

CASE AND COMMENTARY

How Should Clinicians Respond When Different Standards of Care Are Applied to Undocumented Patients?

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Abstract

A challenge in caring for patients in resource-poor settings is the ethical discomfort and discouragement clinicians might experience when they're unable to provide optimal care due to lack of resources. This case, in which a resident is faced with rationalizing substandard care for certain classes of patients, probably represents the top of a slippery slope. This article argues that physicians should identify and advocate for optimal care for each patient. Moreover, physicians should advocate to improve the health system that allows for substandard care. Physicians should disclose to patients all available evaluation and treatment options, even those that seem cost prohibitive or unrealistic for some other reason. Transparency and objectivity in the patient-clinician relationship require good communication skills and are central to avoiding harm.

Case

Dr K is an internal medicine resident starting his community-based rotation at Salud Completa, a clinic that provides health care primarily to undocumented immigrants. He is eager to apply his clinical skills to providing care to this underserved population. After an afternoon so busy that some patients had to be turned away, Dr K's last patient is Mr L, who presents with persistent epigastric pain and nausea. He has visited the clinic twice over the past 5 months with similar symptoms and was prescribed a proton-pump inhibitor. Since his symptoms have not resolved, Dr K wants to order an upper endoscopy. Upon discussing Mr L's case with his attending physician, he learns that the gastroenterologist, who had been performing upper endoscopies free of charge for Salud Completa patients, has moved. Since there is nowhere else to refer Mr L, who cannot afford to pay for an endoscopy himself, the attending physician told Dr K to increase Mr L's medication dose and follow up with him at the clinic in a few months.

Dr K considers this recommendation, worried that he is providing substandard care to Mr L. Although there are often no other options for undocumented patients like Mr L, Dr K still wonders about his role in providing care that's different in quality from care he provides patients in the university teaching hospital setting. He wonders whether and

how he should respond to his attending physician's recommendation. He also wonders how he should respond to Mr L, who is still waiting for him in the exam room.

Commentary

In approaching this case, we start with the ancient oath of Hippocrates, which begins its declaration on caring for patients with the line, "I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing."¹ This deontological or duty-based ethic of helping the sick according to ability and judgment, however, does not mention resource considerations, such as ability to pay or availability of resources. In recent years, medical students have been modifying the Hippocratic oath to modernize its language and increase its relevance to the present day.^{2,3} For example, the Yale School of Medicine Class of 2018 Physician's Oath—itsself based on the Declaration of Geneva⁴—says, "We will not permit considerations of age, disease, disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, financial status, or any other factors to stand between the care we seek to provide and our patients."³ Although at first blush this modern augmentation might appear to add little to Hippocrates' ancient oath, the explicit reference to financial status is particularly relevant to our case. The newer oath insists that Dr K help Mr L, regardless of his insurance status or ability to pay. Medical professionals should always advocate for optimal care for each individual patient and resist any temptation to settle for a lower [standard of care](#). What neither oath addresses, however, is what the clinician is to do when in his or her professional judgment a particular treatment is needed that is not readily available, due to practicing medicine in a resource-poor setting, a national shortage of a particular drug, or a patient's personal financial difficulties. The Yale School of Medicine Class of 2018 Physician's Oath does "not permit consideration of ... financial status ... to stand between the care we seek to provide and our patients,"³ but *seeking* to provide care and *actually* providing care could be two entirely different things.

Based on the case, it is not evident which disturbs Dr K more—the fact that the patient cannot access endoscopy or that the attending doctor, without compunction, recommends increasing the proton-pump inhibitor, which seemingly adopts a lower standard of care. Both lack of access and lower standard of care raise the question of beneficence. Mr L probably *needs* the endoscopy; it is an important procedure for fully evaluating his symptoms. But Dr K cannot help him access one. What should he do? Furthermore, the attending physician's seeming indifference to a substandard treatment highlights the slippery slope of acquiescing to suboptimal care for patients. How might Dr K advocate for his patient?

Strategies for Providing Care in Resource-Poor Settings

Physicians routinely face such challenges in low-resource settings and attempt a variety of strategies to address them. They prescribe generic medications instead of name

brand, order screening blood tests instead of diagnostic procedures, ask specialist colleagues to provide free care to patients, and help to enroll patients in charity care or discounted prescription drug programs. In our community of New Haven, Connecticut, we established in 2009 a volunteer specialty-physician network that donates medical care in partnership with hospitals and local community organizations for uninsured patients with urgent medical needs.^{5,6} Patients identified at our student-run free clinic with urgent specialty care needs are referred to a specialist who provides medical care at no charge to the patient in the specialist's own office.⁷ Although not a panacea for lack of insurance, voluntary physician networks and free clinics are widespread in the United States and help to shore up the safety net in local communities.⁸

In this case, in which the barrier to care is primarily financial (ie, the patient lacks health insurance due to his undocumented immigration status), the endoscopy might be difficult to obtain. Nevertheless, the ethically appropriate action is to provide the best possible care available, even if it falls below accepted standards of care. In such circumstances, the physician's task is to recognize that his or her patient is receiving suboptimal care, articulate the alternative options to the patient, and do what is possible to advocate for the patient's improved care.

An important caveat is in order. What is ethical in any scenario hinges on the intended action of the physician. If physician A intends to provide substandard care regardless of what is available, he is acting unethically and providing unethical care. If physician B strives to provide the best possible care in the face of dire circumstances, she is acting ethically—even if the treatment that the patient receives is identical to the treatment rendered by physician A. The moral philosopher Immanuel Kant argued that all people, in accordance with their means, have a duty to be beneficent toward others, although this beneficence is not unlimited.⁹ In the case at hand, Dr K and the attending physician act unethically if they purposefully seek inferior treatments for Mr L, and they act ethically if they seek to pursue the highest quality treatments available.

Dr K should be as transparent as possible and should use his best judgment to explain to his patient Mr L the options for diagnosis and treatment, including state of the art treatments that may be unaffordable or unavailable. The discussion should be sensitive and include less expensive diagnostic options that may be safer to pursue first (eg, stool testing for *H Pylori*, esophagram). Ideally, the physician, social worker, or care team could work to procure optimal care for the patient. For example, Dr K might search for other local safety net clinics or other gastroenterologists willing to provide free care. Although such individual efforts are laudable, they are not always successful, and Dr K fulfills his obligations by offering the best care possible alongside a transparent explanation of alternatives.

Transparency can be challenging but has benefits for the patient-physician relationship. It could be tempting to omit discussion of treatments that a patient cannot afford in an effort to protect the patient from feelings of disappointment, but failing to inform the patient could harm the patient-physician relationship. For example, if a patient learns elsewhere about a treatment that the physician did not discuss, it could diminish the patient's trust and confidence in the physician and in the medical profession more broadly. When clinicians explain clearly all appropriate treatments, they serve as *doctors* in the truest sense of the word. To doctor, from the Latin *docere*, is to teach. Health care professionals teach by fully informing their patients of all aspects of a specific medical condition, including treatments options, prognosis, and natural history of the disease. The informed patient is thus empowered to make decisions for himself or herself. In this way, physicians respect the autonomy of their patients.

However, beyond transparency lurks the danger of "tokenism," which Schiff defines as "doing too little and feeling satisfied and excused from addressing the social and economic injustices that underlie poor patients' suffering."¹⁰ Schiff describes the surprising professional criticism he faced after giving \$30 to one of his patients who could not afford her medication. He eloquently defends his personal investment in his patient's welfare, recognizing that it [crossed a professional boundary](#) and was therefore potentially risky. He also recognized that limits need to be set. He asks, "Are 'limits' protecting the patient, or are they protecting us—protecting our time or even protecting our consciences, allowing us to avoid painful questions of inequality or taking needed moral action?"¹⁰ Helping individual patients meet their medical needs through personal advocacy can inform our collective advocacy for societal change.

Agency or Activism?

Should physicians primarily be focused on advocating for individual patients or advocating for the system? Dobson and colleagues propose dividing advocacy into 2 components: *agency* (working on behalf of the interests of an individual patient) and *activism* (working to change social conditions that impact health of populations).¹¹ Both approaches are important, and they can cross-fertilize and nourish each other. Many physicians support advocacy for individual patients, but there is less wholehearted support for [advocacy for social and political change](#). In support of the latter, the American Medical Association's "Declaration of Professional Responsibility: Medicine's Contract with Humanity" states that physicians should "advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being."¹² Similarly, in "Advocacy by Physicians for Patients and for Social Change," Joshua Freeman argues that physicians have an ethical obligation to practice advocacy, both agency and activism.¹³ He suggests that the lack of support for activism is partly the fault of medical schools and faculty who do not provide adequate role models for students and residents. The same could be said of the attending physician in the case above.

Conclusion

Ultimately, all physicians have ethical obligations to act beneficently, to do their best for the individual patients seeking their care. But, as Kant noted, beneficence has limits. A reality of modern health care is that some patients have access to the best that money can buy and others have access to significantly less. Regardless, a physician must do her best to advocate for and inform her patient of best possible treatments even when state of the art care is not available. This is good care. Francis Peabody perhaps put it best when he said, “[T]he secret of the care of the patient is in caring for the patient.”¹⁴

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Editor's Note

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