability of not having the trait at all. These possibilities raise 2 questions: (1) Why was this consideration never addressed during his adolescence when Drew could have fathered a child? and, (2) Why do the Krausers not want to divulge this important health information to their only son?

One would hope Dr Twitchell has some information here that may prove helpful. If Dr Twitchell divulges the Krausers' genetic information to Drew, it would likely be construed as a violation of the parents' autonomous right to keep their health information private. To tell the Krausers about Drew's intention to wed (and thereby encourage them to divulge the information to Drew) would likewise violate the fidelity to trust in the patient-physician relationship. One possible solution for Dr Twitchell is to find out if Drew has knowledge of any family history of genetic disease (without divulging information about his parents). If Drew says his family is positive for the sickle cell disease/trait, this knowledge is quite sufficient to encourage genetic counseling and testing before a precipitous marriage—but something he can also refuse.

What may have helped this case is a model of care I have proposed called the *family covenant* [1-3]. This family-based model of care is predicated on a health care agreement between consenting family members (prior to a genetic-ethics crisis like this one) defining how medical information will be held confidential or divulged to other family members, according to their agreed-upon boundaries. This essay is too brief to expound on the family covenant at length; suffice it to say that it allows the exchange of information between the family members in the covenant to benefit other family members, within boundaries pre-set by those members. The agreement is grounded in family-based bonds of trust and the desire to protect kin from harm. It also helps the physician facilitate discussion of difficult boundary issues regarding genetic information. Nevertheless, the family covenant is intended as a proactive instrument, rather than for use in the middle of a fracas. We can use its underlying concepts of trust, avoidance of harm, and respect for autonomous wishes to address this case.

There is no clear-cut "rule" regarding how a physician should treat genetic information within the context of the family [3]. *Pate v Threlkel* in Florida (1995) held that the physician had a duty to inform a patient that a genetic disease was found, and that it would then be the patient's responsibility to inform at-risk relatives [4]. But, in 1996, the New Jersey court in the case of *Safer v Estate of Pack* went beyond the Florida court, holding that the physician's duty to inform might *not* be satisfied by informing only the patient [5]. While helpful, these guidepost cases in Florida and New Jersey have no standing outside of their respective states. Further, both involved lethal diseases that engendered risk to currently living persons, harm to whom could have been mitigated through surveillance—quite a different situation than the case now under consideration.

Given the lack of parental permission to divulge to Drew, Drew's unwillingness to divulge to his parents, and the doctor's belief that he cannot violate a patient's confidence (as in the above case), Dr Twitchell is left with the option of temporizing and educating all parties as best he can. The desired endpoint is either Drew's telling the Krausers of the impending marriage (with the Krausers' divulging their carrier status to Drew) or Drew's parents informing Drew about the genetic risk posed to him (with him then pondering the issue of testing).

So what is a family doctor to do if the parties are reluctant to discuss their "secrets"? Do what comes naturally for family doctors: hold a family meeting (with all those who consent). Beforehand, Dr Twitchell should inform the Krausers that they should consider coming to discuss Drew's genetic risk with him, as Drew's reaching the age of majority confers a fidelity-based moral obligation to inform their son of his genetic risk. Drew similarly might be advised to come in to discuss the ramifications of his action with his parents if he wishes to share this information.

If the Krausers refuse to tell Drew directly (and Dr Twitchell should ascertain *why*), then Dr Twitchell could work with them to address their fears or concerns (such as stigmatization or insurance company discrimination). Dr Twitchell could serve as a valuable intermediary to inform Drew (with the Krausers' permission) if they cannot bring themselves to do so. However, if the Krausers refuse to divulge this information to Drew, Dr Twitchell has little left to offer, as the impact of this knowledge on Drew's future is not an imminent threat to his health or, at this point, to the health of any identifiable person.

Now, if Drew is eventually informed and gets genetic testing that *is* positive, than we have another set of moral issues if Drew refuses to share this information to his soon-to-be spouse.

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*David John Doukas, MD, holds the William Ray Moore Endowed Chair of Family Medicine and Medical Humanism, and is professor of family and geriatric medicine, at the Institute for Bioethics, Health Policy, and Law at the University of Louisville. He is also the director of the Program for Education in Humanism, Ethics, and Professionalism, and a practicing family physician in Louisville, Kentucky.*

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## **Virtual Mentor**

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### **Clinical Case**

#### **When Depression Affects Treatment Decisions**

Commentary by Jason A. Hughes, MD, and Mark A. Graber, MD

Mr Li moved to the area about a year ago, and this is his second visit to Dr Rodale's office. Dr Rodale reviews her notes from the last appointment. At that time, Mr Li's blood pressure was elevated (143/88) and his total cholesterol was 235 mg/dL, with LDL at 163 mg/dL, HDL at 44 mg/dL, and triglycerides at 427 mg/dL.

Dr Rodale remembers informing Mr Li of the findings and saying "Mr Li, although making certain lifestyle changes like more exercise and healthy eating may help with your blood pressure, I think you should get a prescription to help with your high cholesterol numbers."

Mr Li simply shook his head. "I think you're overestimating the risk and I'm not sure it matters anyway."

"Have you taken a prescription for high blood pressure or high cholesterol before?" Dr Rodale inquired.

"Nope."

"Well, I've got a few samples here in the office. Perhaps you could see if you're able to keep up with the regimen and, if so, I can call in a full prescription later on."

Mr Li began gathering his things without responding.

"Mr Li, although your risks are not dangerously high yet, if you don't do something about your blood pressure and cholesterol, they will be."

"It doesn't really make a difference, doc."

"I'm not sure what you mean, Mr Li. In terms of your future health and risk of cardiovascular problems, it very much does make a difference." Dr Rodale responds.

"Thanks for seeing me, Doc." Mr Li mumbles as he walks out the door.

Two weeks later, as Dr Rodale enters the room for Mr Li's next appointment, she notices in the chart that his blood pressure is even higher. Mr Li is staring absently at the corner of the ceiling.

"How are you doing today, Mr Li?" Dr Rodale asks.

Mr Li informs Dr Rodale he has a fever, which she thinks is viral. After Dr Rodale informs him that he should drink plenty of fluids, she asks for his permission to retest his cholesterol. As during the last appointment, Mr Li is despondent, and nothing that Dr Rodale tells him seems to have an effect.

Dr Rodale informs Mr Li that he should make a follow-up appointment for a couple of weeks later to check on his viral infection and discuss the results of the cholesterol test.

Mr Li fails to make an appointment as he leaves and does not return any phone calls during the next week about his cholesterol test. Dr Rodale is concerned that he is depressed.

### **Commentary**

by Jason A. Hughes, MD, and Mark A. Graber, MD

Mr Li visited his physician with several medical problems including a high triglyceride level and a high total cholesterol. A middle-aged Asian-American, he also seemed to be exhibiting signs of depression, which could be the most *acutely* life-threatening of his medical problems. Dr Rodale, his primary care physician, noted evidence of depression in the way Mr Li responded, including his apathetic attitude and responses such as, “It doesn’t really make a difference, doc.” He seemed especially despondent during a follow-up visit, when he essentially refused treatment. He subsequently did not return phone calls from Dr Rodale. Medical and ethical questions arise when the phone calls from a potentially seriously ill patient are not returned.

Depression often goes undetected in the outpatient clinical setting [1] but it has been noted that more than 12 percent of outpatient family practice clinical visits are due to depression [2]. Intervention is critical because of the potential for suicide or other destructive behavior. Considering Mr Li’s answers and his general despondency, depression was the most important medical problem to address during the second visit. Mr Li’s answers to questions pointed towards a worsening and possibly life-threatening depression. Addressing the depression during the initial visit might have prevented the ethical dilemma in which Dr Rodale now finds herself: can she break patient confidentiality in order to check on Mr Li? The second question facing Dr Rodale is what action(s) should she take if she decides that is acceptable to breach this patient’s confidentiality?

Confidentiality is so crucial in the medical setting that breaking this bond should not be considered lightly. The American Medical Association’s *Code of Medical Ethics*, Opinion 5.05 acknowledges this important aspect of the patient-physician relationship [3]. This guideline states that patients have the right to fully disclose their medical history without adverse consequences. If this ethical “contract” were to be broken routinely, patients could suffer severe consequences. For example, if patients did not feel free to discuss their medical history candidly due to fear of disclosure, then diagnoses might easily be missed, and the physician could be “driving in the dark

without headlights.” Thus, violating confidentiality has the potential to result in adverse medical consequences, violating the principle of nonmaleficence (do no harm) [3]. Additionally, disclosure of patient information to a third party in and of itself can constitute malfeasance when adverse outcomes occur. These could include social harms such as rejection by family and friends or economic harms such as denial of insurance.

While confidentiality is a keystone of Western medical care, it is not an inviolable absolute. In the case of imminent danger of self-harm or harm to others, confidentiality can be justifiably subverted. In fact, the recognition that breaking confidentiality and intervention should take place *immediately* is codified in the American Medical Association’s *Code of Medical Ethics* [3]. In our case, if Dr Rodale decides that Mr Li is in danger, she has the duty to prevent harm to him. That said, breaking confidentiality should be done in the least damaging manner available. A “welfare check” by law enforcement has the potential to limit the adverse consequences of breaking confidentiality; only the police or other authority need be involved. Other options include discussions with family members, or, in extreme cases, through the use of court-ordered psychiatric admission.

Rapid and emergent decision making without the luxury of consultation with colleagues or an ethics committee is often necessary. In *Ethics in Emergency Medicine*, Dr Kenneth Iserson proposes a framework for making ethical decisions. First and foremost, Iserson notes that if there is a rule for the situation at hand, this rule should be applied [4]. The applicable rule in this case is the obligation of the physician to prevent patients from harming themselves or others. If there is a reasonable belief that the patient could harm himself or others, confidentiality should be broken and the family or the judicial system should be notified.

If there is no immediate threat but there is an *emergent* ethical concern, Iserson suggests that the physician consider delaying the decision. In our case it is *not* clear that Mr Li is a threat to himself; indeed, we have not even established with certainty that he is depressed. Perhaps he is not returning calls because his phone is not working. There may be scheduling difficulties, transportation difficulties, or other circumstance that account for his failure to return calls or keep his appointments. Collecting more data before acting seems prudent [5]. This can be done in a manner that limits the breach of confidentiality. For example, Dr Rodale may choose to leave a message with Mr Li’s family members asking that Mr Li call the office or set up an appointment (assuming Mr Li has consented to have messages left at home or with his family members). This can be done without disclosing the nature of the concern (ie, depression) and may also allow the family to express their own concerns about Mr Li.

A second problem raised by this case is the patient’s refusal of treatment. Mr Li is reluctant to take medications for his elevated cholesterol levels even though the risks have presumably been discussed with him. This brings the principles of respect for autonomy and beneficence into possible conflict. Respect for autonomy can be defined as allowing patients to dictate their care, and beneficence, as a physician’s deciding for the good of the patient.

In general, patients should be allowed to dictate their own care. However, there are several assumptions inherent in the principle of respect for autonomy, including the patient's ability to understand and weigh the options available, his or her ability to communicate and act on the decision once it is made, and the absence of coercion. In the case of Mr Li, it is not entirely clear that he is *currently* able to understand and weigh the options available, nor is it clear that he is free from coercion.

The ability to weigh options depends on a patient's framework of beliefs and values. It can be argued that, if Mr Li is depressed, his beliefs and values as well as his framework for decision making may be distorted *at this time*. In depression, a patient's framework may change to immediate goals (eg, suicide) precluding consideration of long-term outcomes and consequences. Even in the absence of the short-term goal of suicide, a patient's despondency can interfere with the ability to concentrate and clearly weigh options. Depression, a potentially overwhelming force in one's life, can be coercive, pushing one towards a single goal. An overwhelming feeling of helplessness and the belief that one is not "worth the effort" that chronic illness management requires can be coercive even though the coercion is not externally applied.

This leaves Dr Rodale in the position of determining Mr Li's ability to be autonomous and whether or not she should push Mr Li to take his medication. As with breaking confidentiality, respect for autonomy can be overruled by the need to save someone's life. In the case of Mr Li, there is no immediate threat caused by his decision to forgo therapy for his cholesterol and lipids. Thus, Dr Rodale has no right to intervene by forcing therapy. Nor, however, does Dr Rodale have the right to ignore the issue and accept Mr Li's current decision as final and binding. Beneficence suggests that we should do the best for our patients.

As noted above, Mr Li may not currently meet all of the criteria needed to be truly autonomous. Thus, the physician should address the issue of treatment again with the patient at every opportunity and assess Mr Li for clinical depression. If he truly is depressed, treating Mr Li's depression may change his decision-making framework and allow him to consider his long-term goals. Once his depression is treated, Dr Rodale should readdress the issue of cholesterol (and other long-term goals) with him. If Mr Li still refuses treatment once he is clearly capable of autonomous decision making, that is his right. However, Mr Li's decision is not irrevocable even then. A patient's decision-making framework changes over time. What is important to a 60-year-old facing his or her own mortality may not be important to a 30-year-old. Thus, it is incumbent on the physician to raise the question of long-term treatments periodically. It remains crucial that patients be given permission to change their decisions as their framework for decision-making changes.

In conclusion, Dr Rodale may have been able to avoid the ethical decision to break patient-physician confidentiality by recognizing Mr Li's depression sooner. However, due to the lack of early recognition of the depression, Dr Rodale must now decide upon the "least worst answer." In terms of long-term therapies, she must ensure that Mr Li is free from any interfering factors when making decisions. Because a patient's

decision-making frameworks may change over time, readdressing questions of long-term therapies remains important.

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*Jason A. Hughes, MD, is an assistant professor of emergency medicine at the University of Iowa.*

*Mark A. Graber, MD, is an assistant professor of family medicine and emergency medicine at the University of Iowa Hospitals and Clinics.*

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## Clinical Case

### Doctor and Friend

Commentary by James Hallenbeck, MD

Dr Cleveland has been treating Mr Neezer for 20 years, and they've been fishing buddies for at least 15. Two years ago Mr Neezer began consistently complaining about lower back pain. Initially Dr Cleveland tried to treat it with muscle relaxants and referred Mr Neezer to a physical therapist. Mr Neezer went the first time, but failed to show up for the second appointment. When Dr Cleveland asked him about it, Mr Neezer just said he wasn't into "that physical therapy thing."

"And besides," he said, "Medicare won't cover all of it."

As the back pain continued, Dr Cleveland noticed that Mr Neezer moved more stiffly and had particular trouble getting onto and off the exam table. He began including a prescription analgesic along with the muscle relaxants. For the last several months, Mr Neezer has been making appointments every 6-8 weeks. He consistently asks Dr Cleveland "What're we going to do about this pain?" and requests stronger pain control, while refusing to schedule the surgery consult that Dr Cleveland has recommended.

"Look, Doug, with you as my doctor I don't need to go see some surgeon, you're doing a great job taking care of me."

### Commentary

by James Hallenbeck, MD

This case raises 2 ethical issues, both involving patient-physician relationships. One might first ask, "How should the patient's refusal of recommended care affect the provision of care by the physician?" The second issue relates to the dual relationship shared by these individuals, which is both professional and personal. In this case these issues overlap to create a serious problem.

At the simplest level, competent patients have a clear right to refuse any medical therapy, based on the ethical principle of respect for autonomy [1]. Legally, within the United States this right is based on battery statutes that guarantee freedom from unwanted touching [2]. So there is no question but that the patient is within his rights to refuse a surgery consult. The trickier question is how the exercise of this right should affect the physician's decision making and obligations to the patient. In many cases, patient refusal is not a major problem; acceptance or refusal of recommended therapy is well within a range of reasonable choices with minimal implications for care. Sometimes, however, patient refusal (or less direct noncompliance) can have more serious implications. In such situations, it is recommended at a minimum that the

physician approach the problem as a matter of informed consent [3, 4]. While informed consent is too often narrowly defined in terms of procedures or therapies the physician wishes to do *to* the patient, a broader interpretation suggests a professional obligation to inform the patient of the potential consequences of *any* action by either the physician or the patient that are important to the health of the patient [5]. Thus, for example, if a patient has a solitary lung nodule suspicious for cancer, and a biopsy is suggested and refused by the patient, the physician has an obligation to present possible *benefits* of the patient's choice *not* to have a biopsy (eg, avoiding possible complications and costs associated with the biopsy of a possibly benign lesion), burdens or risks of *not* having the biopsy (if the nodule is a curable cancer, this opportunity for cure might be missed, resulting in a terminal illness), and possible alternatives (serial chest x-rays or sputum cytologies).

Refusal of care may also have significant implications for decisions by the physician. While competent patients have the right to *refuse* any therapy, this does not translate into a right to *receive* any therapy they wish. In this case what should the physician do about the request for stronger pain medications in light of the patient's refusal to see the surgeon? While not explicitly stated, the wording of the case suggests that the physician is being pressured to prescribe opioids in a situation where they would not be appropriate—especially given the patient's refusal to consider other diagnostic and therapeutic options. Would the prescription of opioids be within the bounds of reasonable practice? It is impossible to say from this brief vignette, although there are warning flags that this might not be appropriate.

What about the dual relationship between the doctor and patient? Dual relationships exist whenever physicians treat individuals with whom they have other, non-patient-physician relationships [6]. They vary in intensity from minor—treating a member of a common social organization such as a church or work group—to major—treating a family member. Dual relationships can even exist if and when the physician shares the same illness as the patient [7]. They are not necessarily bad; sharing a common bond can improve mutual understanding and empathy. Friendship may in fact be something that patients need from physicians and can be a positive professional attribute. The risk inherent in dual relationships, however, is that objectivity can become blurred by emotions or extraneous concerns—financial interests, for example, or one's status within a group or on the job. It is too simplistic to state that the relationship should not exist; the question, rather, is how does one best guard against a dual relationship resulting in harm?

I suspect that the dual relationship between Dr Cleveland and Mr Neezer developed slowly over time. A particular risk in their case (and arguably in many friendships) is that a “slippery slope” may be encountered, in which “special considerations” insidiously lead from small acts of friendly kindness to requests for favors that lie outside the bounds of propriety. Each step down the slope seems reasonable enough, but, at a certain point, one realizes he is in trouble, and climbing back to safety seems impossible. I worry that this may be exactly what has happened here—unbeknownst to either the patient or physician.

How do you know when a dual relationship is on a dangerous slippery slope? I think the best safeguard against the danger is to abide by 2 principles: “the patient comes first,” and “first, do no harm.” The very nature of a dual relationship implies that the physician has some investment in the relationship beyond his or her professional role. This is not necessarily a problem unless that investment creates such a conflict of interest that professional judgment is compromised. Friendship may serve the patient, if the physician is motivated to “go the extra mile” and has a better understanding of the patient as a person. It is not hard to imagine, however, that the friendship might result in harm—the possibility of which is strongly suggested in this case—if interactions with the patient are driven more by the need to maintain the friendship and not offend than by professional judgment.

If the dual relationship poses a risk of harm to the patient, what should the physician do? It almost goes without saying that, when it is clear from the outset that a dual relationship poses a serious risk, professionalism requires that the physician not serve in the professional role. More difficult, as likely happened in this case, is the situation in which the professional relationship was entirely appropriate initially, but where, over time or due to changing circumstance, a potentially harmful relationship evolves. In clear-cut situations, the patient must transfer to another physician following discussion as to the reason for the referral. In borderline cases, the potential conflict of interest should be disclosed and discussed with the patient, at a minimum, and a continuation of the relationship weighed against transfer of care.

While I have addressed these 2 ethical issues—the patient’s refusal of recommended treatment and the patient–friend–physician relationship—separately, they come together in terms of the communication skills needed to manage the situation. If it is clear that the professional relationship should not continue, then the major question is how best to break this news to the patient and explore the implications both for continued care (referral options to other physicians) and their friendship.

If the situation is less clear-cut and continuation of care is contemplated, then a discussion must occur regarding their relationship, and future care plans must be negotiated [8]. While the patient in the above vignette indirectly refers to their friendship status (“with you as my doctor...”), their friendship has likely remained a subtext to their clinical conversations. The positive and negative implications of this for the patient’s health care must be addressed more directly. If continued care by this physician is contemplated, the physician should consider establishing certain rules regarding the overlap between their friendship and professional relationship and negotiate a mutually agreeable plan for addressing the patient’s back pain [9]. If either of these attempts fails, there is little choice but to transfer the patient.

Negotiation in health care is an underappreciated art, a detailed discussion of which is outside the scope of this text [10, 11]. The biggest risk in this case is that the issues in dispute will be personalized. Indeed, the patient has already done so, by dismissing consideration of the surgery consult because “Doug” is such a great doctor. Should Dr Cleveland challenge the status quo—either their relationship or his approach to Mr Neezer’s back pain—he should not be surprised if the personalization turns negative.



“Doug, I thought you were my friend! Do you think I’m some kind of drug addict?” While the physician cannot control the response of the patient, he can avoid making the same mistake of personalizing the situation. Using the language of Fisher and Ury in their book, *Getting to Yes*, separate the people from the problem [12]. Here, it is important to separate the people—patient and doctor—from the problem—that a conflict of interest can compromise care. Fisher and Ury also stress the importance of using objective criteria and mutual interests, rather than “positioning” in negotiating. In this case, the patient has taken the position that he does not want to go to the surgeon and he does want more painkillers. The physician could use more objective standards of care in supporting both his concerns about their dual relationship and his argument that the patient see the surgeon, based on their shared interest in maximizing good health outcomes and maintaining personal and professional relationships.

Fisher and Ury also introduce the term, BATNA (best alternative to a negotiated agreement). Prior to having the suggested discussion with the patient, the physician must be clear on his bottom line(s), his BATNAs. One bottom line might be, “I am only willing to consider a change in pain medications if you agree to see the surgeon and the surgeon concurs.” Another might be, “I am agreeable to continuing as your physician, but only under the following conditions....” In establishing one’s bottom line, one must be prepared for the consequences if it is not met. In this case, the friendship may be a casualty, one which the physician must be willing to sacrifice for the good of the patient, if necessary.

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*James Hallenbeck, MD, is assistant professor of medicine at Stanford University. He is board certified in internal medicine and hospice and palliative medicine. He is also the hub-site director for the Department of Veterans Affairs Interprofessional Palliative Care Fellowship Program.*

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## **Virtual Mentor**

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### **Clinical Case**

#### **Dual Loyalties**

Commentary by Stanley K. Dorst, MD

Mr and Mrs Samir have both been patients of Dr Lachman for 4 years. They live a 30-minute drive from his office, so they regularly schedule their appointments on the same day. As usual he sees Mrs Samir first.

During the examination, Mrs Samir asks if she should see an obstetrician—she and Mr Samir have stopped using birth control (a barrier method) because they are trying to get pregnant. She's a little worried because she's had some lower abdominal pain and post-coital bleeding.

“Well, have you taken a pregnancy test? Some abdominal pain and light bleeding are not uncommon in pregnant women.”

“No, we just started trying a few weeks ago.”

“Perhaps we should go ahead and do a pregnancy test now,” Dr Lachman suggests.

“Would you like me to get Mr Samir in here for the results.”

Mrs Samir fidgets for a moment. “Perhaps we better not,” she finally says, “I just don't feel very pregnant and that would get his hopes up.”

Dr Lachman continues the physical examination and tries to isolate the cause of Mrs Samir's abdominal pain, but he's unable to identify more than just general tenderness.

“Mrs Samir, I'd like to run a couple of tests to rule out infection. Is that okay with you?” Dr Lachman suspects that Mrs Samir has contracted some kind of STD, perhaps from Mr Samir, but he doesn't want to upset her by saying so. She agrees to undergo a few tests.

Just as Dr Lachman guessed, Mrs Samir tests positive for Chlamydia. He informs Mrs Samir, and tells her that she needs to start a course of antibiotics and that he needs to test Mr Samir.

Mrs Samir demands that Dr Lachman not disclose what he has discovered to Mr Samir—test him if he agrees to it, but do not tell him about her condition.

## **Commentary**

by Stanley K. Dorst, MD

This is a classic case of confidentiality, and the conflicts physicians can run into because of its requirements. The wrinkle in this case is that both Mr and Mrs Samir are Dr Lachman's patients. As family physicians, we often see many, if not all, members of the same family, and to some extent may view the family itself as being in some sense "our patient." In discussing the case, though, I think it makes sense to start by discussing the confidentiality issues and conflicts in general, and then to analyze whether the particular role Dr Lachman plays raises any other ethical issues.

The expectation that physicians will respect the confidentiality of information disclosed to them by patients dates back at least to Hippocrates. In the Hippocratic Oath, physicians promise "What I may see or hear in the course of the treatment... which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about" [1]. Similar promises are part of the Code of Geneva, and other modern professional codes [2]. There is also significant legal precedent for holding physicians liable for breach of confidentiality [3].

At the same time, physicians may have a conflicting duty to warn others about potential harms which their patients pose. In the classic *Tarasoff* case, the California Supreme Court found a psychologist liable for not warning a young woman and her parents about his patient's intent to kill her [4]. Medical ethicists have generally embraced this ruling, viewing the obligation to preserve confidentiality as being a relative, not an absolute, requirement.

As is true for most situations where there are conflicting ethical duties, there is no clear decision rule that can be followed to determine which duty trumps another in any particular situation. There are, however, some generally accepted guidelines for making that decision in this context. Lo, for example, states that,

in general, exceptions to confidentiality are warranted under the following conditions: (1) the potential harm to identifiable third parties is serious; (2) the likelihood of harm is high; (3) there is no less-invasive alternative means for warning or protecting those at risk; (4) breaching confidentiality allows the person at risk to take steps to prevent harm; and (5) harms resulting from the breach of confidentiality are minimized and acceptable [5].

In the situation facing Dr Lachman, conditions 2, 3, and 4 seem to be met: it is fairly likely that Mr Samir would become infected with Chlamydia if he and Mrs Samir continue to have unprotected intercourse; there does not seem to be any other way of warning or protecting him from the risk; and it would certainly be possible for him to take steps to prevent infection if he were told of the risk. Condition 5 may also be met, although it is not clear who decides whether the harms would be "acceptable."

The real debate, though, is about condition 1. The usual context in which this has been discussed has to do with partner notification of HIV infection. Despite the marked improvement in our ability to treat HIV infection, I doubt anyone would argue that HIV infection would not be a serious harm to someone. Exactly how serious venereal chlamydia infections are in men is more debatable. Such infections commonly cause urethritis, which is an uncomfortable, but not very serious condition. It could reasonably be argued that urethritis is not a serious enough harm to justify breaching Mrs Samir's confidentiality. However, men with chlamydia infections can also develop epididymitis, although the frequency with which this happens is not clear. In addition, approximately 1 percent of men with Chlamydia develop reactive arthritis, and approximately one-third of those develop Reiter's syndrome. Chlamydia has also been implicated as a possible cause of chronic prostatitis, although the current evidence for this is not very solid [6]. Clearly, these possible harms to Mr Samir are more serious than a simple urethritis, but none of them is life-threatening, like HIV infection would be, and some of them, at least, are quite unlikely to occur.

At the same time, while the potential consequences to Mr and Mrs Samir's relationship from breaching confidentiality could be significant, the overall consequences of this breach are not as serious as they would be for HIV infection, with its potential social stigmatization and loss of insurability. Overall, though, the balance of harms is not as clearly in favor of breaching confidentiality as it would be for a disease like HIV. Does that mean that breaching confidentiality is not justifiable in this situation? There is no clear answer to that question, and probably different ethicists, and different physicians, would come to different conclusions.

It is probably worth mentioning that legal liability in this situation, either for breaching or for maintaining confidentiality, is extremely unlikely to be an issue. Even for HIV, the statutes I am aware of allow physicians to breach confidentiality, but do not require it, so it is most unlikely that a court would have a stronger requirement for a less serious infection. In addition, because most people would feel that Mrs Samir should not have acted in a way that resulted in her infection, and that she certainly should inform Mr Samir of the risk he is facing at this time, it is almost inconceivable that a court would hold Dr Lachman liable for breaching confidentiality if he chose to do so.

So, it appears that breaching confidentiality may or may not be justified in this situation, at least based on Lo's criteria. However, Mr Samir is also Dr Lachman's patient. This certainly makes the conflict more professionally difficult for Dr Lachman, because in order to maintain confidentiality for one patient he would have to withhold important health information from another patient. The question, though, is whether this fact is only emotionally relevant, making the situation upsetting for Dr Lachman, or whether it is ethically relevant, and actually changes the ethical conclusion we should reach in this case.

The patient-physician relationship certainly does impose some special duties on physicians. Many beneficent actions that are generally considered morally obligatory for physicians in relation to their patients are considered to be excessive for

nonphysicians. Most ethicists believe, for example, that health care professionals have an obligation to provide care for HIV-infected patients, even if there is some risk that they may become infected in that process. Taking that same degree of risk would be considered excessive for individuals who do not have the same set of role-based expectations [7].

This type of obligatory beneficence is a matter of weighing personal risk against the good of one's patient, though, and doesn't tell us anything about how physicians should weigh the good of one patient against the good of another patient. Ethicists have generally argued that decisions about each patient must be made separately, and that therefore violating one's obligation to one patient cannot be justified by the fact that it benefits another patient. On the other hand, some theorists have argued that the family unit itself should be considered to be the focus of care in family medicine. If so, treating Mr and Mrs Samir separately would not be justified. Christie and Hoffmaster discussed this in some detail and concluded that considering the family to be the focus of care results in multiple problems, both practical and ethical, and that it should therefore be rejected [8]; I agree with their conclusion. In addition, I would argue that a physician has a moral obligation to protect identifiable others from foreseeable harm and that this obligation is not greater for his or her patients than it is for nonpatients. Specifically, if asked why I didn't warn someone of a risk to her health, I do not feel that stating "because she is not my patient" would be an acceptable response.

In summary, then, it seems that breaching Mrs Samir's confidentiality may be justifiable, depending on how serious one thinks the potential harms to Mr Samir are, and that the fact that Mr Samir is also Dr Lachman's patient would make not breaching confidentiality more uncomfortable, but that alone is not an ethically relevant concern.

On a practical level, of course, breaching confidentiality is not something that should be undertaken lightly. Even if such a breach is felt to be an acceptable option, every effort should be made to avoid doing so. Mrs Samir should be strongly encouraged to either tell her husband about the situation herself or to allow Dr Lachman to do so, in her presence or absence, as she chooses. She should be offered support in going through this difficult experience, including joint meetings with her and her husband, and referral to couples therapy if desired. She should also be advised that it would be unethical for Dr Lachman to test her husband without obtaining his consent for testing and that gaining his consent would require giving him a reason for the test. In addition, she should be reminded that if he is not tested and treated he is likely to develop symptoms, which would certainly result in questions being asked about how he became infected. If he remains untreated, there is also significant risk to her of becoming re-infected, with resultant risks for pelvic infection and infertility. Frequently, working through the practical aspects of the situation helps patients to realize that informing their partners is the best option, and the physician can usually provide valuable assistance in this process.

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*Stanley K. Dorst, MD, is the associate director of the Family Practice Residency Program at the University of Missouri–Columbia. He is also an associate professor of clinical family and community medicine.*

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# Virtual Mentor

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## Journal Discussion

### Three Proposals for Renewing CME

by Betsy Doherty

**Van Harrison R. Systems-based framework for continuing medical education and improvements in translating new knowledge into physicians' practices. *J Contin Educ Health Prof.* 2004;24(Suppl 1):S50-S62.**

**Grol R. Changing physicians' competence and performance: finding the balance between the individual and the organization. *J Contin Educ Health Prof.* 2002;22:244-251.**

**Davis NL, Willis CE. A new metric for continuing medical education credit. *J Contin Educ Health Prof* 2004;24:139-144.**

Continuing medical education (CME) is on the precipice of change. The medical community faces a widespread problem in translating rapidly changing and increasingly complex biologic and clinical knowledge into treatment modalities that can be implemented in physician practice. Although the professionals charged with executing the CME programs addressed this challenge by proposing new approaches, some of the approaches place too heavy a burden on instructors and downplay individual physician accountability.

In "Systems-based Framework for Continuing Medical Education and Improvements in Translating New Knowledge into Physician Practices," Van Harrison describes the network of players involved in updating physicians' knowledge and clinical practices and suggests ways to make the process more effective and efficient [1]. Each of the systems that Van Harrison diagrams (health care environment, physicians, information, education, implementation, and regulatory oversight) has its own separate structure and funding. He points to the systems' disparate conceptualizations and vocabularies as problems in optimizing the process of expanding physician knowledge and creating clinical practice change. Van Harrison recommends both intra- and inter-system changes that require incentives for increasing efficiency within each system and cooperation among systems. He also notes that the financial burdens of good health care illustrate the need for these improvements, but that their cost is a major obstacle.

Van Harrison describes 2 models of physician change—active learning on the part of "individuals seeking solutions" and organizational directives that treat physicians as "uniform contributors to a larger process" [2], but he neglects to integrate these models when he discusses recommendations. For example, to facilitate physician use of new information, he recommends that CME instructors identify authoritative information sources and increase accessibility to them. It would have been useful here



to demonstrate how physician membership societies would organize this increased volume of knowledge and resources into a practical context for individual physicians.

In “Changing Physicians’ Competence and Performance,” Grol foreshadows Van Harrison’s multifaceted approach to change but puts more emphasis on intra-system problems (eg, the individuals and teams giving care) [3]. He cites the Institute of Medicine’s finding that appropriate care is generally lacking in our health care system. Grol’s solution is to recognize the complex problems in good health care delivery and design plans targeting specific goals and agents. Grol also notes that individual doctors will not change unless the team and organization to which they belong are simultaneously doing so. He states that only educating physicians is not enough; CME providers and other professionals in the role of physician educators need to become better managers of change. What remains unclear is how they will produce the needed organizational change through the individual physicians who take part in CME. Grol recommends a radical shift in the understanding of the goal of CME when he suggests that the classic concept of CME is a good strategy only for providing insight into change but not in facilitating its acceptance, implementation, or maintenance.

In “A New Metric for Continuing Medical Education Credit,” Davis and Willis write about how CME in practice can be better tailored to the needs of physicians and patients [4]. They describe the history of CME from the perspective of licensing/regulatory bodies such as the American Medical Association and American Academy of Family Physicians and how those groups have envisioned physician learning and integration of new knowledge into practice through the years. The authors argue for a new CME metric because, they claim, credit hours (the current measure of physician education) have proven to be an inadequate reflection of patient care improvements in physician practice.

Authors of all 3 articles acknowledge the need for both individual and organizational change in CME. Moreover, they recognize that for CME to succeed in facilitating physician learning which will then translate into improved clinical outcomes, CME offerings must strike a balance between the need for rigorous, externally supervised education and the value physicians place on their professional autonomy. Davis and Willis, for example, note that the promotion of nontraditional, independent-learning CME was ill-received by many physicians in the early 1990s [4].

The proposals for changing the way continuing education operates are extensive. The hierarchical, 5-level model recommended by Davis and Willis requires greater involvement on the part of CME professionals. The recommendations include “[ensuring] methods of documenting actual learning rather than participation” [5], and require that CME providers offer both quality improvement and clinical practice skills. This argument shows up in Grol as well, though he indicates that all teachers of physicians need an updated skill set and a commitment to individual learners. As yet, the topic of the considerable funds needed for teacher training and incentives remains largely untouched by these authors.

These articles are valuable descriptions and criticisms of the health care environment and CME, but they fail to specifically offer models or suggest steps for positive change. For example, Van Harrison brings up the need for “closer working relationship[s]” among professionals in the CME network and states, “The efficiencies of centralization and standardization across systems will have to be balanced with the flexibilities of decentralization and local variation” [6]. These points are hard to dispute, but the more relevant issue is how do professionals from different structures begin to work more closely and strike this balance? Davis and Willis claim that, “...activities will require more resources, fresh thinking, and considerable effort by the physician, CME professionals, and the health care system” [5]. Again, professionals in the network of systems comprising health care need clearer guidance to reach these ideals. By necessity, a cultural shift—at least within the health care environment and likely beyond—will accompany a new method for expediting changes in individual and organizational practices, and CME professionals seem poised to take on that responsibility. Who will lead this charge, and how it will be funded remains to be seen.

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*Betsy Doherty received a BA in biology from Northwestern University in 2000 and an MA in medical sciences from Loyola University in 2005. Between degrees she worked in the social services and basic science research fields.*

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# Virtual Mentor

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## Medical Education

### Form Follows Function: Moving Medical Education into the Community

by Samuel C. Durso, MD

In 1910 Abraham Flexner exposed the appalling quality of North American medical education in his seminal report *Medical Education in the United States and Canada* [1]. Flexner, a trained educator—not a physician—visited the 155 medical schools of that time and found students who were poorly prepared academically attending sterile lectures and learning patient care in loosely organized apprenticeships. Medical training was largely unscientific and divorced from hands-on clinical experience. Johns Hopkins was one of few medical schools that were exceptions. There, led by the great clinician-educator William Osler, students worked under the supervision of clinician role models at the site of patient care—the bedside. As Osler himself said, “Medicine is learned at the bedside and not in the classroom” [2].

The Flexner Report motivated radical change and a remarkable transformation in medical education. Dozens of proprietary, nonacademic medical schools vanished, and American medical schools began to adopt scientifically rigorous education paired with supervised clinical training in academic teaching hospitals. In an age of acute medical disease, this model was rational, and American medical education came to be widely acknowledged as the best in the world.

Yet, despite the stature that US medical training commands throughout the world, it again finds itself at a crossroads at the beginning of the 21st century. Though prospective trainees now enter medical school with solid undergraduate credentials, many within and outside the profession feel that physicians emerge without the full complement of knowledge, skills, and attitudes necessary for ideal patient care. As a result, we must re-examine how medical education occurs and how faculty should best provide the training that is needed. The principle that Osler espoused—that medical education occurs at the patient’s bedside—is as valid today as it was a century ago. *But the circumstances of medical care have changed* since Osler made his observation. Changes in demography, epidemiology, and technology have radically altered the patient-physician encounter and dramatically shifted the dominant site of patient care. Medical educators must reapply the Oslerian principle to modern curricula in order to produce physicians who are optimally prepared to meet the public’s expectation for safe medical care that is patient-centered and cost-effective.

### What are the implications of these changes in medicine for medical education?

As a result of public health victories in the 20th century and a “baby-boom” following World War II, the US population is becoming older. Racial and ethnic diversity is also

increasing. These demographic changes have resulted in an epidemiological shift from a population plagued by acute episodes of illness to one that is more often burdened by numerous and often chronic conditions that sometimes produce disability. Parallel to this demographic and epidemiological shift has been a remarkable explosion in medical technology and consumer awareness. Since the 1970s, American's expectation of medical quality, assisted by ubiquitous medical information available through electronic formats and other sources, has grown. Consequently, patients exercise personal choice in medical care more than ever before. Furthermore, delivery of care—driven by economic incentives toward cost-effectiveness and propelled by the promise of more accessible diagnostic and therapeutic technology—occurs most often in ambulatory settings, many times in community-based practices begun by trainees of parent academic medical centers. The result is that most patient care decisions, evaluations, and treatments occur, not in hospitals, but in offices. Moreover, the vast majority of patient encounters happen in community-based practices affiliated with non-academic medical centers and concern management of chronic medical conditions. So where would William Osler educate his trainees?

The location is obvious. The ambulatory setting, though not the exclusive site of care, is the better place for much of today's clinical learning. Making the change from the traditional hospital setting, however, is not simple. In addition to logistical and financial hurdles, training medical students and postgraduates in community-based settings requires recruitment of a cadre of community-based faculty who are conversant with the goals of modern medical education, broadly categorized by the American College of Graduate Medical Education as:

- Patient care,
- Medical knowledge,
- Practice-base learning and improvement,
- Interpersonal and communication skills,
- Professionalism,
- Systems-based practice.

What attributes make community-based practice highly suitable for achieving these goals? Here the form of clinical medical education should follow directly from the functions that community-based practices are developing in response to the demographic, technological, and financial imperatives that medicine currently confronts. Consider the following characteristics of ambulatory practice that make it ideally suited for meeting this century's educational imperative.

#### *Disease Prevalence*

Trainees exposed exclusively to hospitalized patients in academic medical centers often develop a distorted sense of disease prevalence. Rare diseases seem more common than the conditions most physicians routinely encounter. In the typical community-based setting, the medical students and residents are able to gain experience evaluating and treating common medical conditions, while learning another important skill: how to properly incorporate the low pre-test probability for

uncommon illnesses into diagnostic and screening strategies while recognizing and managing common conditions.

#### *Disease Stage and Severity*

Many chronic conditions develop gradually over time, usually with a preclinical stage that only later gives rise to symptoms or disability. Students exposed to advanced-stage disease in hospitalized patients do not have the opportunity and satisfaction of discovering medical problems early when symptoms are subtle and prevention is most likely to be rewarded. Furthermore, detection and management of chronic disease, before symptoms become glaring, requires physicians to rely on sensitive, fully disclosed, and thorough patient history and physical skills. Under the supervision of office-based faculty, students can learn to enhance these skills without over-reliance on medical technology.

#### *Longitudinal Care*

With ever-shortening length of stay for hospitalized patients, trainees no longer have the luxury of watching the presentation and evolution of medical illness in the way that one could on hospital wards of Osler's time. Only through longitudinal observation over multiple office visits are students likely to understand how patients respond to treatment. Other important principles such as watchful waiting and regression to the mean are more easily appreciated when students follow patients over time.

#### *Organizing Care Within a System*

Organizing ambulatory care is challenging in ways that differ from organizing complex care within the hospital. For instance, sequencing diverse specialists and studies for an individual patient in the ambulatory setting requires special judgment and skill. Yet this skill, which sometimes presents an alternative to hospitalization, has benefits, such as reducing exposure to hospital-acquired infection and preserving a patient's comfort at home. Furthermore, ambulatory practice requires physicians to develop patient care plans that are consistent with the patient's resources and priorities within a system of care.

#### *Practice Improvement*

To survive in an increasingly competitive environment, all practices must implement quality improvement. During a longitudinal experience with an ambulatory practice, trainees can not only learn but also contribute to new or ongoing quality improvement projects. In fact some training programs help medical students develop practice improvement projects as a means of adding value to the practice while at the same time learning the process.

#### *Emphasis on Patient Comfort, Function, and Independence*

Teaching students to focus on patient comfort, function, and independence puts medical care into terms that are meaningful to patients and their families. Furthermore, students exposed only to acute disease management sometimes come to view medical problems that lack resolution as inherently unsatisfying to treat. Chronic care management in the ambulatory setting that successfully improves the patient's

comfort, function, and independence accentuates the importance of this dimension of patient care and can be as satisfying to witness as the resolution of an acute medical illness.

#### *Patient-Physician Communication and Professionalism*

The ambulatory setting depends, perhaps more than the acute hospital environment, on effective patient-physician communication, since ambulatory patients who are unsatisfied with their care vote with their feet. The office-based setting allows students to practice communicating with large numbers of patients under the supervision of a preceptor and role model. A busy practice creates ample opportunities for preceptors to observe students interacting with patients and their families and provide feedback on performance.

#### *Mastery of History and Physical Skills*

In the ambulatory-based practice, where technology is less readily available than in the hospital setting, physicians learn to rely on their history taking and physical exam skills. Clinical educators can help trainees develop these proficiencies by implementing focused, time-efficient techniques, such as the One-Minute Preceptor (first described by Neher, Gordon, Meyer, and Stevens) [3].

What can ambulatory-based preceptors gain? In my experience, much. In addition to the intangible benefit of helping a junior colleague master new knowledge and skills and become professionally acculturated, clinical educators in office practice enjoy the following benefits:

- Expanded collegial contacts with learners and colleagues in academic medical centers,
- Opportunity to recruit future trainees into practice,
- Enhanced practice prestige,
- Continued learning on their own part, and
- Typically, enhanced practice resources such as electronic access to medical school libraries.

Both the need to educate a new generation of physicians at the point of patient care and the need to train physicians who are responsive to a changing population argue for relocating a significant portion of medical education into the ambulatory setting. The benefits will not be limited to trainees and their academic institutions. Teaching, perhaps the most potent form of continuing education, will strengthen community-based physicians and link practical patient care to the wellsprings of academic medical centers.

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*Samuel C. Durso, MD, is an associate professor of medicine and clinical director in the Division of Geriatric Medicine and Gerontology at Johns Hopkins School of Medicine in Baltimore, Maryland.*

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# Virtual Mentor

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## Clinical Pearl

### Recognition and Treatment of Depression

by Holly A. Swartz, MD

#### Scope of the Problem

Major depressive disorder is a prevalent illness associated with considerable morbidity, mortality, and pervasive impairment in psychosocial functioning [1-4]. Approximately 16 percent of the adult population will experience an episode of depression in their lifetime [5]. Depressive disorders are linked to a high disease burden [6] with tremendous socioeconomic sequelae [7]. According to a World Health Organization study, by the year 2020 depression will be the disease associated with the second greatest number of disability-adjusted life years worldwide [6]. And yet, major depression remains underrecognized and undertreated with less than a quarter of those suffering from depression receiving adequate treatment for the disorder [5].

#### Signs and Symptoms of Major Depression

According to the Diagnostic and Statistical Manual, 4th Edition (DSM-IV) [8], an episode of major depression is defined as 5 or more of the following symptoms occurring nearly all day every day for at least 2 weeks:

- Depressed mood,
- Markedly diminished interest or pleasure in activities,
- Significant weight loss (when not dieting), or weight gain, or change in appetite,
- Insomnia or hypersomnia,
- Psychomotor agitation or retardation,
- Fatigue or loss of energy,
- Feelings of worthlessness or guilt,
- Diminished ability to think or concentrate,
- Recurrent thoughts of death, recurrent suicidal ideation, or a suicide attempt [8].

To meet DSM-IV criteria for an episode of major depression, 1 of the 5 symptoms must be either depressed mood or diminished interest. These symptoms must cause clinically significant stress or impairment in functioning and cannot be directly attributable to another medical condition.

#### Epidemiology of Major Depressive Disorder

Major Depressive Disorder (MDD), characterized by 1 or more episodes of major depression, affects approximately 1 out of 6 individuals. The rates of depression in women are disproportionately high: twice as many women as men are diagnosed with



this illness. This finding has been replicated in many countries around the globe, suggesting that this represents a “true” disparity and not a spurious effect of reporting bias (as had been hypothesized initially) [9]. Although MDD can have its onset at any age, the average age of an individual experiencing a first episode of MDD is approximately 22. Fifty percent of affected individuals experience a first episode before age 40. MDD is a heritable condition, with a 2- to 3-fold increase in risk among first-degree relatives of affected individuals. Interestingly, offspring of adults with MDD often initially present with anxiety disorders in childhood or adolescence and then develop MDD symptoms in adulthood [10].

### **Sequelae of Major Depressive Disorder**

MDD is a serious medical condition characterized by high mortality rates (4-15 percent die by suicide) [11] and significant morbidity. MDD leads to loss of productivity in the workplace, impaired interpersonal relationships, and difficulty meeting life goals. If untreated, an episode of MDD tends to last about 1-2 years. More than half of individuals with a single episode of MDD will go on to have subsequent episodes [12]. Serial episodes of MDD, not surprisingly, erode families, lead to downward social mobility, and contribute to long-term disability.

### **Treatment Strategies for Depression**

Despite the gravity of this illness, there are many treatment options available to individuals suffering from MDD.

#### *Pharmacotherapy*

The most commonly prescribed medications for depression are the selective serotonin reuptake inhibitors (SSRIs). These compounds include fluoxetine (Prozac and others), sertraline (Zoloft and others), paroxetine (Paxil and others), and citalopram (Celexa and others). SSRIs are characterized by relatively benign side effect profiles, few drug-drug interactions, and once-daily dosing. The most common side effects are headaches, gastrointestinal distress, and sexual dysfunction.

Other commonly prescribed medications include tricyclic antidepressants (TCAs) such as desipramine (Norpramin), nortriptyline (Pamelor) and amitriptyline (Elavil), and monoamine oxidase inhibitors (MAOIs) such as phenelzine (Nardil) and tranylcypromine (Parnate). TCAs and MAOIs are excellent antidepressants but require more careful monitoring and supervision. Side effects include dry mouth, orthostatic hypotension, urinary retention, cardiac conduction delays, and (in the case of MAOIs) life-threatening hypertensive crises.

Finally, many psychiatrists and primary care physicians have found that the so-called “mixed” or “dual agonist” agents such as bupropion (Wellbutrin), venlafaxine (Effexor), and duloxetine (Cymbalta) provide an alternative for individuals whose depressions do not respond to the serotonergic medications such as SSRIs or who have historically responded to a combination of serotonergic and noradrenergic medications in the past but prefer to take a single pill. Side effects from these medications tend to be a combination of those seen with SSRIs and TCAs and vary with neurotransmitter receptor affinities.

It is difficult to demonstrate differences in *efficacy* among these agents because of unique individual responses. Thus, the choice of a medication for a patient usually depends on prior history of response/nonresponse and side effect profiles of individual agents. It is important to remember that antidepressant effects often do not appear until 4-8 weeks after reaching a therapeutic dose, while unwanted side effects tend to emerge immediately. Unless forewarned about the delay in response, patients may stop taking a medication prematurely or refuse to take a high enough dose to bring about recovery. Physicians can preempt nonadherence by prefacing treatment with a clear explanation about expected response time and by scheduling a follow-up appointment 4-6 weeks after initiation of treatment to evaluate the need for dosage adjustment.

### *Psychotherapy*

Depression-specific psychotherapies are also excellent treatments for depression. Unfortunately, most psychotherapies do not target specific disorders and have not been tested in randomized clinical trials. Detractors of psychotherapy have questioned its theoretical value, and insurance companies have ceased to reimburse for many of these treatments. Nevertheless, there are several psychotherapies that have been evaluated in rigorous clinical trials and have demonstrated efficacy as treatments for MDD. These individual treatments (indeed, they are all individual therapies) include cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPT), cognitive behavioral analysis system of psychotherapy (CBASP), and psychodynamic-interpersonal therapy (PI) [13]. Depression-specific psychotherapies have demonstrated efficacy both as monotherapy and as adjuncts to medication. Other psychotherapies such as psychoanalysis, group therapy, and supportive psychotherapy have not been systematically evaluated as treatments for MDD.

### *Other Treatment Strategies for Depression*

One of the most powerful treatments for depression is electroconvulsive therapy (ECT). Although much maligned by popular accounts (eg, *One Flew Over the Cuckoo's Nest*), ECT is an effective option for selected patients [14]. Because ECT is a cumbersome procedure to conduct in outpatient settings, it is typically reserved for severely depressed or refractory patients. Phototherapy with high energy (lux) light boxes is clearly effective for individuals prone to seasonal MDD and may be used to prevent MDD in individuals who have recurrent winter depressions. Implantable vagus nerve stimulators and transcranial magnetic stimulators have attracted attention as potential treatments for refractory depression, although the efficacy of these therapies has not been clearly established.

### **Depression: An Illness, Not a Weakness**

Perhaps the most important message about MDD—for both health care professionals and patients—is that depression is an illness, not a personal weakness or failing. Like many other medical conditions, MDD is a biologic process that interacts with life circumstances (similar to diabetes mellitus) and responds to proper treatment. It is heritable, serious, and associated with both death and poor functioning. As physicians, we should routinely consider MDD as part of our differential diagnosis in patients

with multiple somatic complaints, vague feelings of malaise, or the specific constellation of complaints listed in the criteria above.

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*Holly A. Swartz, MD, is an assistant professor in the Department of Psychiatry at the University of Pittsburgh School of Medicine. She is also an attending psychiatrist in the Depression and Manic Depression Prevention Program at Western Psychiatric Institute and Clinic in Pittsburgh.*

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# Virtual Mentor

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## Case in Health Law

### A Physician's Role in Informing Family Members of Genetic Risk

by Faith Lagay, PhD

Individuals whose illnesses have a genetic component—as certain cancers, neurologic diseases, and many other illnesses do—should be told about the inheritable characteristic of their diagnosed conditions. This knowledge allows patients to make informed reproductive decisions and enables those who already have biological children to take action to protect or preserve the health of those children. That action may be genetic testing of a child, if appropriate, informing an adult child of his or her potential risk, or doing nothing at all. The appropriate course of action depends not only on the probability of a child's inheriting the trait and the seriousness of the illness, but also on whether symptoms of the disease first develop in childhood, young adulthood, middle age, or beyond, and whether any lifestyle or medical intervention can protect the children from the disease or ameliorate its severity.

How great is the physician's ethical duty to insure that the patient informs his or her offspring? Certainly physicians cannot be expected to track down their patients' adult children, wherever they may be, to notify them of possible risk. But what about family medicine specialists who often care for parents and children in the same family? Does this physician have a greater duty to protect these children because they are also his patients? The more medical science learns about the genetic component of disease, the more prevalent this conflict will become; a conflict that pits the principle of respect for patient confidentiality against the principle of nonmaleficence—do no harm. In law, the medical injunction to “do no harm” has been interpreted to impose, under certain circumstances, a duty to warn those who are in immediate risk of serious harm [1].

### Duty to Warn About Potential Genetic Disease

The court system first faced claims against physicians for failure to perform genetic tests (and hence inform parents-to-be of potential risk) in the late 1980s [2]. Claims for failure to inform patients' children of their risk followed shortly after, in the mid 1990s. Two landmark cases (that reached the higher courts in their respective states within 1 year of each other) came to different conclusions on the question of the scope of a physician's responsibility to inform.

The earlier of these 2 cases, *Pate v Threlkel*, was decided by the Florida Supreme Court in 1995 [3]. Heidi Pate, after learning in 1990 that she had medullary thyroid carcinoma, discovered that her mother had been treated for the genetically transmittable disease 3 years before. Pate sued the physicians who had treated her mother and their employers, claiming that they had a duty to inform her mother of the genetic component of the disease so that she could have her children tested. Pate's suit

alleged that, had she been tested in 1987, her condition could have been prevented or cured. The Florida court agreed that Pate's mother's physician had a duty to inform his patient of the genetic component of her disease. But, the court said further, in any circumstances in which a physician has a duty to warn of genetically transferable disease, that duty is satisfied by warning the patient.

A year later, the New Jersey Superior Court reached a decision in *Safer v Estate of Pack* that implied a more extensive duty for physicians [4]. In this case, Donna Safer's father died from colorectal cancer that had metastasized to his liver. Donna was 10 years old at the time. Twenty-six years later she was diagnosed with colorectal cancer that had spread to one ovary. She retrieved her father's medical records and learned of her father's cause of death. Thereupon, Safer sued the estate of the late-Dr Pack who had treated her father, contending that the cancer was known 26 years earlier to be a hereditary condition and that Dr Pack was required, by medical standards of the time, to warn those at risk. She claimed that, given the opportunity for monitoring, early detection, and treatment, she would have been spared the severe consequences of her metastasized disease. The Safer court decided that a physician's duty to warn may not be satisfied in all cases by informing the patient. While not specifying how, exactly, the physician's duty to warn should be fulfilled—especially in the case of a young child, as Donna Safer had been when her father died—the court said that it might be necessary for a physician to weigh his or her broader duty to warn against his or her duty to respect patient confidentiality [4].

### **Implications for Physicians**

In the decade since these precedent opinions were issued, physicians have been asking which opinion they should follow. It must be emphasized that the New Jersey court did *not* go so far as to say that a physician who maintains confidentiality and does not warn a patient's children of their risk is negligent. Legal and bioethics scholars have, by and large, taken the conservative approach that favors preserving patient confidentiality, and no recent court cases against physicians for failure to warn about genetic disease have come to light.

The representative thinking of the medical community is expressed in the AMA's *Code of Medical Ethics*, Opinion 2.131 "Disclosure of Familial Risk in Genetic Testing," issued in December 2003 [5]. The overriding message of this guideline is that "physicians have a professional duty to protect the confidentiality of their patients' information, including genetic information" [5]. The opinion also advised that physicians should counsel patients before genetic testing, explaining that, if the illness or predisposition to the illness is found to be genetically transferable, the patient will be expected to share that information with at-risk, biological children. Physicians should also offer to participate in the communication to at-risk children in any way the patient desires. But that's as far as the guideline goes in establishing a physicians "duty" to warn; it does not—explicitly or implicitly—encourage physicians to breach patient confidentiality. The AMA's position on the primacy of patient confidentiality, demonstrated in this opinion, is shared by most physicians and ethicists in the field, all of whom acknowledge that, without assurance of confidentiality, patients will not feel

free to share the history and lifestyle information that physicians need to diagnose and treat them most effectively.

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# Virtual Mentor

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## Policy Forum

### **The Right Intentions but Wrong Prevention: On Informed Consent for Preventive Services of Controversial Effectiveness**

by Michael D. Fetters, MD, MPH, MA

Physicians following the literature cannot help but notice a steady stream of calls for informed consent dialogue about the risks and benefits of a preventive service of controversial effectiveness. Authors of studies with conflicting or inconclusive results often make recommendations such as, "The clinician should have an informed consent dialogue with the patient about the potential risks and benefits of testing." While these authors may have the right intentions, it is the wrong prevention if services of unknown effectiveness monopolize the physician's and patient's attention. Here, I argue against clinicians routinely suggesting tests of controversial effectiveness to patients. Furthermore, researchers who have insufficient evidence to make clear recommendations about the effectiveness of a preventive service should refrain from "ambiguity dumping" on primary care physicians and their patients.

#### **Barriers to Service**

Primary care physicians are already under fire for failure to meet benchmark delivery rates of preventive services of known effectiveness [1-6]. One barrier to delivery of such services is the sheer number of procedures that are recognized by The United States Preventive Services Task Force (USPSTF) and could be provided to each patient [7]. Interventions of proven effectiveness as defined by the USPSTF are too numerous to be delivered in the allotted time of a health maintenance examination [8]. For example, there are no less than 38 preventive services with an A or B recommendation from the USPSTF for an asymptomatic woman in her 40s, and 27 preventive services for an asymptomatic man in his 40s (Table 1) [7]. For patients with risk factors, the number of effective preventive services increases.

Physicians have always had a compelling ethical imperative to act beneficently, and this obliges them to provide these effective services to their patients. Similarly, the principle of nonmaleficence directs physicians to not omit services of known benefit. Such errors of omission can result in harm, as in the case of a woman with a delayed diagnosis of breast cancer due to a failure to screen. Inasmuch as beneficence (doing good for patients) and nonmaleficence (not harming patients) share the goal of advancing patients' best interests, I will treat these as one overriding concern in the arguments below.

A second barrier to delivery of preventive services of proven effectiveness is the need for physicians to address the patient's agenda. As illustrated by the competing demands model, many other interests compete with prevention delivery. Among these interests are medication refills, management of chronic problems, supporting patients



under stressful circumstances, and providing treatment or other support to family members [9]. In the interest of providing patient-centered care and working on a shared agenda with the patient, there is an ethical imperative to address the patient's concerns to the fullest extent possible.

Tests of controversial effectiveness stand as a third obstacle during prevention visits. The ethical principle of autonomy and respect for persons supports an informed consent discussion of all tests. In the case of a controversial test, it can be argued that there is no evidence-based “best” answer to whether a patient should receive a service. Consequently, the patient's values and preferences have particular bearing on whether he or she has the test. For example, PSA screening has not conclusively been shown to change outcomes of prostate cancer treatment. Moreover, there are significant risks from positive screening results such as anxiety; and risks from treatment include incontinence and sexual dysfunction. Patients frequently have opinions about these risks and benefits, and the ethical arguments for involving patients in such discussions about their opinions and concerns are compelling [10].

In sum, there are 3 competing ethical considerations: providing benefit to the patient through delivery of effective preventive services (and avoiding harm through errors of omission), meeting patient needs by using a patient-centered approach, and respecting patient decision making through an informed consent dialogue about preventive services of controversial effectiveness. Each of these has ethically compelling merit. In an ideal world, physicians would address all 3 morally worthy agendas. Unfortunately, these ethical considerations compete with each other due to a physician's limited time [8].

Given time constraints, it is frequently not feasible to provide all the effective services, address the patient's agenda, and conduct an informed consent dialogue about services of controversial effectiveness. I contend that providing services known to be effective has greater moral weight than providing services of controversial effectiveness. Beneficence claims supporting provision of the effective preventive services outweigh those associated with provision of controversial services.

While the above seems straightforward, patients sometimes request preventive services of controversial effectiveness as part of *their agenda* with physicians. In these circumstances, clinicians need to conduct an informed consent dialogue and help patients make a choice [10]. The ethical basis for providing a test of controversial effectiveness becomes stronger when associated with patient-centered care and respect for patient decision making. But such discussions run the risk of causing harm if they are so long that they preclude delivery of the effective preventive services.

Hence, I argue that the “best ethical practice” with regard to preventive services of controversial effectiveness is for clinicians not to address these issues unless raised by the patient. If an informed consent dialogue about a controversial test does occur, these dialogues should be kept as short as possible in order to save time for delivery of effective preventive services (and reduce harm by minimizing errors of omission). Keeping these discussions short will help maximize time for addressing other concerns

raised by the patient. Patients need a sufficient understanding of the risks and benefits of tests of controversial effectiveness, but prolonged deliberations have an ethical cost.

Critics of this position might argue that such controversial tests may have a yet-undiscovered benefit and that the real flaw is the lack of well-designed research. Of course, the alternate possibility is that such controversial tests truly are not effective and subsequent, better-designed research will prove their ineffectiveness. A dialogue with the patient, no matter how detailed or comprehensive will not change the quality of the existing data for deciding whether testing will lead to a statistically improved outcome. In the absence of effectiveness data, a coin toss might be as likely to yield the better choice.

The implications of this analysis are 2-fold. First, clinicians should de-emphasize preventive services of controversial effectiveness. Second, investigators who conduct research that yields equivocal results about a service's effectiveness should be judicious in their time allotment for an informed consent dialogue by clinicians and patient. Editors and reviewers of manuscripts should discourage such "ambiguity dumping" during the publication process.

Eliminating the expectation that doctors and patients have informed consent dialogues about tests of controversial effectiveness unless raised by the patient will help protect the limited time available for prevention. Despite well-meaning intentions, clinicians should be liberated from routine expectations to spend time on unproven services, as this is the wrong prevention to dominate the agenda.

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*Michael D. Fetters, MD, MPH, MA, is an associate professor in the Department of Family Medicine at the University of Michigan and director of the Japanese Family Health Program at the University of Michigan. His involvement in this work was made possible by the Robert Wood Johnson Generalist Faculty Scholars Program and the Michigan Consortium of Family Practice Research.*

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## Medicine and Society

### Overcoming Obstacles in US Health Care Delivery with a New Practice Model for Family Practice

by Martey S. Dodoo, PhD, and Andrew Bazemore, MD

Despite brisk advances in science and technology and a bounty of medical knowledge, tools, and techniques to enhance patient care, US physicians still labor daily to provide the highest quality care to their patients at reasonable cost. They struggle against a complex collection of economic and business hurdles and obstacles imposed by the health care system. These challenges have made the current system unworkable for many physicians. Policy analysts have argued that the system cannot continue this way for much longer and have speculated that health care service delivery in the US will soon become a crisis unless it undergoes a major overhaul. This essay will highlight some of the hurdles and obstacles that have hindered physicians and present brief summaries of some proposals currently being discussed to overcome them.

### The Economic and Business Pressures on Physicians

Numerous financial obstacles confront physicians in the US today. There are, for example, increasing threats of lawsuits that result in escalating malpractice insurance premiums [1], and soaring practice overhead costs. Physicians also face unfunded legal mandates, including the HIPAA confidentiality regulations and the demand for independent translators for non-English speaking patients, while they find themselves providing increasing levels of uncompensated care. Meanwhile many primary care physicians' compensation has either declined relative to the cost of living or leveled off at best. Many face increased work hours in order to perform growing administrative tasks that add little or no value to patient care [2]. Some practices have hired additional nonclinical staff to handle some of these tasks.

The new administrative tasks physicians have to perform include increased billing and coding, resubmitting denied claims, phone calls with pharmacies to resolve formulary drug issues, verifying insurance coverage, co-payments and deductibles for patients, and negotiating or renewing insurance contracts with multiple health plans. A large portion of US health care dollars goes to paying for the ever-expanding bureaucracies that insurers set up to handle these tasks and the staff hired by physicians to deal with these bureaucracies. So large bureaucracies have evolved not to deliver care, but to negotiate payments and, in many cases, to try to avoid paying for care. Physicians are then compelled to increase their overhead expenses as they fight to make sure somebody pays for the services they provide.

Financial pressures also come from steadily falling reimbursement rates in government health programs like Medicare and Medicaid. The reimbursement rates for these programs are relatively low, and physicians are finding it increasingly difficult to

participate. Many also believe that the formulae for updating the Medicare reimbursement rates are flawed. Despite these concerns, beginning next year, the Centers for Medicare and Medicaid Services plans to go even further and use the same flawed formulae to cut reimbursement rates by more than 30 percent over 6 years [3]. Because third-party payers frequently use the Medicare rates as a reference point, they are likely to cut their own rates as well in the near future.

**Family physicians are exposed to even more pressure.**

The financial pressures on primary care and family physicians are even greater. Primary care physicians see, on average, fewer patients per day and bill for fewer high-reimbursement procedures per day, than do specialists. They perform fewer tests per patient visit and treat more patients for conditions whose complexity is often not valued by the reimbursement systems, even though these are conditions with important psychosocial components. Because family physicians see patients with virtually any clinical problem and experience amplified exposure and sensitivity to the financial pressures noted, they are frequent leaders in the search for health care system improvements. Responding to these pressures, leaders in family medicine have proposed a groundbreaking and landmark new model of practice and care in 2004 [4].

**A Solution: the New Model of Practice in Family Medicine**

The new model [4] stresses a patient-centered, health care team approach; elimination of barriers to health care access; organized chronic disease management; advanced health information systems, including electronic health records and computers that can automatically exchange information; redesigned, more functional offices; a focus on health quality and outcomes, including computer analysis capabilities in each office; and enhanced practice finance. The model also commits family medicine to providing a comprehensive basket of medical services for everyone in the population. Subsequent to the new family medicine care design, Task Force 6 formulated a financial model to sustain it [5], with a focus on practice reimbursement and health care finances. The report of Task Force 6 suggests that full implementation of the new model of care within the current fee-for-service system of reimbursement would result in a 26 percent increase in compensation for each physician in a 5-physician practice, if they maintained their current number of work hours [5].

If the present reimbursement system were to be revamped so that all Americans—rather than the current half—had reliable sources of primary care, the new model forecasts a 5.6 percent decrease in the national cost of health care, or a savings of \$67 billion dollars per year, in addition to improvements in the quality of health care [5].

But the forecast is not simply for increased compensation. For example, greater access and better outcomes from enhanced prevention and disease management may mean that, even though physician panel sizes increase, the number of physician visits or patient contacts will actually decrease. It is also true that, if the current fee-for-service system of reimbursement is maintained, innovative features of the new model like chronic disease management can easily become a drain on physician revenue streams. Thus it is imperative the current reimbursement system be scrapped and replaced for these reforms to be viable.

Meanwhile the American Academy of Family Physicians (AAFP) has invested millions of dollars in a practice resource center. The center will implement and evaluate a national demonstration project that would transform up to 20 family medicine practices to the new model of care advocated in the Future of Family Medicine project report.

### **Additional Solutions**

An important component of the proposed reforms is the introduction of secure electronic health technologies into every physician's practice. This should result in greater practice efficiency and lower cost of operation and should support many of the features of the new model for family physicians. The high cost of acquiring the technology has created the need for adoption incentives for physicians (particularly those in solo or small group practices) before this can be fully implemented.

Another solution proposed to relieve some of the pressures on physicians has been tort reform that places legislative limits on physician exposure to malpractice liability. Alternatively, direct caps on insurance premiums and limits on attorneys' fees have been suggested. Despite numerous attempts at the federal level, only some state efforts have been successful at imposing legal limits [6].

### **Conclusion and Some Next Steps**

This essay has highlighted some of the numerous financial pressures on physicians, and the amplified exposure and sensitivity of primary care physicians to these pressures. It has also provided a synopsis of some proposals to overcome these pressures. The AAFP new model offers landmark innovation in the delivery and funding of primary care. Without physician buy-in, however, the model remains merely a concept. Interested physicians can become part of the reform movement by: (1) learning more about the new model of practice [4] and the report on financing the new model [5], (2) adapting to the changes in the profession and becoming lifelong learners, (3) using new innovations and advances, (4) organizing their practices to provide care through multidisciplinary teams, and (5) engaging other partners outside their practice to form teams and develop collaborative relationships. Educators can translate the new model concepts into guidelines for patient-oriented training of physicians. Students and practicing physicians can seek and demand training to provide the full basket of the new model services. And, above all, every physician should join the debate on the merits of cutting out the administrative bureaucracy of insurers and providing health coverage for all.

Economic pressures on the health care delivery system in the US have been mounting for several decades. The system is close to a breaking point now. Avoiding a collapse will require a complete revolution or paradigm shift. All physicians should obtain as much information as they can so they can play their rightful roles in this reform effort.

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*Martey S. Dadoo, PhD, is a senior economist at the Robert Graham Center: Policy Studies in Family Medicine and Primary Care and adjunct associate professor at Georgetown University School of Medicine, both in Washington, DC.*

*Andrew Bazemore, MD, is assistant professor of family practice at the University of Cincinnati, director of the International Health Program in the Department of Family Medicine, and a health services researcher in the Institute for the Study of Health.*

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# Virtual Mentor

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## Op Ed

### Four-Year Residency Training for the Next Generation of Family Physicians

by Marguerite Duane, MD, MHA, and Robert L. Phillips, Jr, MD, MSPH

Family medicine training is still largely based on a model developed more than 35 years ago, with 3 years of required rotations in multiple areas of medicine, combined with a longitudinal clinic experience in model family practice centers [1, 2]. The physician trained in this model has been prepared to practice in a range of settings and with diverse scopes of practice. The outcome is a physician workforce that is distributed across urban and rural America with important positive effects for the health of communities [3, 4]. The durability and beneficial outcomes of this training model suggest that it should continue, but there are several reasons to consider innovative changes in its character if not its duration:

- The aging of the US population and increasing prevalence of chronic disease,
- Reduction in resident work hours leading to a reduction in training time,
- Migration of new diagnostic and treatment technologies into outpatient care, and
- Need for a new relationship with patients that delivers traditional benefits but in updated and recognizable ways.

Though some have argued for a shorter residency program for family medicine, we believe that a longer and more refined (4-year) training program may be a better option to meet the changing needs of the US health care system. For starters, the cresting wave of baby boomers is producing a shift in the US age demographics that will continue for decades, and the majority of this group will suffer from 1 or more chronic diseases. Family physicians, particularly those with added training in geriatrics, care for a large share of the current elderly population, but more capacity will be needed. The restricted 80-hour work week for residents, while beneficial in a number of ways, reduces time for clinical and didactic education. Graduates from family medicine programs are providing a narrower spectrum of care than they did just 5-7 years ago, but it is unclear whether this is due to changes in training, lifestyle choices, or forced scope reduction [5, 6].

“Entire fields of study [such as genetics, HIV, and sports medicine] have been created,” since the specialty of family medicine was founded in the early 1970s [4]. As technology in a variety of fields becomes cheaper and more refined, it migrates to outpatient settings, so that care previously delivered in hospitals and by subspecialists becomes available in primary care. Finally and most importantly, Americans identify



the characteristics of family medicine as valuable and desirable but fail to identify family physicians as the source of such care [7].

Family medicine has accepted these challenges as an opportunity to develop a new model of care that patients can identify as a source of sustained, healing relationships. The new model is based on the concept of a personal medical home, where patients will receive acute, chronic, and preventive care services that are accessible, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians. Residency training must be where the next generation of family physicians adopts this new model of medical care.

In a recent study of residency directors, practicing family physicians, and family medicine residents, many supported the current 3-year training model because it allows sufficient time for a basic foundation and adequate exposure to inpatient and outpatient medicine [1]. Many respondents, however, said they would favor a change to a 4-year program if there were a genuine increase in the depth and breadth of training. As one resident commented, there is “so much to learn, so little time” [1]. In a Graham Center study of graduating residents’ views on a fourth year of residency training, respondents nominated training experiences that could fill 7 additional months—and only recommended 5 weeks of reductions from current training. To the extent that the respondents were expressing discomfort with their preparation for a fuller scope of practice, the results support the option of a fourth year of training [2]. A small proportion of family physicians pursue additional certifications or fellowship training, and others supplement their skills with CME; however these opportunities do not appear to sufficiently meet the expressed needs of the survey participants. The openness to additional training time in exchange for a commitment to enhanced training may be a real opportunity to meet the challenges we have outlined.

The current 3-year model has effectively and efficiently prepared nearly 70 000 family physicians whose care is associated with beneficial outcomes. With the new challenges we face and the specialty’s commitment to a new model of care, it is time to consider transforming the manner and length of time in which we train family physicians. It is highly doubtful that a reduction in training time is an option if family medicine is to grow as a specialty and respond to the desire of many Americans for a new relationship with the health care system. Reducing the training time of family physicians would be a retreat from current trends and opportunities. What is needed is a period of purposeful innovation, with desired training outcomes geared to a new model of delivering care [8]. We believe that medical students and patients will respond to this direction and that trainees will accept the change whether or not it involves an additional year of training.

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*Marguerite Duane, MD, MHA, is an assistant professor of family medicine at Georgetown University School of Medicine, in Washington, DC.*

*Robert L. Phillips, Jr, MD, MSPH, is director of The Robert Graham Center: Policy Studies in Family Medicine and Primary Care in Washington DC.*

*The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.*

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## Op Ed

### **An Argument for Reducing Family Medicine Training to 2 Years**

by John Zweifler, MD, MPH

What is the proper length for family medicine residency training? Well, medical knowledge is exploding, expectations are rising, and there is pressure to incorporate more sophisticated information technology into everyday practice. So we should increase family medicine training from 3 years to 4 years, right? This, in fact, is one of the recommendations of a comprehensive assessment, known as, the *Future of Family Medicine*, carried out by leading family medicine organizations [1]. But before we jump on the bandwagon, let's take a closer look at the field of family medicine and how we train family physicians.

Family physicians are taught to provide comprehensive, continuity of care to patients throughout the life cycle, paying particular attention to biopsychosocial issues. Newborns, sports physicals, deliveries, counseling for depression, caring for hospitalized patients and those in nursing homes, death and dying, we do it all. However, are we the best physicians to provide each of these services? Before we decide the length of family medicine training we should first clearly define what is our unique expertise.

Family medicine, along with pediatrics, internal medicine, and perhaps obstetrics/gynecology are primary care fields. The ability of primary care physicians to evaluate patients with undifferentiated, multiple, often ill-defined complaints distinguishes them from their specialist colleagues. Because family physicians are broadly trained and are sensitive to the psychosocial needs that play such a huge role in primary care, they are uniquely positioned to provide primary care services in ambulatory settings. At the same time, it is hard to argue that family physicians do a better job in inpatient care, labor and delivery, or the operating room that are the domains of internists, obstetricians, and surgeons, respectively. Therefore, family physicians should define themselves as the "specialists" in primary care, while acknowledging the more intensive preparation other specialties receive in areas including inpatient care and labor and delivery.

If we accept the premise endorsed by the *Future of Family Medicine* report that family medicine should focus on primary care services in ambulatory settings, what are the implications for residency training? I believe The Residency Review Committee for Family Medicine should reduce mandated training in specialty areas including inpatient medicine, obstetrics, and surgery. At the same time we should signal to our residents as well as to the public that we train our residents to be experts or—

specialists—at providing primary care in ambulatory settings by emphasizing educational and practice experiences in family health centers.

Reducing training in specialty areas would allow family medicine to cut back its training from 3 years to 2 [2], which would be a boon to recruitment efforts. The number of American medical school graduates who select family medicine has plunged over 50 percent in the last 6 years. This reflects not only a lack of clarity regarding the role of family physicians that an emphasis on primary care in the ambulatory setting could address, but also an economic imperative. After all, as politicians are wont to observe, "It's the economy stupid!" As the director for a family medicine training program, I want more and better applicants. So, let's reduce training to 2 years to appeal to students who want to graduate and get paid as full-fledged board certified family physicians 1 year sooner. At the same time, let's create opportunities for family physicians to receive additional postgraduate training in areas of interest including hospitalist services, obstetrics, research, emergency medicine, rural health, and sports medicine, to name a few.

What are the ethical implications of a 2-year training program? Certainly if we were to unleash unprepared physicians solely out of self-interest and a desire to increase our graduates' lifetime earning potential that would be cause for concern. It is my contention, however, that emphasizing primary care in ambulatory settings will help integrate important advances in medical education even in the context of a slimmed-down curriculum. The family health center can naturally incorporate information technology, evidence-based principles, and teaching strategies that address practice-based learning, systems-based practice, and interpersonal and communication core competencies through chart audits, videotaping, and shadowing. The notion of 2-year training is not completely untested. There have been several hybrid medical school/residency programs that graduated participants in 6 years rather than 7 years with no apparent differences in outcomes [3-5]. Canada already trains family physicians in 2 years, and internal medicine is contemplating changes based on an initial 2-year training period followed by specialization [6,7].

We can also consider ethical implications from a societal perspective. Training a physician is subsidized to the tune of close to \$100 000 per resident per year by us, the taxpayer, directly through Medicare and indirectly through Graduate Medical Education payments to hospitals. A 2-year primary care training program would allow us to allocate resources to address other pressing societal needs. Retooling family medicine could also lead to a discussion of health workforce issues. We can potentially increase the efficiency of our health care delivery system by clarifying the role of primary care and its relationship to the other medical specialties.

These are turbulent times for health care and medical education. A 2-year family medicine training program emphasizing primary care in the ambulatory setting would position family medicine to respond flexibly and nimbly to the changing paradigms we face.

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*John Zweifler, MD, MPH, is chief of the Department of Family and Community Medicine at the University of California-San Francisco-Fresno (UCSF-Fresno). He is also program director for the Family Medicine Residency Program at UCSF-Fresno.*

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