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CLINICAL CASE
Establishing Common Ground in a One-Time Patient Encounter
Commentary by Benjamin Levi, MD, PhD, and D. Micah Hester, PhD

Mrs. May took her 4-year-old daughter Emma to Dr. Smith because Emma had a cold. Dr. Smith had not seen Emma before, and asked Mrs. May who Emma's primary care doctor was.

She responded, "I just haven't been able to find a doctor who is right for Emma. I took Emma to a general pediatric clinic 3 weeks ago when she had a rash on her back, and 1 week later we went to an acute-care clinic because she was vomiting and had diarrhea."

Dr. Smith examined Emma and found that she had an upper respiratory infection (URI) that would probably resolve in the next day or so and did not need treatment. He explained this to Mrs. May.

"I think that Emma needs some sort of treatment to help her get over the infection," Mrs. May said. "She is not going to get better without it."

Dr. Smith told her that if the condition did not resolve in a couple of days, she could bring Emma back in or give him a call and he would reconsider.

At the end of the visit, he asked, "Can we schedule Emma for a follow-up well-child visit in a few months?"

"Let me think about it," said Mrs. May. "I am not sure that we are ready to commit to you as our primary pediatrician quite yet."

Two weeks later, Dr. Smith saw Mrs. May and Emma at his office, but they were visiting one of the other doctors, Dr. Moore. Dr. Smith asked him about the visit.

"Emma had another URI," said Dr. Moore. "Her mom was concerned so I gave her some antibiotics for Emma to take."

"Were you able to set up a follow-up visit?" asked Dr. Smith.

Dr. Moore replied, "Mrs. May said that she will bring Emma in next month for a well-child visit."

"You know Mrs. May probably wants you as her primary provider because you will

do whatever she wants you to for Emma," said Dr. Smith.

"I don't think that it is especially harmful to give a kid some antibiotics, even if in all likelihood she has a viral infection," said Dr. Moore. "Anyway, I was able to get Mrs. May to agree to a follow-up visit so that Emma is going to receive care from me rather than from random physicians. I think that it was a small compromise to make in order to ensure a better level of care for Emma."

Commentary 1
by Benjamin Levi, MD, PhD

It is not uncommon within a group practice for clinicians to disagree about treatment regimens. Medicine is far from an exact science. Clinical decisions are often influenced by a clinician's training, past experiences, and his or her propensity to accept uncertainty and risk [1]. What makes this case problematic from the standpoint of ethics and professionalism is that it raises questions about what constitutes *medically necessary*, whether it is justifiable to do something wrong in the pursuit of a (presumed) greater good, how professional standards are determined, and what are the limits of patient and parental rights.

First, however, a variety of process and communication issues warrant some comment. We know from both research and personal experience that how a message is *delivered* can make a great difference in how it is *received* [2]. When Mrs. May expresses her view that without some sort of treatment Emma is not going to get better, Dr. Smith could have agreed and then gone on to explain: "I think you're right that without proper treatment it's going to take longer for Emma to get better. The question is, what's going to help her most? Everything I see today suggests that Emma has a viral infection, and, while they tend to be less serious than bacterial infections, we have fewer medicines to treat them. Antibiotics, for example, wouldn't do anything for her other than possibly give her diarrhea, and of course cost you money. What we can do to help her feel better, though, is give her anti-inflammatory medicine that will decrease many of her symptoms."

In this way, Dr. Smith positions himself as an ally of Mrs. May and Emma, rather than the gatekeeper to desired (and forbidden) medication. Further, Dr. Smith can validate Mrs. May's concern: "You're doing the right thing. It's *your* job to worry, and it's *my* job to help you figure out what to worry about. If you're not going to worry about your daughter, who is? Now, let me tell you about the things that would make me worry—the red flags for a bacterial infection or serious medical condition."

Building Patient Trust
A significant part of a physician's job is to provide a context for patients and parents to understand what various signs and symptoms mean. Many people don't know the difference between a bacteria and a virus, much less how antibiotics work. It is also helpful to reinforce that a physician should always have a good medical justification for what he or she does, since virtually any treatment has potential adverse effects.

Dr. Smith might also remind Mrs. May with a smile that much of the time in pediatrics, children get better despite our efforts rather than because of them.

Such approaches often help parents place their concerns in better context. That said, there are some parents who will not be satisfied by anything short of receiving the medical treatment they think is appropriate. When the parent is also a health care professional, this can be especially challenging, particularly if he or she fails to appreciate the impact that emotional attachment can have on professional judgment. Sometimes, though, what is really at issue is a lack of trust—the *sine qua non* of effective medical practice. Parents and patients invariably bring expectations to their clinical encounters, shaped by previous interactions with doctors—some good, some not. Good physicians know that, in the face of skepticism, one builds trust through clear communication, transparency, and treating others with respect, and with some individuals it just takes time. But if at the end of the day a parent or patient *insists* on being unreasonable, then it is unlikely that reasoned approaches of any sort will have a significant effect.

We do not know how amenable Mrs. May might be to the approaches mentioned. But the description we have suggests that when she disagrees with a physician's medical judgment, she will reject it. And this is her prerogative—in most cases. Parents have wide discretionary authority in how they raise their children, and (barring abuse or neglect) they have the right to reject others' recommendations [3]. Such rights of refusal are termed *negative rights* [4, 5]. They may be contrasted with *positive rights*, which entitle an individual to receive something from another party—be it property, a service, or some process (e.g., schooling or due process of law). In the context of medical care for children, parents have the negative right to reject sound medical treatment—such as vaccines, tests for tuberculosis, medicine to treat acne—so long as doing so does not constitute medical neglect. But parents do not have the corresponding positive right to demand medically inappropriate treatment [6].

Medically Indicated Treatment

What ultimately constitutes medically indicated treatment is determined by the professional judgment of qualified physicians [7]. Medical licensing boards and society at large expect that physicians can provide medical justification for their treatment decisions. It is on this basis that society grants exclusive treatment privileges to physicians. This is not to say that what counts as medically indicated is always clear-cut. But in the case of prescribing antibiotics for what is clearly a viral infection, Dr. Smith is on solid ground in being critical of Dr. Moore. In fact, one could argue that such criticism is required, insofar as the medical profession is expected to be self-policing in maintaining its standards and codes of conduct.

Examining the Prescribed Treatment

Though seemingly minor, Dr. Moore's treatment decision is actually problematic on many levels. First, the unnecessary use of antibiotics contributes to the growing problem of antibiotic resistance [8]. Second, it unnecessarily risks adverse effects

associated with antibiotic use—from *Clostridium difficile* disease to Stevens-Johnson syndrome—when there is no need to incur these risks. Such unwarranted treatment puts the prescribing physician (and his or her practice) at legal and financial risk should a serious adverse event occur. It reinforces the parent's inappropriate request, setting a precedent for future requests—with full knowledge that the average 4-year-old child has six to 10 upper respiratory infections per year. By validating the parent's unreasonable expectations, such prescribing creates the potential for conflicts with other physicians who may subsequently provide medical care to Emma. Finally, Dr. Moore's treatment of Emma is deceptive insofar as it indicates (disingenuous) agreement that viruses should be treated with antibiotics.

Is it worth incurring these potential costs to establish a medical home for Emma? If Mrs. May is truly an unreasonable person, it's not at all clear that future encounters are likely to reach conclusions that are any more medically appropriate. There are some parents and patients whom we can neither help nor appease. But if Mrs. May *is* open to reason, then why not begin the relationship by appealing to her good sense? With effective communication skills and a respectful and supportive attitude, many seemingly intransigent parents and patients "come around." Conversely, many treatment decisions physicians make for patients have room for negotiation and can accommodate at least some individual preferences. Making one's reasoning transparent and remaining open oneself allows for medical decision making that is professionally defensible, intellectually honest, and reasonably flexible.

Communication with Colleagues

How to best approach colleagues with constructive criticism of their clinical decisions is an entire topic unto itself. That said, the following ideas offer some guidance:

- Such conversations are part of a healthy relationship.
- Many factors contribute to how another person will receive your efforts. Among them are timing and location; tone and choice of language; and ability to nurture and convey a sense of openness—where openness involves not only suspending judgment, but being willing to learn (and perhaps accept) others' perspectives and interpretations of the issues at hand.
- Be prepared for the unexpected, both in the form of a breakthrough and defensive response.
- Find cooperative ways of communicating that do not bludgeon people, recognizing that yours is but one of many windows on the truth. Sometimes this can be done simply by stating your understanding of the situation or inquiring whether there's something you're missing. It can be useful to introduce independent standards—e.g., professional codes, hospital policies, peer-reviewed publications, etc. In fact, reaching agreement about what might serve as an independent standard could itself become both a means and a goal of one's conversation.

References

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Suggested Reading

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Commentary 2

by D. Micah Hester, PhD

To analyze ethical issues that arise in the story of Dr. Smith, Mrs. May, and Emma, it's useful to look at the scenario in three parts—roughly following the chronology as given. What the analysis shows is missed opportunities by Dr. Smith and questionable judgment by Dr. Moore.

In the initial encounter between Dr. Smith and Mrs. May (we do not hear from 4-year-old Emma), we learn that Mrs. May is concerned that Emma has a cold and that Dr. Smith is interested in whether Emma has a primary care physician. Such an exchange is not unusual, but we should note that they begin their dialogue in two different places. Mrs. May, looking for a response to her child's illness, initially finds an inquiry into her relationship to pediatric care. Nothing is made of this in the scenario itself, but it is worth pausing to recognize that this kind of exchange can undermine trust. Rather than reflecting Mrs. May's concern—an indication that he is

listening and that "we are in this together"—Dr. Smith turns to his own (well intentioned, I suspect) concern for good primary-care continuity.

Given Dr. Smith's line of inquiry, it is striking that, when Mrs. May states that she has not "been able to find a doctor who is right for Emma," Dr. Smith follows by asking about other recent visits to the doctor. This is a missed opportunity. Crucially, Dr. Smith does not ask what seems to me to be the reasonable follow-up: "What kinds of things are you looking for from your daughter's primary care physician?" This question allows Dr. Smith to elicit Mrs. May's story—at least as it relates to her child's health care—and provides the opportunity to develop common ground *before* the exam and diagnostic discussion occur. Again, we quickly see two incidents in the brief communication where Dr. Smith's responses are not those of someone who is listening carefully and engaging directly the concerns of the patient's mother.

Part two of this scenario describes an exchange about treatment for Emma's condition. Here again, Dr. Smith loses an opportunity to connect. While acknowledging that Emma has a URI, Dr. Smith indicates it is not something that needs treatment. Mrs. May disagrees. Rather than providing a "wait and see" response, Dr. Smith could have stopped here to acknowledge that Emma is, in fact, ill. This simple acknowledgment can establish a connection with Mrs. May, who clearly worries about her child's health (as evidenced by the several trips to a physician she has made in the last few months). Dr. Smith, then, could continue by moving from this common point to explore why Mrs. May believes Emma will only get better with treatment. Through this he may be able to help distinguish actions that can help relieve troubling symptoms from "treatment" intended to cure underlying conditions. If he is correct that the URI is viral in origin, a "curative" treatment may not be available, but he should also not allow Mrs. May to have the impression that "no treatment" equals "nothing can be done to help your daughter." Our language often betrays us, and we do not work carefully to make sure we are understood and that our patients and parents are understood as well. Had a conversation about what can be done occurred, Dr. Smith's comment about reconsideration if symptoms did not subside in a few days could be taken in light of having done *something* rather than nothing. Part two ends with a reprise of the primary care physician inquiry, and, again, Dr. Smith drops the ball. When Mrs. May states she is "not sure that we are ready to commit to you as our primary pediatrician quite yet," Dr. Smith should react to the comment not as if it ends the conversation but as an invitation to explore what Mrs. May is looking for in a primary care physician and to reassure her that he has the goal of providing the best health care for Emma—a goal they share.

Behind the exchange between Dr. Smith and Mrs. May resides a fundamental ethical tension in pediatrics—given the medical expertise of physicians, how far should parental authority be allowed to operate? Or put another way, who gets to decide what is best for the pediatric patient, and why? Assuming that children (especially 4-year-olds) do not have decisional capacity for such medical considerations, others must speak in their behalf. Our society strongly supports a broad scope for parental authority, and yet parental demands for treatment in the face of physician

disagreement create a tension that challenges this authority. Dr. Smith, if correct in the diagnosis (and that is still questionable), is right not to provide antibiotics, but, as noted above, no antibiotic treatment is not the same as no treatment at all.

The scenario's final section describes an exchange between Dr. Smith and his partner Dr. Moore after Mrs. May brings Emma to see Dr. Moore some weeks later. Here, a number of ethical issues arise. First, while it may be natural curiosity on Dr. Smith's part, he should, in fact, refrain from asking about another physician's patient. Unless he is consulted, Mrs. May's current visit to Dr. Moore establishes a relationship exclusive, not inclusive, of Dr. Smith. Here, Dr. Moore errs too, for, even if asked by a partner, he should not give confidential information about his patient to a (now) unrelated party. While it is not uncommon for colleagues to have such conversations, sharing an office is not equivalent to sharing patients—if it were, Dr. Smith would not need to distinguish between Mrs. May's choosing him or Dr. Moore as a primary care physician. Mrs. May appears to be making a distinction, even within the same office, and part of the importance of the distinction is the trust she places in the person chosen as the primary care physician. Confidentiality is an expected extension of that trust. Further, it is clear that Dr. Smith and Dr. Moore have more to talk about concerning their own professional relationship.

One more issue remains. Dr. Moore, unlike Dr. Smith, provides antibiotics to Mrs. May. Given that this is a recurrent (or sustained) URI within 2 weeks of the previous visit, medication may, in fact, be indicated, though it would seem that the intent in prescribing antibiotics, according to Dr. Moore's own comments, is not so much about Emma's present illness but her long-term care. Should medications be used for reasons other than to cure a disease or alleviate symptoms? Dr. Moore is simply wrong in saying that no harm comes of giving an antibiotic to a child who does not need it, even though he is certainly not alone in this belief and practice. Medications are not benign and should be directed at signs and symptoms, not the psychology of the patient's parent. While Dr. Moore's desire to provide long-term continuity of care for Emma is laudable, the ends, here, do not justify the means. Emma may need antibiotics, and to that end they should be prescribed, but Dr. Moore's rationale does not speak to alleviating infection as their intended purpose, and that is troubling.

This case presents missed opportunities and misplaced intentions; it demonstrates the need for a good preventive ethic that can help mitigate, if not completely avoid, troubling issues that surface when careful communication and forethought are not marshaled.

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