Virtual Mentor. June 2004, Volume 6, Number 6.
doi: 10.1001/virtualmentor.2004.6.6.ccas3-0406

Clinical Cases

Unnecessary Tests and Ethics of Quality of Care

Patients' requests for unnecessary medical tests erode health care quality for all.

Commentary by G. Caleb Alexander, MD

Mr. Mansion, 69, has a history of poorly controlled hypertension, obesity, and a 30-year, pack-a-day smoking habit. During a visit with his primary care physician, Dr. Lal, for a routine annual examination, Mr. Mansion's physical examination is within normal limits with the exception of the conditions noted above.

After the examination is over, Mr. Mansion questions Dr. Lal about having a PSA (prostate specific antigen) test as a screening for prostate cancer. He says that his wife read that PSA screenings can save lives and he wants one. After several questions, Dr. Lal determines Mr. Mansion is not experiencing any symptoms related to his prostate. However, his patient's concern for having this test done is clear. Dr. Lal explains the test is nonspecific, and elevated results can be an indication of any number of prostate conditions, from prostate cancer to benign prostatic hypertrophy. Even prostate cancer, if confirmed after a costly work-up, is not necessarily a terminal condition. All in all, Dr. Lal advises, it's fine to rely on the office exam unless Mr. Mansion experiences symptoms that indicate prostate problems.

Mr. Mansion also inquires about getting a screening chest x-ray. His cousin was recently diagnosed with lung cancer and he has been smoking for almost as long as Mr. Mansion has. Dr. Lal quickly adds that there is even less evidence to suggest that a chest x-ray should be used as a screening test for lung cancer, even if a relative has developed lung cancer.

Despite this information, Mr. Mansion remains set on having both tests done. He tells Dr. Lal that while he is sure the doctor is giving him sound medical advice, he needs to know these test findings are normal for his own peace of mind.

Commentary

Here we are presented with Mr. Mansion, an elderly man who requests a PSA test and screening chest x-ray from his primary care physician. The physician appears skeptical regarding the clinical benefit of either of these tests. Despite this, the patient continues to "remain set on having both tests done." This raises the question as to how to balance patient preferences with the "best evidence" in a way that is satisfactory to both parties and respectful of the professional responsibilities of the physician.

Successful resolution of any case depends first and foremost on establishing all of the facts [1]. Many unanswered questions in this case should be considered, including:

- What are the medical indications? (eg, What is the best evidence about PSA testing and chest x-ray screening for this patient? Of note, evidence regarding the effectiveness, and cost-effectiveness, of PSA testing differs from that supporting chest x-ray screening.)
- What are the patient's preferences? (eg, What is the basis for Mr. Mansion's anxiety or strong desire to achieve "peace of mind"?)
- How about impact on quality of life? (eg, How might various scenarios of test results impact his quality of life?)

- What about social, environmental, and economic considerations? (eg, Who is to pay for the tests?)

Comfort At What Price?

Although requests such as those by Mr. Mansion may be relatively uncommon, their frequency may be increasing in the age of growing patient empowerment and a continued movement from paternalism to autonomy. Such a case poses an important and nonobvious challenge. Should Mr. Mansion be offered, or is he entitled to, the services in question? What are the appropriate boundaries of patient autonomy in this setting?

Patient Preferences vs Clinical Judgment?

Norms regarding the role of patient preferences in decision-making have changed markedly over the past decades, from settings where they were rarely if ever explicitly considered, to settings today where patient preferences and respect for patient autonomy receive considerable emphasis. Such respect does not necessitate that physicians abdicate their professional responsibilities or clinical judgment. Rather, physicians not only are in a privileged position to guide patients but have an obligation to do so based on their cumulated clinical knowledge and experience. Such a model of "enhanced autonomy" is respectful of physician professionalism and the difference between patient independence and patient control [2]. While respect for patient preferences is important, these preferences must be balanced with other considerations, including the medical indications, costs, and other contextual factors of the case. Only by carefully considering the entirety of the evidence in each of these domains can a physician act in a way that is in accordance with the patient's best interests and the physician's professional obligations.

Who Is to Pay for Medical Services?

Should the line that one draws regarding marginally clinically appropriate services vary based on who is to pay? The question of whether one should be eligible to obtain "clinically inappropriate" tests is distinct from but related to the question of who is to pay. Given the scarcity of health care resources and inevitability of rationing, principles of justice mandate that appropriateness of services be considered as coverage decisions are made. One level of care of a certain appropriateness may be available to all, eg, emergency care, while a second level may be available to those who can afford prescription coverage, while a third may be available only if paid out-of-pocket—screening body CT scans, for example. In other words, all other things being equal, the level of evidence to support a test or treatment should be higher when the treatment is covered than when offered as an uncovered service alone.

Impact on Health Care Quality

What is the impact of "unnecessary testing" on health care quality? The decision as to whether the testing being considered is "unnecessary" is one which rests on more information than is provided in the case alone. However, let's assume that the testing is unnecessary in that it is without scientific basis and unlikely to be of sufficient relief to Mr. Mansion's anxiety so as to be considered appropriate on that basis alone. If this is the case, there are several ways that performing the testing threatens health care quality. These have been elegantly elaborated and include "distraction complexity," the label *pseudodisease,* and a lowering of treatment thresholds, which in turn may lead to increased health care costs without concomitant increases in quality [3].

How then should Dr. Lal approach the patient in this setting? After all, "distraction complexity," "pseudodisease," and "treatment threshholds" are rather abstract concepts that may not be of much interest to this patient. Dr. Lal might explain to the patient that since the tests are not indicated they would not be covered by insurance. For many patients this alone would suffice to decrease their interest in the test or treatment. Should the patient wish to pay out-of-pocket, Dr. Lal must consider the potential for harm that might follow from the tests and based on this either assist the patient in obtaining the services out-of-pocket or, consistent with the principle of beneficence, inform the patient that he (Dr. Lal) is not comfortable ordering these tests in this setting.

There is another ethical question raised by a hypothetical extension of this case. If it is decided that Mr. Mansion is entitled to these tests yet they are not covered, how far should his physician go to help him obtain them? This question

is relevant to the balance between patient advocacy and physician professionalism that challenges many physicians as they seek to obtain uncovered tests or treatments for the patients [4].

The Bottom Line

The bottom line is that successful resolution of this case requires Dr. Lal to consider additional information. With this information, Dr. Lal can discuss the options and propose to Mr. Mansion one of three courses of action: (1) get PSA test and chest x-ray as covered services, (2) get PSA test and chest x-ray as uncovered services, or (3) not get PSA test and chest x-ray at all. This case, as with many where testing is considered and health care quality is at stake, offers an opportunity to examine several interrelated ethical issues, including questions of rationing and resource allocation (eg, who should be eligible and who should pay?) as well as different models of the patient-physician relationship and the appropriate bounds of physician professionalism.

References

1. Jonsen AR, Siegler M, Winslade W. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine.* New York, NY: McGraw-Hill Publishers; 2002.
   Google Scholar
2. Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. *Ann Intern Med.* 1996;125:763-769.
   View Article PubMed Google Scholar
3. Fisher ES, Welch HG. Avoiding the unintended consequences of more medical care: how might more be worse? *JAMA.* 1999;281:446-453.
   View Article PubMed Google Scholar
4. Alexander GC, Werner RM, Ubel PA. The costs of denying scarcity. *Arch Intern Med.* 2004;164:593-596.
   View Article PubMed Google Scholar

Caleb Alexander, MD, is a general internist and health services researcher at the University of Chicago. He is an instructor in internal medicine and associate faculty in the MacLean Center for Clinical Medical Ethics and the Robert Wood Johnson Clinical Scholars Program at the University of Chicago.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.