

Virtual Mentor

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BANDER CONTEST WINNING ESSAY

Medical Ethics and Retail Clinics

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Scenario

Dr. Bunell was surprised to see Mrs. Scott and her second-to-youngest child when the office assistant showed them into his exam room.

“Long time, no see, Mrs. Scott,” he said. “Everyone’s been well, I take it?”

“Well, I’m worried about this one,” she said, looking down on her son who sat in her lap. Dr. Bunell figured he must be about 5 years old by now.

“I’ve been taking the boys [she had four] to the SureCare Clinic at the mall for the last 2 years,” Mrs. Scott said. “I can get their immunizations there, get them seen for colds and bouts of poison ivy. My oldest even got his physical to be on a pony league team last spring.” She took a breath. “And it’s so quick and far less expensive than coming here. With a family of six,” she said, “it makes a huge difference in medical bills.”

Before Dr. Bunell could speak, Mrs. Scott started again.

“But, we’ve been treating this one,” she looked down again, and Dr. Bunell wished she’d say the lad’s name because, to tell the truth, he’d forgotten it, “with antibiotics for 3 weeks and he seems to be getting worse, not better. Just look at him.”

Visits like Mrs. Scott’s were becoming familiar to Dr. Bunell. More and more of his patients were showing up after long periods during which he figured they had been well and had had no need for medical care. He found out, instead, that they had been going to retail clinics for the “everyday stuff,” and making appointments with him only when something more serious cropped up. It would be months or years since he had seen them and he’d have no record of what had transpired at the clinics.

A family practice specialist, Dr. Bunell did not know the best and most professional way to manage this situation. Some of his colleagues had told their patients that they (the physicians) had to manage all the care or none. But Dr. Bunell didn’t know if that was ethical; besides, it was entirely unenforceable. How would one know if a patient had received care elsewhere between visits to the doctor’s office?

On the other hand, Dr. Bunell's practice depended on routine immunizations, sports physicals, and treatment of everyday infections and injuries. He wasn't a hospitalist, after all. This was a medical and business problem, as he saw it.

Response

"The health and life of my patient will be my first consideration." So rang the Declaration of Geneva of 1948, attempting to respond to Nazi atrocities by revitalizing and reinterpreting the Hippocratic Oath. Many of the leaders at Geneva were also familiar with the words "It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has" [1]. So spoke Sir William Osler, the famous polymath who established medical residency programs and effectively brought medical education into the wards.

Together, the principles of Geneva and of Osler may provide guidance even for the medical dilemmas of today, including those dilemmas related to business ethics. For example, one important question has arisen as a result of the rise of nontraditional retail clinics [2]. Namely, many a physician must now ask herself, what should one say or do with a patient who opts to receive most of his routine care at a retail clinic—coming to his primary care physician only sporadically, for more pressing problems? After describing this quandary in greater detail, I shall attempt to answer it in two parts: first, by considering the "health and life of the patient" and second, by considering "what sort of patient has the disease" (the nonmedical factors that influence the patient). Next, I will discuss how the particular status of the physician herself might affect the question. I shall conclude with practical recommendations for the physician.

What precisely is the problem? In the past 10 years, and as a result of multiple factors—including an increase in costs, in the number of uninsured patients, and in corporate expansion—the number of retail-based clinics has grown exponentially, from only one clinic in 2000 to nearly 1,200 clinics by the end of 2009 [2-4]. The clinics, typically located in large retail stores such as Walmart, Target, and especially CVS (owner of the most widespread version, MinuteClinic), offer minimal waiting times for walk-in visits, most commonly with a nurse practitioner [5]. A short list of health problems accounts for nearly 90 percent of visits: the list included upper respiratory infections, pharyngitis, otitis media, otitis externa, conjunctivitis, and urinary tract infections. In addition, many patients come to receive immunizations; indeed, this is the main reason for visits from most elderly patients [3].

Importantly, these same issues account for 28.2 percent of children's and 12.5 percent of adults' visits to a primary care physician (PCP); furthermore, such simple visits require less office time from the PCP [3]. Given the significant overlap between the problems treated, the concern is that "as [retail] clinics proliferate and their use increases, PCPs may see reduced demand to treat minor conditions.... Losing shorter, simpler visits could have a financial impact on PCPs' practices" [2]. Not surprisingly, the American Academy of Family Physicians and American Academy of Pediatrics have both repeatedly raised objections to retail clinics [6, 7].

On the more individual level, a single family practitioner or pediatrician might well ask, what am I to do with the parent who brings her child to me only sporadically, but receives most of her acute care, immunizations, and sports physicals at retail clinics?

When considering this and other medical ethical questions, one may recall the fundamental principle evoked at Geneva: what is best for the physical health of the patient? To quote the famous Oath attributed to Hippocrates: “Whatever houses I may visit, I will come for the benefit of the sick.” In more modern terms, the principles of beneficence and nonmaleficence require that a physician work toward the patient’s good—in particular, by being competent in her chosen field, by discussing the known benefits and risks of medical interventions or alternatives, and by allowing the autonomous patient to make an informed choice. If, for example, the data indicated that retail clinics consistently produced health outcomes superior to those achieved by primary care, it would be the physician’s ethical and professional responsibility to divulge this information to the patient.

As it is, however, there are insufficient data to show that retail clinics have superior outcomes than those of the “medical home” model, which generally includes a PCP. Although recent studies have suggested that retail clinics and PCP offices have similarly positive health outcomes when treating a few simple conditions (such as otitis media, pharyngitis, and urinary tract infections), a number of legitimate concerns have been raised about such studies—including that otitis media and pharyngitis often resolve without therapy [8-10]. Currently, the evidence showing equal or superior outcomes from retail clinics is still somewhat limited and disputed [2].

On the other hand, one finds less-disputed evidence for superior outcomes when health care has the qualities of a “medical home,” namely being “accessible, continuous, comprehensive, family-centered, [and] coordinated” [11]. The study results are most impressive for children with special health care needs (such as asthma), but researchers have also shown moderately improved outcomes even with non-special needs children and adults who have a “medical home” or “regular source of care” [11-13]. These improved outcomes include earlier diagnosis, better needs recognition, less emergency department (ED) use, fewer hospitalizations, better monitoring, fewer prescriptions, lower cost, increased satisfaction, and decreased health care disparities [12]. Significantly, these positive results are seen more commonly in patients who identify with a particular person (such as a PCP) rather than a particular place [12].

Thus, as a physician, one has a duty is to inform the patient that there may be a risk of somewhat worse outcomes from health care that is discontinuous and uncoordinated—whether at EDs or at retail clinics—particularly for any complicated or chronic medical problems. Of course, one should hardly claim that retail clinics are all bad—indeed, some data suggest that patient satisfaction with such clinics is generally high, and that visits to retail clinics do not increase the rate of return visits

to the PCP's office (for an unsolved problem) [14-16]. Nonetheless, there remain significant risks from fragmented care, namely missing potentially complicated problems, repeating tests, immunizations, and prescriptions, and neglecting a patient's larger developmental, social, or family issues [10, 17]. Even those in favor of retail clinics have noted several potential problems. There is no assurance that records of visits will be sent to the PCP, and, for example, 30 percent of patients visiting retail clinics actually have no PCP at all [8, 15].

One can imagine numerous potentially serious scenarios. If the patient had slowly fallen off the growth curve, or if he had an infection history consistent with common variable immunodeficiency, such important problems might be missed if there were no PCP with consistent chart documentation. In sum, it is the responsibility of the physician to serve the "health and life" of her patients by at least mentioning that having a regular medical home may lead to better outcomes than using a retail clinic. Some patients might be particularly receptive to such a conversation [18].

On the other hand, a patient is more than a conglomeration of pathologies and immune defenses, and "health" is influenced by a great deal more than organic disease processes. One recalls Osler's words, "[know] what sort of a patient has a disease." The empathetic physician must be aware of larger issues affecting the welfare of the patient, including finances and scheduling. A parent who takes her child to retail clinics might well prefer more regular visits with her PCP, but the cost—particularly when compared to those retail clinics—may seem prohibitive. Furthermore, time and transport may be serious issues for the parent [2]. All of these factors are particularly significant today, when money, employment, and inexpensive transport are all in short supply. Since a physician should hardly expect her patients to become impoverished (itself a poor prognostic factor for disease) in the interest of seeking medical care, the physician should do her best to accommodate families in difficult situations.

At the same time, one must not forget the physician herself. There is more than one person in the patient-physician relationship, and the physician's own position could certainly change her options. For example, if the physician is particularly well-off, perhaps she could afford to offer lower prices or free visits for patients in special circumstances. On the other hand, perhaps the young physician—in order to pay her debts or support her family—has a very busy practice with many patients but little time for volunteering. And perhaps one of her patients has refused to follow physician advice regarding retail clinics. When confronted with the consistently uncooperative patient (who might distract from her ability to care for other patients), she might ask herself, can I legally "fire" such a patient?

The question is somewhat complicated; to begin with, a physician certainly cannot discriminate on the basis of race, national origin, sex, religion, or disability [19]. Nonetheless, several judges have stated that a physician may legally withdraw from a nonemergent case if she gives the patient sufficient written notice, to allow the patient time to "procure other medical attention" [20]. Although laws vary by state,

some “legally justifiable reasons for terminating a patient” may include the patient’s missing appointments, failing to pay bills, behaving offensively, or being consistently uncooperative with the treatment plan [19, 21]. Using the last criterion, a physician might terminate a patient who failed to make the recommended follow-up appointments (for routine vaccines, for example) and instead visited retail clinics—despite the physician’s continued requests to the contrary. Nonetheless, what is legal is not always what is ethical...or charitable.

There are a number of ways that a physician can attempt to accommodate both the best health interests of the patient and the patient’s socioeconomic context without violating her own financial needs and tight schedule. First, the physician or her team could investigate financial assistance options, such as Medicaid or CHIP, to help the patient maintain consistent care with the PCP. As a second option, the physician could employ a nurse practitioner or physician assistant to provide the patient with care that is both affordable and continuous—the latter a requirement of the “medical home.” Indeed, nurses in many countries serve as primary care providers, with no worse (and oftentimes better) health care outcomes than the United States [12, 22]. Furthermore, employing a NP or PA could also allow the physician to increase his patient load.

Thirdly, the PCP might consider practices that reduce the patient’s inconvenience, waiting time, and cost, such as answering simple questions via phone or e-mail, utilizing focus groups (e.g., for well-child care issues), and using either previsit checklists or questionnaires from staff (such as medical assistants) [23]. Fourthly, although the physician should probably not encourage the use of retail clinics, she could request that any patients going to such clinics maintain a portable record (as required in France) documenting the retail visits, or (better) that the patient have the retail clinic fax all documentation from each visit (as recommended by the AAP) [6, 22].

Finally, the physician might recommend the patient enroll in a local program for low-resource families, such as Dallas Parkland Hospital’s Community-Oriented Primary Care (COPC) Program, which provides the poor with continuous and coordinated care—i.e., a medical home for the indigent [24]. These recommendations are not mere hypotheses; even as a student, I have personally witnessed each of them effectively put into action. Thus, an ethical physician should use one or more of these options to accommodate the patient’s situation without compromising either care quality or the physician’s own livelihood.

As we have seen, the fundamental principles laid down by Hippocrates, William Osler, and the Declaration of Geneva may shed light upon the dilemmas faced even in twenty-first-century America. A physician must serve the health of her patient foremost. In the case of retail clinics, such service may require informing her patients about the improved health outcomes from care that is consistent and comprehensive. However, a physician should also treat the person qua person, which may involve some alternative to full-fee care with the physician. Individual doctors need not

follow an unbending formula. Ultimately, the core of medicine remains the personal relationship between a physician and a patient. In the case given, even a sympathetic look, nod, or touch could go a long way toward calming the rushed and worried mother of the patient—thereby opening the door to an ethical and mutually acceptable solution.

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