

# Virtual Mentor

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## Clinical Case

### Patient-Requested, Non-Recommended Screening

Commentary by Mark T. Hughes, MD, MA, and Bimal H. Ashar, MD, MBA

Mrs Ackerman went to visit Dr Noell for an annual gynecological exam that included a Pap smear. She sees Dr Noell regularly for check-ups and the recommended screening tests for women in her risk and age groups. So far, she has been remarkably healthy—she exercises regularly, does not smoke, and is a vegetarian—and no screening test has ever shown cause for concern.

Following the exam, Mrs Ackerman told Dr Noell that she had seen an ad in a newspaper for a whole body CT scan for \$600. “I’d like to have this done to make sure there’s not a treatable problem in there,” Mrs Ackerman said pointing to her stomach. “The problem, Dr Noell, is that it’s a pretty expensive test. But imagine how much *more* expensive it would be if they didn’t find something until it was too late.” Dr Noell gently told Mrs Ackerman that there was no reason to think that there was a disease “lurking” inside her and that, after having a scan, many patients believed that it was a “waste of time and money” as it did not show anything that wasn’t already known. As a compromise, Mrs Ackerman suggested ordering a CT scan of only the abdomen and pelvis “just to check.”

## Commentary

Dr Noell is faced with a situation seen much more frequently today than in the past. Patients now have a greater role in deciding what medical services they receive. Viewing the patient as a consumer of services has led to the growth of direct-to-consumer (DTC) advertising for both pharmaceuticals and diagnostic tests. DTC advertising often preys on patients’ fear of the unknown and may suggest that a particular test is necessary for “peace of mind.” This advertising tack is taken despite the fact that no clear data currently support the use of many of these new technologies and, specific to this case, whole body CT scanning for disease screening [\[1\]](#).

Dr Noell’s first step in addressing Mrs Ackerman’s request should be to get a better understanding of the reasons for her inquiry. Patients often withhold symptoms from a busy practitioner despite being worried that they may have a serious problem. Mrs Ackerman may be using the discussion about the CT scan as a way to talk about abdominal symptoms that she is experiencing. She may have opened up the subject of the abdominal scan to prompt further questioning by Dr Noell. Then, rather than appearing as if she is complaining about her health, Mrs Ackerman can concentrate on responding to pointed questions posed by her physician. Or it might be the case that a family member or a friend had an illness in the past that was distressing for Mrs

Ackerman to observe, and her desire for “peace of mind” arises from apprehension that a similar fate awaits her. It is Dr Noell’s responsibility to try to uncover unspoken reasons for the patient’s request.

If specific symptoms or other concerns are not uncovered after a thorough history, and the patient’s physical exam does not reveal any worrisome signs, then the scan would be solely for screening purposes (that is, not diagnostic). In such a case, Dr Noell should engage in further discussion with Mrs Ackerman (remembering that *docere*, the Latin root for doctor, means “to teach”). In doing so, he must be guided by certain underlying ethical principles [2].

First, medicine is a scientific discipline. While much of medical practice has been passed down without the rigors of “gold standard” clinical trials, there is nonetheless a scientific basis for the recommendations that physicians make. This is demonstrated by the fact that evidence-based medicine is emphasized in all disciplines. Emerging diagnostic technologies should be held to the same scrutiny, so that test performance, bias, and cost-effectiveness all figure into the recommendations about these modalities. While it may not be necessary for Dr Noell to go into lead-time bias, length-time bias, sensitivity, specificity, and other highly technical details of a test, he should convey the real possibility of false positives and false negatives in scanning. The physician has the responsibility of communicating to the patient a basic understanding of science and technology and their proper applications in each individual case.

Second, the physician should be guided by the patient’s best interests. The first step in acting beneficently in this case is, as already mentioned, that Dr Noell explore the patient’s motivation for testing. If Mrs Ackerman wants to pursue the test out of fear, it is more appropriate for the physician to address her fear and see what is behind it than to simply order the scan. The ethic of care directs the physician to understand the individual patient in a particular context, recognizing that emotions factor into decisions but should not necessarily be directive. Acting in the patient’s best interest also means that Dr Noell will use his expertise to uphold his duty to warn patients about the risks and benefits of the scan and to protect them from harm. Despite the appeal of whole body CT scanning to diagnose problems in the early stages, existing medical evidence does not support this anticipated benefit. In fact, some clinicians are concerned that harm may result if, for example, an ill-defined abnormality is detected on the scan and leads to invasive follow-up testing that increases the physical risks and the financial costs to the patient. The patient also risks being labeled by insurers as having a pre-existing condition, a label that could affect the insurer’s coverage of the condition for which the patient was tested. So Dr Noell may have grounds in the interest of both beneficence and nonmaleficence for dissuading the patient from pursuing the scan.

Third, respect for autonomy means that Dr Noell should act as teacher and counselor to guide Mrs Ackerman to a thoughtful decision. Respect for autonomy also dictates that Dr Noell engage Mrs Ackerman in the process of informed consent. He should feel confident that Mrs Ackerman is making a voluntary decision, free of coercion or undue influence (such as the emotional impact of fear). He should disclose to her the risks and benefits of a whole body CT scan, giving special attention to their unproven nature. As

a consumer of medical care, Mrs Ackerman may decide, in the end, to pursue the whole body scan at a stand-alone facility without a physician order, should Dr Noell refuse to write her one.

But respect for autonomy applies to the physician as well. Respecting Mrs Ackerman's autonomy does not mean that Dr Noell simply has to acquiesce to her personal preferences. When a patient seeks a physician's opinion, the physician is not obligated to order a test or supply a service that he or she does not think is medically indicated simply because the patient requests it. The Charter on Medical Professionalism promulgated by the American Board of Internal Medicine and other professional organizations states that the physician strives for "scrupulous avoidance of superfluous tests and procedures" [3]. If Mrs Ackerman proceeds with testing without Dr Noell's involvement, even if he disagrees with the decision, he should remain available to her for counsel if an abnormality is found.

Next, physicians must be mindful of social justice. A physician's professional duty encompasses responsiveness to social concerns. Physicians have an obligation to contain costs and improve access to health care for all. If Mrs Ackerman wants her insurer to pay for the abdominal CT scan, then Dr Noell would have to say that there is some indication for the procedure, so that the health plan will cover the expense. If the only way to achieve this is for the physician to put erroneous information on the requisition (ie, "game the system"), then this goes against the physician's duty of truth telling and honesty. Dr Noell has a contractual obligation to the insurer to order only those tests that are medically necessary. Moreover, he has to have an eye toward proper utilization of society's resources. When physicians order additional tests and discover that ill-defined abnormalities noted in public screening reports are of no clinical consequence, society bears the costs of those downstream tests through higher insurance premiums and more limited access.

Finally, medicine is an art. The physician should be adept at patient-doctor communication in order to put the above-named principles into action. In discussing new technologies with a patient, the physician should explore the patient's concerns and motivation for pursuing testing and convey his or her desire to act in the patient's best interests. Sometimes, the physician's objective will be the likeminded goal of preventing disease, but in other circumstances it may be to protect the patient from harm by recommending against unproven tests. Science can serve as the arbiter in responding to patients' demands as a physician practices the art of medicine. In the end, the physician should bear the words of William Osler in mind, "Let us remember that we are the teachers, not the servants, of our patients."

## References

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