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CASE AND COMMENTARY
Billing for Services Performed by Another
Commentary by Faith Lagay, PhD

Case
Mr. Nelson, who has a history of alcoholic liver disease and esophageal varices, presents complaining of epigastric pain and black, tarry stools for the past 3 days. Dr. Lee, the on-call resident, calls his attending physician, Dr. Franklin, for guidance regarding care of the patient. Dr. Franklin believes that because the resident has completed several gastroenterology rotations and will begin a gastroenterology fellowship next year, he is qualified to perform the esophagogastroduodenoscopy (EGD). Dr. Lee does the EGD and sees gastritis, but no active variceal bleeding. After informing the attending physician of his diagnostic findings, Dr. Franklin decides that the patient can be treated medically with a proton pump inhibitor. However, the attending physician bills for the EGD, even though the resident performed the procedure.

Question for Discussion
Is it ethical for the attending physician to bill for this procedure?

See what the AMA *Code of Medical Ethics* says about this topic in Opinion 4.03 Billing for housestaff and student services. American Medical Association. *Code of Medical Ethics 1998-1999 Edition*. Chicago, IL: American Medical Association; 1998.

Faith Lagay, PhD is managing editor in of *Virtual Mentor.*

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.

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IN THE LITERATURE
The Illusion of Futility in Clinical Practice
Faith Lagay, PhD

Lantos JD, Singer PA, Walker RM, et al. The illusion of futility in clinical practice. *Am J Med*. 1989;87(1):81-84.

Questions for Discussion

1. How would these obligations be affected by disagreements between patients and physicians about the goals of therapy?
2. Are these goals strictly medical with no other implications?

Faith Lagay, PhD is managing editor in of *Virtual Mentor*.

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ART OF MEDICINE

Diagnosing Rembrandt: The Role of Visual Evidence in Medicine

Audiey Kao, MD, PhD

Oh, I see!" one might exclaim on grasping a new intellectual concept. The metaphor of vision has long been linked to knowledge and understanding — indeed, it is only a small etymological move from "sight" to "insight." As the modern technological world becomes ever more reliant on visual culture, however, physicians are challenged to strengthen this metaphorical link by developing new ways of interpreting visual images to create clinical and diagnostic knowledge.

The work of Dr. Carlos Espinel, a Colombian cardiologist at Georgetown University, challenges medical students to hone their diagnostic skills by viewing art from a clinical perspective. In his course "Art Medicine," Dr. Espinel uses the masterpieces of great painters to teach students to enhance their observational skills. Perhaps his most compelling examples of Art Medicine are drawn from a series of Rembrandt Van Rijn's self-portraits, painted over a span of 27 years. Through these paintings, Espinel provides a medical evaluation of Rembrandt's health, combining clinical observation with art technique.

Two self-portraits are compared by Espinel. "*In the London Portrait of 1640* (Available at: ibiblio.org), Rembrandt is 34 years old…His eyes shine…but he turns his face and underneath his haughty pose one discovers distressing signs…He has gained some weight...3 lines cross his forehead; 2 others lie underneath his right eye. Note, however, that these lines do not contribute to his expression. They are wrinkles, showing prematurely for his age. Why" [1]? Espinel moves to a later portrait Available at: ibiblio.org for the answer:

> The… portrait is startling. It was painted in 1659, so Rembrandt must be 53 years old. Time has passed quickly. But what has it done to him? His face is covered in wrinkles. His skin is thick in places, thin in others… notice the ominous sign — a white arc in his left eye, denser than the normal reflection of light, suggests arcus senilis, cholesterol deposits. The creamy impastos underneath his eyes suggest xanthelasma, high triglycerides. I have counted 9 blotches of rosacea on his face. His nose is bulbous with rhinophyma …Notice that in the other portrait[s] Rembrandt places the light on the right. But in the Washington portrait he puts it directly on his forehead, on his left temporal artery, as if to say, 'Look at me. See what is happening to me' [1].

Dr. Espinel's diagnoses of Rembrandt's ills from the self-portraits have provoked some controversy. Harvard psychiatrist Albert Rothenberg takes Espinel to task for making "medical and psychiatric diagnoses as though the paintings were a series of autobiographical photographs [2]." Another physician writes that without the

opportunity to examine the patient physically, "we are left with only inspection — percussion and palpation being out of the question" [3].

These criticisms leveled against Dr. Espinel's work are echoed in concerns raised about another visual medium of diagnosis — the Internet. The 2 questions raised about Dr. Espinel's approach — whether an image can capture the necessary dimensions of illness and whether diagnosis is possible without direct physical contact with the patient — can be easily applied to current discussions regarding medical diagnosis and treatment through the Internet. At the heart of the current uncertainty about medicine at an electronic distance is the question of what information is needed to link sight to insight. Unease about accepting Dr. Espinel's medical diagnosis of Rembrandt based on painted images reflects an implicit recognition that visual evidence is often not enough in the clinical encounter. Yet, as we move toward the age of "telemedicine," in which images increasingly become the evidence of illness, physicians will need to grapple with the question of what constitutes sufficient information for a clinical diagnosis.

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PERSONAL NARRATIVE
Through the Patient's Eyes: For My Father
Audiey Kao, MD, PhD

What is it like to be a patient experiencing a debilitating, potentially life-threatening illness or encountering the health care environment, perhaps for the first time, from a position of vulnerability? Through the stories of patients, physicians come to see themselves, and most especially their communications, from the other side of the equation. When patients — including physicians who become patients — voice their most intimate thoughts, feelings, and reactions, much can be learned.

June Patient Story
Awan KJ. ...For my father [A Piece of My Mind]. *JAMA*. 1994;271(18):1386.

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VIEWPOINT
History of Oral Contraception
Audiey Kao, MD, PhD

- The Food and Drug Administration approved the first oral contraceptive in 1960. Within 2 years of its initial distribution, 1.2 million American women were using the birth control pill, or the "pill," as it is popularly known. Since its introduction, more than 300 million women worldwide have used the pill as a simple, safe, and effective means of achieving reproductive freedom. Thus, many observers consider the pill to be one of the most socially significant advances in modern medicine [1].
- Drs Gregory Pincus and Min Chueh Chang of the Worcester Foundation for Experimental Biology and John Rock, a prominent Catholic gynecologist, were instrumental in the clinical development and testing of the birth control pill. At the urging of Margaret Sanger, an ardent supporter of women's rights, Katharine Dexter McCormick provided the critical financial support for this breakthrough research. McCormick was heir to the International Harvester fortune and one of the first women to graduate from the Massachusetts Institute of Technology.
- The first oral contraceptive preparations contained 100 to 175 µg of estrogen and 10 mg of progesterone. At this dose, significant adverse effects were seen, including increased risk for venous thromboembolism. However, the modern pill contains only 30 to 50 µg of estrogen and 0.3 to 1 mg of progesterone, and at this lower dose, many of the concerns about adverse effects have been allayed [2-5].
- Research into testosterone/progestin combinations provides evidence that male hormonal contraception can be a safe and effective means of birth control [6-9]. However, the need for frequent testosterone injections reduces the acceptability of hormonal contraception currently available to men. Thus, the potential market is believed to be small and the pharmaceutical industry has not been active in this area of clinical pharmacology, contributing to the perception among women that they carry too much of the burden of responsibility for contraception [10].
- On May 17, 2000, the Field Museum in Chicago unveiled Sue, the largest and most complete skeleton of a *Tyrannosaurus rex* ever discovered. Sue is named after Sue Hendrickson, the paleontologist who discovered her. However, scientists cannot determine with any certainty that Sue is actually female. Thus, it is unclear whether she worried about giving birth and would have responded to oral contraceptives. Two full-size replicas of Sue will be

traveling the United States, educating people of all ages on the wonders of this dinosaur. Check "her" out for yourself if you get a chance.

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VIEWPOINT

Herbert Nickens, MD
Audiey Kao, MD, PhD

Born on December 28, 1947, in Washington, DC, Nickens graduated from Harvard College in 1969. He received his MD from the University of Pennsylvania in 1973, concurrently earning a master's degree in sociology. In 1986, Nickens became the first director of the Office of Minority Health at the Department of Health and Human Services. He was appointed to that position by Otis Bowen, MD, who was the Health and Human Services Secretary at the time. He served in that post until joining the Association of American Medical Colleges in 1988 and was Vice President for AAMC's Community and Minority Programs until his untimely death of a heart attack at the age of 51 years.

As the AAMC's first Vice President for Community and Minority Programs, Nickens was instrumental in heading The AAMC's Project 2000 by 3000. The goal of this innovative program was to greatly increase the number of underrepresented minorities in medical education. He also developed a program to mentor and promote the careers of minority academic physicians. Nickens wrote passionately about a variety of issues, including minority health status, ethnic and racial diversity in medical education, and access to health care [1-5].

"Herbert Nickens was a passionate advocate for fairness and a tireless worker for equity in health care," said AAMC President Jordan J. Cohen, MD. "Trained as a psychiatrist, he sought throughout his professional life to heal one of our country's most distressing ills--limited opportunities for minorities in the health professions. No one in recent memory did more than Herbert Nickens to bridge the painful and persistent diversity gap in medicine."

For his lifetime devotion to issues of health care justice and physician diversity, we are proud to recognize Dr. Nickens with the Virtual Mentor Award for being an exemplary role model in medicine.

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