

Virtual Mentor

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Clinical case

Managing chronic conditions in uninsured patients

Commentaries by Saul J. Weiner, MD, and Emily E. Anderson, MPH

Mr. Jacob Rangston is a substitute janitor at a junior high school in Gary, Indiana. Because he is only employed part time, he is not eligible for insurance benefits. He does not qualify for Medicaid or, at 53 years old, for Medicare. He comes into a student-run free health clinic on Chicago's West side after a long commute from Gary. A year earlier, he had been referred to the clinic by a county public hospital. He had been diagnosed and treated for chronic recurrent prostatitis on multiple previous visits to the free health clinic, and on the current visit he reports having pain in his pelvic region and upon urination. He is sexually active but refrains from sex with his girlfriend when his symptoms flair up for fear of transmitting an infection.

During a recent visit to the clinic, Mr. Rangston tested negative for sexually transmitted infections, had a negative urine dip, no glucose in his urine, normal prostate specific antigen (PSA) levels and an enlarged prostate but no nodules. He has traveled to the clinic almost monthly during the past year and has kept all scheduled appointments but one. His health literacy appears high according to a triage volunteer who read his medical history, and he is conscientious about choosing healthy behaviors.

Usually, the physician or fourth-year medical student at the clinic recommends a course of antibiotics for Mr. Rangston, which helps relieve his symptoms during the treatment course. Some antibiotics have seemed to work while others have not. A few days or a few weeks after each antibiotic regimen his symptoms return. He has been experiencing this pattern for almost two years and takes Flomax regularly to help relieve his enlarged prostate. During his last visit, the physician recommended Levaquin, which the patient said worked best for him in the past. For some undocumented reason, the physician noted offering it to Mr. Rangston on this visit only if he could pay for a prescription. If not, the physician recommended doxycycline.

A fourth-year medical student, Blake Thierry, having just reviewed Mr. Rangston's chart and test results before walking into his room, felt the status quo needed to change starting with this visit. He was frustrated with the lack of continuity of care for Mr. Rangston and the often incomplete or inadequate documentation in Mr. Rangston's chart. Mr. Thierry noted that no referral had been suggested for Mr. Rangston. He thought he knew why since the average wait period for an urologist at

Cook County hospital for the uninsured was at least five months. Mr. Rangston was becoming increasingly frustrated, as he all too kindly let Mr. Thierry know.

Mr. Thierry researched chronic prostatitis quickly and determined that there were additional imaging services and procedural tests that might help diagnose Mr. Rangston's disease and treat it more effectively than the perpetual and often ineffective antibiotic treatments. None of these had been discussed with Mr. Rangston. Mr. Thierry explained that the clinic did not provide these services and recommended that Mr. Rangston approach Cook County hospital or a federally qualified health care center for more affordable, out-of-pocket testing if he did not feel he can wait the year or so it may take to eventually get the tests through Cook County.

The tests would be expensive, and Mr. Rangston expresses his concerns over his ability to pay for them. Mr. Thierry thinks Mr. Rangston should get tested sooner rather than later due to the recurring symptoms, and he ponders how he might be able to "hurry the system" along. It is apparent to Mr. Thierry that Mr. Rangston is not receiving the standard of care, given his symptoms. He does not know what other alternatives he can recommend to Mr. Rangston. Should he refer him to a private physician where he would accrue debt but at least receive more timely and comprehensive care? Should he just continue the status quo and prescribe yet another antibiotic? Should Mr. Thierry just accept the unfortunate aspects of the system for his patient?

Commentary 1

by Saul J. Weiner, MD

While we think of health insurance as a prerequisite to expensive high-tech medicine, it is important to recognize that the uninsured are often disproportionately deprived of another resource perhaps more valuable: access to a long-term therapeutic relationship with a primary care physician. The clinic that Mr. Rangston attends has fallen short in its care for him, not because it lacks subspecialty services but because of inadequate continuity and adherence to evidence-based primary care. Supporting and educating patients so that they have the best chance to adapt to a chronic condition requires an ongoing relationship and a foundation of interpersonal trust—it does not happen "on the fly."

Mr. Rangston has a condition that is now referred to as chronic prostatitis/chronic pelvic pain syndrome, or CP/CPPS, based on a classification approach supported by the National Institutes of Health to categorize prostate syndromes [1]. It has also been called abacterial prostatitis or prostatodynia. CP/CPPS is defined by symptoms of chronic pelvic pain for at least three months in the absence of other identifiable causes [2]. Although it is a diagnosis of exclusion, it can be made in the primary care setting based on a patient's history, physical exam and basic lab tests. Mr. Rangston's characteristic symptoms, negative urine analysis and culture are sufficient to make the diagnosis.

There is no strong evidence that a specialized urological evaluation for this condition improves patient care, although some guidelines recommend referral nevertheless [3]. Unfortunately, there is also a lack of evidence for any effective therapy [4]. The repeated use of antibiotics for recurrent CP/CPPS is considered inappropriate; studies show no additional benefit from antibiotics when compared with placebo [4]. Patients should be educated about their situation, which, while debilitating, is neither contagious nor associated with any malignancy or other progressive condition. That said, it is important to acknowledge and address the suffering the patient may be experiencing.

Instead of being educated about the often chronic, waxing and waning course of his condition, it appears that Mr. Rangston has been left wondering whether he is victim of a missed diagnosis and an easy cure. Furthermore, there is no mention that he has been reassured that it is safe to continue to have sexual relations with his girlfriend when his symptoms flair—there is no risk of her acquiring an infection [5].

While suboptimal care can occur in any office-based practice setting, it may be more common in the clinic setting described here, with a revolving door of volunteer providers, each with varying degrees of training and experience, little oversight or investment in quality and spotty record keeping. Hence, while Mr. Rangston may not need high-tech medicine, his lack of access to health insurance has deprived him of a good health care environment for the management of a chronic condition.

Paying for private care

Mr. Rangston may, in fact, have first sought care in a private setting. The majority of uninsured patients are actually cared for not in free clinics or public hospitals but in regular office-based practices [6]. Receiving care outside of the “safety net” when one is uninsured, however, creates its own set of challenges for both patients and providers [7]. While some patients receive all needed services regardless of their inability to pay, often they and their physicians factor in costs when creating treatment plans.

When considering the impact of nonpayment on both patients and those who care for them, it is useful to make a distinction between two kinds of uncompensated care: “Charity care” occurs when the physician, hospital or clinic opts not to charge for all or a portion of a service, so that the patient can receive that service for free or at a reduced fee. By contrast, “bad debt care” occurs when the physician charges the going rate but is never paid. Although precise figures are not available, it appears that about 80 percent of uncompensated care is bad debt care [8]. That means that in most cases physicians and hospitals generally attempt to collect payment, often with severe consequences for their patients. Unpaid medical bills are now the leading cause of personal bankruptcy in America [9].

Because of these financial tensions, indigent patients and their physicians often face three dilemmas when creating a treatment plan [10]: (1) whether to forgo appropriate tests and therapies because of cost, (2) whether to negotiate a reduced fee, or (3)

whether to attempt to locate the necessary services elsewhere at a lower cost. It would not be surprising if Mr. Rangston had originally sought care at a local practice and declined basic laboratory tests, such as urinalysis and culture, which on a substitute janitor's salary can rapidly eat up a month's rent. It is also possible that a local physician might have offered to reduce his professional fee, but would most likely not have been able to waive other expenses since most laboratory tests are outsourced. And finally, although we not are told how Mr. Rangston decided to travel all the way from Gary, Indiana, it would not be surprising if he had been referred to the free clinic.

Lack of insurance is a proven risk factor not only for worse outcomes from treatable conditions but also for higher incidence of a number of preventable illnesses [11]. For instance, because Mr. Rangston is a 53-year-old man, he should be screened for colon cancer according the U.S. Preventive Services Task Force [12]. At a cost of about \$800, it seems unlikely that colonoscopy will be offered to him or that he could afford it given his current financial situation.

I wonder if the desire of private physicians to send patients like Mr. Rangston "somewhere else" is motivated, however, not only by concerns about profit and loss or even access to care but also by the discomfort of having to confront financial hardship in one's patients, particularly when one may be contributing to it. Perhaps the greatest service we can provide for individuals who are struggling to receive care without coverage is to continue to care for them, offering expert counsel regarding their medical needs, eliciting their preferences regarding trade-offs between cost and quality (and documenting those preferences particularly for medicolegal protection), reducing fees when we can arrange to do so and picking up the phone to enlist the generosity of our colleagues during times of greatest need. Last but not least, let us not forget that we are dealing with an issue of social justice and have a responsibility as healers to advocate publicly for reforms that will broaden access to medical care and services for all.

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Commentary 2

by Emily E. Anderson, MPH

There are two key ethical dimensions to this case: physicians' obligations to individual patients and physicians' responsibilities to promote social justice. Although Mr. Rangston's situation is unfortunate, Mr. Thierry's ethical obligations to this patient are fairly straightforward. Prostatitis is a complicated condition with multiple etiologies and symptoms; treatments vary greatly in their effectiveness for individual patients. It is difficult to judge the extent to which Mr. Rangston's condition is exacerbated by other factors such as his financial situation, lack of health insurance, discontinuity of care, limited resources at the free clinic, treating physicians' attitudes toward low-income patients and physicians' reasonable differences in clinical judgment. Mr. Thierry believes that information about further tests that could improve diagnosis and treatment—information that could greatly benefit Mr. Rangston—has not been discussed during previous visits, and he is understandably concerned.

The ethical principle of respect for persons demands that physicians present all patients with the full range of reasonable treatment options, regardless of their cost or the patient's insurance status and ability to pay [1]. Although cost is an important consideration for Mr. Rangston and may ultimately constrain his range of choices, Mr. Thierry should still discuss the benefits of additional imaging services and tests

and the potential limits of antibiotics for treating chronic prostatitis. Only then will Mr. Rangston be able to make a fully informed decision about further diagnosis and treatment [2]. Most physicians are understandably hesitant to discuss patients' financial situations and are inadequately prepared to integrate financial matters into clinical decision making. However, for physicians to omit discussion of potential treatment options because they believe a patient cannot afford them is paternalistic and presumptuous (and potentially leaves them vulnerable to legal liability); altering the standard of care also circumvents patient informed consent. Mr. Thierry should recommend what he believes to be the optimal course of action, even if it is costly, but ultimately he must respect Mr. Rangston's decision [3].

Regardless of the course of treatment Mr. Rangston decides to pursue, Mr. Thierry should continue to advocate for him to the extent possible. As a future physician, Mr. Thierry should not simply accept the circumstances or blame the health care system for poor patient outcomes. If Mr. Thierry ignores Mr. Rangston's needs, he is complicit with an unjust system that discriminates against patients based on their ability to pay. Such discrimination further exacerbates the medical problems of patients whose low socioeconomic status contributes to their poor health. Although physicians have an ethical duty to advocate for individual patients and to provide a certain amount of charity care [4], working to improve access to health care for all people is also an ethical obligation [5]—and ultimately will be more effective than working around the system.

There is extensive discussion about universal access to health care and health care as a “right” in the medical literature, the popular press and in politics, but these primarily abstract debates do not offer useful guidance for individual clinicians currently faced with the problems of treating impoverished patients. Mr. Thierry seems already to understand that physicians must familiarize themselves with the special circumstances and needs of patients in their communities and with local safety net and social services. They also must remain committed to engaging in meaningful patient-physician communication to promote adequate informed consent and personal care for each patient [6].

Although medicine has a strong tradition of encouraging social responsibility, professional codes of ethics emphasize physicians' duties to individual patients more than they do physicians' obligations to advocate for social change. The American Medical Association's *Code of Medical Ethics* states that physicians have an ethical obligation to “contribute their expertise at a policy-making level” to ensure that access to an adequate level of health care is available to all society's members [7]. Unfortunately, the specific mechanisms and activities through which individual physicians can and should achieve this goal are ambiguous.

What does it mean for a physician to be socially responsible or promote social justice? At a basic level, social justice means advocating for access to health care for all and personally working to eliminate disparities in health status. Defined that way, social justice may seem outside the sphere of clinical practice. Several practical and

conceptual barriers may prevent physicians from engaging in advocacy beyond the level of the individual patient. For example, many physicians are wary of getting involved in rationing decisions of any kind since rationing (especially when it is done “at the bedside”) is perceived as violating the ethical principles of beneficence and non-maleficence. Physicians also may avoid speaking publicly on issues for fear of being viewed by their patients and other community members as inappropriately involved in political matters. The bureaucratization of health care negatively impacts both physicians and patients. The complications of accessing services can be nearly as prohibitive for doctors as for their patients and can lead to learned helplessness. The common perception that nothing can be done to repair the broken health care system in the U.S. unfortunately functions as a barrier to action.

If physicians are to acquire the skills needed to promote social justice, medical school curricula must change. At minimum, physicians must have broad knowledge of the social, cultural and political factors that affect health. Discussions of the link between poverty and health must be included across the curriculum. Perhaps most importantly, physicians must be familiar with the economics and politics of the health care system in order to influence systemic factors effectively [8].

So what is Mr. Thierry to do? For this patient, his instincts are correct, and his heart is in the right place. However, without systemic change, such dilemmas will appear consistently throughout his medical career. Ultimately, Mr. Thierry must decide if he has the moral courage to take on such a daunting challenge.

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