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Virtual Mentor

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FROM THE EDITOR

Reaffirming Our Commitment to Serve

“What is medicine really about?” One could easily imagine a seasoned medical school professor posing this to a fresh group of first-year medical students on their first day of training. The new students would be hanging on to every word, eager to absorb even the smallest bit of information. Perhaps this question would be the introduction to their first lecture on pathophysiology or clinical diagnosis. How shocked these new physicians-in-training would be if their esteemed professor responded to the question in one word: *service*. “Medicine is about service. We are all here to serve others—our neighbors, our communities, and even complete strangers.” What a surprising and apt answer that would be; acknowledging that above all else, medicine is a profession of service.

In a field dominated by ever-changing technologies and conventions, service remains constant. The purpose of this issue of *Virtual Mentor* is to remind us of the medical profession’s commitment to serving others—a commitment that can easily get lost among competing priorities. The authors in this issue succeed in affording us the opportunity to rediscover the importance of service in our careers—much as former *JAMA* editor in chief Catherine DeAngelis did in her insightful and timely 2009 commentary “Commitment to Care for the Community” [1]. As you begin to peruse this August issue of *VM*, I encourage you to think of your very first patient—the healthy newborn baby in need of routine care or the 70-year-old veteran with COPD being admitted for an exacerbation. Think of the connection, no matter how small, you made with that patient as you attempted to play one small role in serving his or her needs—even if you forgot to perform half of the physical exam to your senior resident’s obvious disapproval.

What does service mean? Need every seasoned physician work at a clinic dedicated to the homeless to truly serve? Need every medical student spend an elective rotation working in a third-world country? Need every resident take precious time to help uninsured patients fill out public insurance applications? I think that the answer to these questions is a resounding “no”—and I believe most of this issue’s authors would agree. As physicians, we need a heightened but not overly simplistic awareness of our responsibilities. Instead of asking “should I be doing more?” or “am I doing enough?” one might ask “do I do something each day to make a difference?” I think our health care system would be more responsive to the health needs of our nation’s communities if all health care professionals—nurses, physicians, and administrators alike—asked themselves this question and made a conscious effort to act upon it each day.

Returning to the medical school lecture hall, perhaps that same professor would have the honor of congratulating the medical students as they walked across the stage at commencement. Perhaps he or she would proudly lead them in the Hippocratic Oath—that historic moral compass of medicine. Although the modern Hippocratic oath does not mention “service” by name, it makes clear the commitment we all share:

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug...

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick...

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm [2].

We serve in a health care system in which 50 million Americans are uninsured, including 7.5 million children—drastically limiting this group’s access to quality medical care [3]. Health disparities, despite an increasing body of research, persist in an era of advancing therapeutics. Socioeconomic status is a major determinant of health status; a family’s income level seems to be a predictor of the overall health and well-being of its members [4]. The questions of who is to blame or who is responsible for the broken nature of the American health care system are nonstarters (to borrow from current political jargon). The real question should be who is best charged with making it better. If we, as a profession, take our commitment to service seriously—reaffirming it each day in the clinic or on the hospital units, I contend that we can steer our health care system toward reflecting the ethics on which our profession is founded.

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CLINICAL CASE

Balancing Practice Economics with Patient Need

Commentary by Glen Medellin, MD

As the medical director for a mid-sized pediatric group practice in a large city, Dr. Sanchez is dismayed to read in the local paper about the state legislature's recent decision to further slash payment rates for Medicaid. Located on the outskirts of downtown, Dr. Sanchez's clinic sees patients covered by a mix of insurance plans: 50 percent Medicaid and SCHIP patients predominantly from the low-income areas of the inner city and 50 percent private insurance patients who come from the nearby suburbs. The clinic is barely making ends meet; increasing expenses for staffing and an EMR have been accompanied by decreasing payment rates from private and public insurance programs.

As the young pediatrician finishes reading the disheartening headline, he takes a moment to remember why he decided to pursue a career in medicine. A quick glance at a colorful display board in his office filled with thank-you notes, holiday cards, and photos from patient families helps him recall the sense of pride with which he and his colleagues care for some of the city's most disadvantaged children. "How are we going to keep our doors open?" he finds himself wondering. "We just can't take any more cuts to our payment."

At a staff meeting held later that week, Dr. Sanchez explains the grim financial situation to his colleagues. "We have to do something about this...and I'm not fond of our options. These impending cuts to Medicaid payment will barely allow us to break even." When he opened the topic to his coworkers, an impassioned discussion ensued. "If we can't take any more Medicaid patients, then so be it. At least we can continue to provide quality care to those already on our panel," remarked one of Dr. Sanchez's colleagues.

Commentary

Many pediatricians struggle to balance their desire to improve the health of underserved children with the financial realities of running a practice. Looking at the dilemma faced by Dr. Sanchez's practice through the lens of medical ethics can clarify this difficult situation. First let us apply the values of medical ethics from the patient perspective. Justice demands that all children receive the same quality of health care. Respect for dignity dictates that each child is valued and that the financial status of his or her parent(s) not determine the quality of care he or she receives. Beneficence demands that each child receive the health care he or she needs, which implies being able to go to the clinicians his or her parents select and receiving all recommended interventions.

Let us now apply the ethical values from the physician perspective. Justice mandates that medical professionals be fairly paid for all patients that they see or services they deliver in non-emergencies and that they not be penalized for caring for low-income patients. Respect for autonomy dictates that physicians should be able to choose which patients they care for. Beneficence and nonmaleficence demand that physicians be paid in a manner that will enable them to stay in practice and to offer quality medical care. As can be seen, balancing patient and physician interests is not easy.

An understanding of government health care programs will further explain the dilemma Dr. Sanchez faces. Medicaid is a public health entitlement program designed to serve low-income families. Costs for the program are shared by the federal government and the states. Each state establishes its own guidelines for eligibility, the benefits package for recipients and the clinician payment rates. The federal government delineates minimum standards that states must meet to receive federal funds. To ensure that eligible children get adequate health care, additional standards were developed under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service legislation. Although children account for 49 percent of enrolled people, only 20 percent of expenditures are spent on children [1]. The Children's Health Insurance Program (CHIP) is an additional program financed jointly by the federal and state governments to expand coverage to children in low-income families who do not qualify for Medicaid.

In 2010, there were 74 million children in the United States, of whom 34.4 million (46.5 percent) were covered by Medicaid [1]. An additional 7.7 million children were enrolled in state CHIP programs [2]. Medicaid expenditures are a significant part of the U.S. budget, accounting for \$380.6 billion in 2009 [1]. Of total expenditures, 20 percent paid for physician and clinic services [1].

Medicaid payment to physicians varies by state, but on average is only 70 percent of Medicare rates and 50 percent of commercial insurance payment rates. Medicaid payment rate has been shown to be one of the driving factors for pediatrician participation in the Medicaid program. Although pediatricians are committed to the health of all children, on average only 54 percent fully participate in the Medicaid program. The main reasons cited for not participating in Medicaid are low payment rates, capitation (that is, a per-patient payment rather than per-service payment), and paperwork [3].

Children are best cared for in a medical home by a clinician who knows the child and family. In areas with shortages of doctors who accept Medicaid, children either do not receive required preventive and management services or use the emergency department for routine medical care, a practice that increases overall health care expenditures. States have struggled to provide the required services. In Texas, inequality of access to care for children receiving Medicaid led to a class action lawsuit against the state that was taken to the level of the Supreme Court. The Court

ruled that, as a participant in Medicaid, Texas had to meet certain federal requirements, including screening, diagnosis, and treatment for children [4].

The budgets of the federal government and individual states cannot cover unlimited health care services, so payment rates are set at the lowest possible level that will support delivery of basic health care. Practices that take patients on Medicaid must either accept lower income or increase the number of patients seen per day to compensate for the low payment. In the case scenario, the physician's right to choose patients and set schedules to keep the practice afloat conflicts with every child's right to have access to health care.

Many pediatricians value the relationships that they have with low-income children, and the families of these children are often very thankful for the services provided. It is hoped that early intervention with preventative health care services may be able to prevent obesity, diabetes, teenage pregnancy, and other conditions that are more common among underserved and low-income families.

Since Medicaid is such a vital piece of health care for children, any decision to limit their access cannot be taken lightly. Dr. Sanchez most likely realizes that closing the practice panel to new Medicaid patients will mean more preventable illness, more severe acute illness among children, and an overloaded emergency department in the community. Before making a final decision, the partners should seek further information: What is the highest percentage of Medicaid patients in the practice that will provide an acceptable income for the practice? How many extra patients per day would have to be seen in order to maintain acceptable income? How would seeing more patients per day affect the quality of care given? What other services in the community are available for children who have Medicaid? What is the distribution of physicians and clinics that accept Medicaid in the area? After reviewing answers to these questions, Dr. Sanchez's practice could calculate how many patients with Medicaid it can maintain in its panel while still providing a reasonable income for the physicians. This would be one approach to ensure that the physicians fulfill their ethical obligations to society and their profession without shouldering an unreasonable burden.

Regardless of their decision to limit Medicaid access, it is imperative that Dr. Sanchez and his colleagues advocate for the underserved children in their community. Since children cannot vote, their needs are often undervalued in the legislative process. Pediatricians and others who provide care for children must foster justice in society by ensuring that legislators and other citizens understand the importance of quality care for all children. Furthermore, they must encourage foresight so that the long-term value of preventive services is recognized. Professional organizations such as the American Academy of Pediatrics advocate for children and the providers that care for them [5].

As in most ethical conflicts, there is no one right and workable solution for the decision Dr. Sanchez's practice faces. If the practice is forced to limit Medicaid

patients, its doctors should continue to fight for the rights of children through advocacy, volunteer work, and philanthropy.

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CLINICAL CASE

Patient Advocacy for Beginners

Commentary by John Brockman

After finishing another grueling morning of pre-rounding, Rebecca found a moment to grab a cup of coffee with her fellow intern, Samuel. As first-year residents at a competitive internal medicine program in a large county hospital, they were already feeling the much-anticipated burnout just halfway through intern year. “I’m so irritated with some of my patients,” Samuel remarked. “I don’t get how so many of them lack insurance. Most of them don’t even have a PCP!” Not sure what to say, Rebecca pointed to her watch. It was time for rounds with Dr. Myers, the Medicine Team D attending physician for that week.

A couple of hours later, Samuel was about to present the last patient. “So tell me about Mrs. Olson,” instructed Dr. Myers. Samuel began, “She is a 52-year-old female admitted through the ED for community-acquired pneumonia after a 5-day history of productive cough and fever.”

When his presentation was finished, Samuel was surprised by Dr. Myers’ first question. “Why wasn’t she seen by her doctor before the infection got to this point?”

The reason seemed obvious. “She doesn’t have insurance or a PCP.”

Dr. Myers replied, “Well, it looks like you have a job to do. Why don’t you go by her room this afternoon and provide her with some information on insurance options for those with low income? I know she’ll appreciate it. And also, if you wouldn’t mind, go ahead and look up Virchow’s essays on public health for rounds tomorrow. I know we can all learn something.”

Over lunch, Samuel was seething. “I didn’t go to medical school so I could be a social worker. Finding Mrs. Olson health insurance is *not* my job.” Rebecca realized this probably wasn’t the best time to start a debate, but she couldn’t help but frown at her colleague’s tirade.

Commentary

There is an Irish proverb that says to count your health instead of your wealth. Unfortunately, here in America, a person’s health is largely dependent upon his or her wealth. Life spans can vary by as many as 20 years between the richest Americans and those who are worst off [1]. However, the amount of money a person has in the bank is just one of a slew of factors that influence health and, therefore, have been termed the social determinants of health. These factors, which can have a

significant impact on outcomes, include access to health care, education level, workplace safety, environmental cleanliness, the number and type of relationships a person has with the people around him or her, and culturally ingrained dietary and health habits [2].

I saw the true meaning of the social determinants during my first year of medical school, when I spent one afternoon going on house calls with a physician working to increase access to health care. Before the other medical student and I got out of the backseat of his car, the physician asked us how it could be 4 o'clock in the afternoon on a school day and yet not a single child was playing outside. He said that there were two lessons to take from this. The first was that in all likelihood a recent incident of intimidation or violence had driven everyone inside and that we needed to be aware of our surroundings. The second lesson was that, if kids can't run around outside and get the exercise they need because their safety is threatened, then it isn't difficult to start to understand pediatric obesity.

As Rudolf Virchow noted more than 150 years ago, health needs to be a social concern—society must promote the health of its members [3]. He argued that the physician stands at the crossroads between the health of individuals and the social conditions that influence it; physicians must not only cure pathologies, they must work harder to correct the social injustices that their patients face.

To speak out about these underlying factors takes courage. At its core, addressing these structural issues is an act of advocacy. While advocacy can be an appealing aspect of the profession, and what ultimately draws many to medicine, this skill set is something that is rarely built into medical school or residency curricula. Since the 2008 presidential election and the subsequent health care reform debate, the role physicians should play in the hospital and in society has been called into question.

Some authors take the position that physicians must become part of the solution by participating in the public dialogue as advocates [4]. Given the trust the public places in the medical profession, those who do so effectively have the ability to become powerful leaders. Others have defined the scope of physician advocacy in broader terms [5]. Being an advocate need not be limited to finding patients health insurance or coming out in favor of a specific policy. It could mean advising local schools on nutrition policy or developing patient safety initiatives. Most physicians are advocates in one way or another.

There is, however, a camp that believes that political advocacy should not be a component of either medical education or medical professionalism [6]. They argue that, since advocacy is inherently political, it is a civic duty and not a professional one; universities and residency programs should not teach advocacy. Given the lack of consensus regarding this higher-level question and the lack of space in current curricula, the likelihood of much time being devoted to teaching advocacy competencies is low. This should not serve as a deterrent to those who wish to bring

about change. It is absolutely possible to effect change without formal training. For those looking to become involved, here are four lessons I have learned.

First, find a mentor. Like most things in medicine, having a relationship with someone who is knowledgeable and willing to lead the way makes things easier and more enjoyable. This is especially true when it comes to advocacy activities. Many medical centers have prohibitions on lobbying but not on advocacy, and a mentor can help you understand and walk this fine line. Furthermore, accomplishing things on a large scale is rarely a one-person task, and a mentor can connect you with other like-minded people.

Second, teamwork is key. The hospital is full of nurses, case managers, and social workers who are all striving for better patient care, both inside and outside the hospital. It is a fallacy to think that tackling social issues is solely the domain of the clinician, and it would be counterproductive to reinvent the wheel or duplicate the work of others who are more skilled in these areas. I have found the best way to do this is simple: just communicate with these other caregivers to find out what they can do for the patient and how I can help.

Third, find win-win situations. Advocacy is fundamentally about change, and often change is met with criticism. One of the best ways to obviate this is to find outcomes that are good for both sides. Some of the best advocates are those who can come up with options for mutual benefit. This takes the ability to look at a situation from other people's perspectives, and that can be enhanced by good mentors and collaborators.

Finally, have appropriate expectations and don't be discouraged by defeat. Setbacks are inevitable, and can easily lead to burnout if expectations and goals aren't attainable and aligned. As such, perseverance and building upon small victories is a must. Don't be willing to accept defeat; no one who has ever accomplished anything ever has.

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CLINICAL CASE

Enforcing Patient Copays

Commentary by Chris Brooks, MD

The Healthy Communities Clinic is a “free” clinic serving the uninsured population of an inner-city area. With the recent economic downturn, there has been a surge in patient visits; an ever-increasing number of residents are relying on the clinic’s services. The clinic director, Dr. Mizrahi, has mixed feelings about the boost in “business.” With most of the clinic’s funding coming from private donors, foundations, and a community health center grant from the federal government, she realizes that a new source of revenue must be identified to keep up with demand for services. After much discussion, the clinic’s board of directors decides to institute a sliding-scale fee system to help care for additional clients, update old equipment, and purchase more medicines for the clinic’s small dispensary. Signs about the new policy are posted throughout the clinic 3 months in advance to ensure that all patients are informed of the change.

A few weeks after the new policy has gone into effect, Dr. Mizrahi is happy to see that most patients have been able to afford the small copays required for clinic visits, as both new and established patients have continued to come to the clinic. In the middle of a busy Monday morning, Dr. Mizrahi pauses to read her next patient’s chart. Mr. Simon, one of her favorite patients, is to be seen for the routine check on his cholesterol. Before she enters the exam room, she is stopped by Ms. Gutierrez, the longtime front office manager for the clinic, who seems exasperated. “He said he couldn’t pay this morning. His proof of income indicates that he makes more than \$30,000 annually, and he says he is still employed. I don’t know why he says he can’t pay—but I roomed him anyway.” Confused, Dr. Mizrahi finishes reviewing Mr. Simon’s medical history, knocks on the door, and receives a friendly wave.

“Let me call you back, Jim, the doctor’s here,” Mr. Simon says into his cell phone. Dr. Mizrahi can’t help but notice that it is a newer 4G model equipped with camera, touch screen, and fancy case. “That’s nicer than mine,” thinks Dr. Mizrahi.

“Nice to see ya, Doc!” booms Mr. Simon. “Sorry about not being able to pay you today—you know how it is at the end of the month!” He points to a brightly colored sign indicating the new policy on the exam room wall and grinned. “I know about your new system, but I thought you wouldn’t mind. What’s one more visit?”

Commentary

The United States is one of few countries in the developed world that does not have universal health care coverage. Of the 30 country members of the Organization for Economic Cooperation and Development, only Turkey, Mexico, and the United States lack this entitlement [1]. Consequently, health care needs for the underserved in the U.S. are met by a variety of mechanisms with heterogeneous funding sources. The Healthy Communities Clinic in this scenario is typical of many across the United States that often struggle to provide the needed resources for their patients. Innovative methods to increase the financial viability of these clinics and allow them to maintain their level of service are constantly being sought. Copayments have been accepted as the standard for insured patients, and such payments instituted on a sliding scale have been adopted by many community clinics. Other methods to collect resources from patients have been less fruitful and can shift the burden to those who are more willing, as opposed to more able, to pay.

The argument that patients should share in the cost of their health care is quite strong. The idea of patient responsibility for health, both in terms of lifestyle choices and the financial burden of care, has been gaining popularity. Accepting this responsibility allows patients to have increased autonomy, making health care decisions that are more informed and based on more realistic cost-benefit assessments. The issue at hand is how can financial responsibility be equitably distributed in a society where the financial resources are not? Sliding-scale payments based on established and equally applied standards have been used as an attempt to address the issue. But when should such copayments be waived? The American Medical Association addresses the issue of insurance copayments in its *Code of Medical Ethics* [2]: “When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment.” The question then arises, who should evaluate for medical need and financial hardship? How should this be done?

Cappelen and Norheim take a liberal egalitarian view, arguing that inequalities that result from “circumstances,” but not those that result from “choice,” should be eliminated [3]. It is the choice itself and not the consequence of the choice for which the individual should be held responsible. Denying health care to patients in need can be a form of holding them responsible for outcomes. (Cappelen and Norheim suggest that financial responsibility for health-related choices can be distributed in the form of rewards or taxes associated with behaviors.) In our patient’s case, however, it might be difficult to argue that he is in a particular time of need.

As part of a trend to increase “personal responsibility” for health status, in 2006 the federal government approved West Virginia’s plan to provide reduced basic benefits to Medicaid recipients and allow them to qualify for enhanced benefits by signing and adhering to a “Medicaid Member Agreement” [4, 5]. Under this plan, patients could lose health care benefits based on tracked behaviors that might be the result of factors beyond their control. The physician was unable to personally evaluate the needs and resources of the individual patient. The ability to intervene in special

circumstances, providing or referring to needed resources, was also removed. In our patient's case, the physician's ability to personally evaluate her patient's need is preserved. Doing so in a just manner requires that pre-established criteria for waiving medical copayments exist at the clinic. Preconceived notions on the part of the clinic staff about what constitute appropriate sacrifices to make to obtain access to health care may not necessarily be congruent with patient values.

Cultural differences in the value of health care, both intrinsically and relative to other needs, can play a large role in the perceived need to make copayments. Patient perceptions of "health" can relate to responsibility, inner peace, justice, independence, God's will, family, mental strength, and growth, among other factors [6]. Differences in how patients view their "health" can change the relative benefit of receiving care as well as the willingness to accept the burden of a copayment. Furthermore, different groups may rank health care differently in the list of perceived needs for their lifestyles. Deviating from cultural norms to obtain health care can also carry a large burden for many patients. For example, should an elderly patient forego a new uniform for the holiday parade or a youth do without a sports jacket in order to obtain basic health care? Many of these values may seem strange to those evaluating the need and ability to pay of patients who seek care at a community clinic.

The just delivery of health care and social justice are increasingly being recognized as inextricably bound. Samia Hurst, a Swiss biomedical ethicist, argues that, if our purpose is just health care, "ordinary medical fairness" (that is, giving preferential treatment to no one) is better than giving high-priority (extra or first) care to the disadvantaged, on the grounds that such preferential treatment erodes social cohesion and may further differentiate or stigmatize marginalized people [7]. This argument may be sound, but "ordinary medical fairness" is not a feature of the decidedly unequal American system. In countries like ours, overcoming other social inequalities must take top priority to allow for a just distribution of health care resources. It is also possible that patients who perceive that they do not have ready access to health care may need incentives to access the system. Physicians must balance the individual needs of patients with the political agenda of distributing goods, services, and opportunities as freely and equitably as possible for the common good [8].

Finally, what avenues are available to Dr. Mizrahi as she deals with Mr. Simon's refusal to pay? Saul Wiener makes some suggestions in "I Can't Afford That!" [9]. Physicians should explicitly ask about financial concerns. Doing so allows the physician to take into account the ramifications for the individual while considering alternative approaches to patient treatment. Physicians should be knowledgeable about the resources available in the community. For example, a clinic that does not charge a copayment might be available to Mr. Simon if he continues to choose not to make them.

Continuity of care should also be considered for the patient. Would he be better served at a location where additional resources might be more accessible? If not, that may increase the likelihood that Mr. Simon's copayment should be waived. If the patient must stay with the clinic that charges a copay, then a nonstandard form of care may need to be adopted. For example, additional copayments for procedures or treatments may change the manner in which these are recommended to the patient. Although this may seem to violate the concept of egalitarian health care, in reality this may be the only option for our patient. Mr. Simon would need to be informed that his desire to avoid copayments has ramifications beyond a single clinic visit. To serve our patients, physicians must ultimately address social justice outside the office.

It is up to the individual physician or organization to decide whose copayments will be waived. This should be done in a just manner that evaluates the medical and financial needs of the individual patient and that takes the patient's individual and cultural values as well as societal needs into consideration. Thorough knowledge of the patient's circumstances and community resources is imperative when making this decision. Expecting patients to share in the responsibility for their health care is acceptable when it is done in a just manner. The ultimate beneficiaries of this are both society and the individual patient, who can acquire a greater ability to make effective health care choices.

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MEDICAL EDUCATION

The Underserved Pathway—Fostering Medical Student Interest in the Care of Vulnerable Populations

Shannon U. Waterman, MD, Amanda Kost, MD, Rachel Lazzar, MSW,
and Sharon Dobie, MD, MCP

The University of Washington School of Medicine (UW SOM) is a regional primary care medical school serving five states in the Pacific Northwest United States. Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) together constitute over 25 percent of the land area of the United States, with 35 percent of this region's population living in rural areas. The mission of the school includes "meeting the health care needs of our region, especially by recognizing the importance of primary care and providing service to underserved populations."

In "Who Is Caring for the Underserved?" Grumbach et al. state:

Earning potential, lifestyle preferences, clinical infrastructure, and cultural barriers perpetuate physician maldistribution in the United States. History has shown the fallacy of expecting growth in physician supply to spontaneously ameliorate this maldistribution through a policy of passive diffusion of physicians to underserved communities.... Achieving a more equitable pattern of service to needy populations will require ongoing, active commitment by policy makers, educational institutions, and the professions to a mission of public service and to implementation of the incentives and support required to promote care to the underserved [1].

Fostering Student Interest in Underserved Care

Founded in 2006, the University of Washington School of Medicine Underserved Pathway (UP) provides curricular focus and support to students interested in the health and care of underserved populations. Between 2008 and 2009 the first 14 UP students graduated. Initially funded with Health Resources and Services Administration Title VII funds, Underserved Pathway faculty currently receive funding from the dean of the School of Medicine with staff support provided by the Department of Family Medicine.

The UP helps prepare future physicians to work with underserved populations by providing a foundation of practical knowledge and real-world experiences. As an elective, longitudinal, supplemental curriculum in the School of Medicine, the UP is open to all medical students. Students can complete the pathway or take advantage of the offerings without earning a certificate of completion [2].

UP goals are that students acquire a knowledge base about underserved communities and populations, have the opportunity to discuss issues affecting these communities with other students, and reflect on their role as future physicians. The hope is that students will ultimately practice in these areas. Longitudinal data regarding UP student residency choice and practice patterns is not yet available.

What is Meant by “Underserved”?

The UP defines “underserved” as individuals or populations who are disadvantaged because of inability to pay, lack of access to comprehensive health care, or other disparities for reasons of race, religion, language group, or social status.

Structure of the Underserved Pathway

UP staff and faculty assist each student to design a pathway tailored to his or her interests and career goals. Students may study broadly, focus on a specific populations or communities that interest them, or explore health policy and advocacy.

Several core elements characterize the UP (see fig. 1), providing pedagogic and practical grounding in the fundamentals of caring for the underserved.

1. **Service and Engagement:** UP students complete 24 hours of service-learning activities through approved university or community-based programs. Activities include direct patient care, health education outreach, fundraising, and advocacy events.
2. **Mentorship:** Mentors are typically practicing physicians who offer valuable insights into what it means to care for underserved populations. Students are in contact with their mentors quarterly. Most students develop a mentor relationship through experiences during their first year. Mentors are assigned to any second-year student who has not identified one.
3. **Required Coursework** includes two main components:
Web-based curriculum. Web-based coursework serves the student population who rotate throughout the five-state region of the UW SOM. Students complete at least eight (of 13) UP modules. To complete a module, students either submit a brief reflective essay to which faculty advisors respond or take a quiz on the material covered. Faculty teach one module in person each quarter so students can meet and discuss the content of the module with their teacher and peers.

Current modules address government programs that provide coverage for underserved populations, care for individuals with disabilities, how race and ethnicity affect health and health care delivery, impact of chronic poverty, intimate partner violence, substance abuse, health care issues faced by people

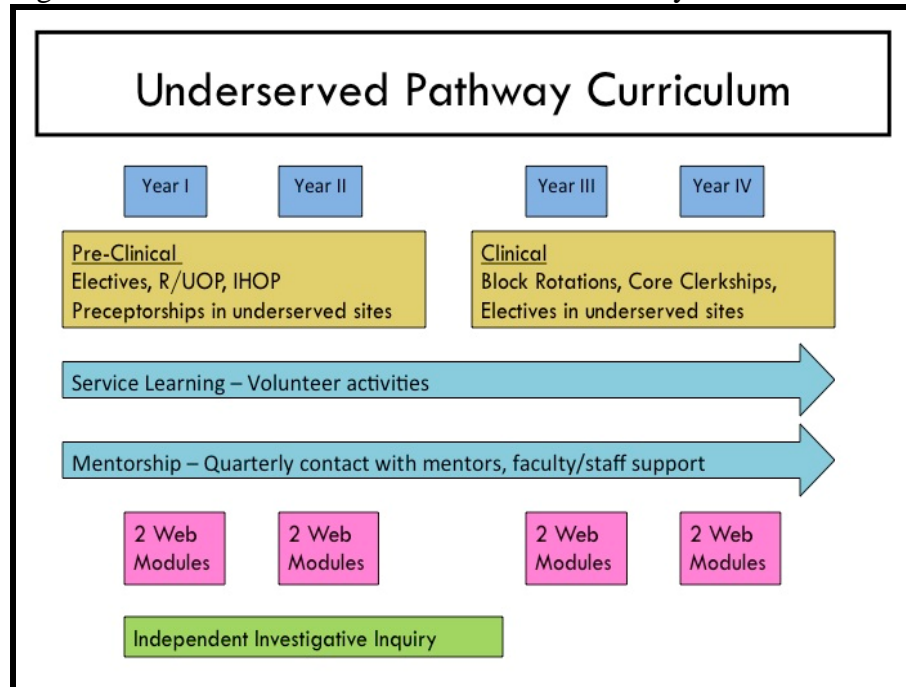
with HIV/AIDS, health literacy, concepts in public health epidemiology, and selected rural health topics.

Clinical and nonclinical courses. UP students select from existing courses that either have a related thematic focus or take place in a setting that cares for people who are vulnerable or underserved. This includes two credits of nonclinical electives from among more than 50 available courses. Advocacy and interdisciplinary care are modeled through many of the conjoint electives.

Students must complete 12 credits of clinical courses (including clerkships, subinternships, and advanced preceptorships) in underserved settings. The Rural/Underserved Opportunities Program (R/UOP) is an elective immersion experience in community medicine for students between years 1 and 2. During this 4-week rotation, students live in rural or urban underserved areas throughout the WWAMI region, providing care alongside practitioners in those communities.

4. **Scholarly Work.** All UP students must complete a scholarly project known as the Independent Investigative Inquiry. They may satisfy this requirement through a hypothesis-driven inquiry, a critical review of a given literature, or an experience-driven community project through either R/UOP or an International Health Opportunities Program (IHOP) that promotes community health in a developing country. The project must address an issue that is relevant to the care of medically vulnerable populations.

Figure 1. Core elements of the Underserved Pathway.



Evaluation Methods

Completion of the UP is based on fulfillment of the required elements. Students do not receive grades or credit; they receive a certificate of completion, and recognition is included in the medical student performance evaluation (dean's letter) upon successful completion of pathway requirements.

Program Improvement

The pathway conducts exit interviews with all graduating UP participants and with any student who leaves the pathway without completing it. These interviews gather feedback about student experiences and explore potential enhancements of the UP. All modules and coursework have built-in evaluation surveys which students are encouraged to complete.

Future Developments

Future activities of the Underserved Pathway include review of existing and development of new online modules, continued expansion of the mentorship network, and standardization of the program evaluation process. Since its inception, the UP has also worked close with the other School of Medicine pathways, including the Indian Health Pathway [3], the Global Health Pathway [4], and the Hispanic Health Pathway [5].

The Underserved Pathway is now a fundamental requirement of the curriculum for a new UW SOM program called TRUST. The Targeted Rural Underserved Track (TRUST) grants admission to a cohort of medical students through a secondary application and separate interview process. TRUST guides qualified, committed students through a special curriculum that connects underserved communities in Washington and Montana to the UW SOM and its network of affiliated residency programs to help meet the workforce needs of the region. As TRUST develops, it will expand to include Wyoming, Alaska, and Idaho [6].

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MEDICAL EDUCATION

Learning to Care for the Underserved—Making the Most of Opportunities in Medical School

William Y. Huang, MD

Let's suppose you are doing your primary care clerkship in a community health center and have just finished seeing Ms. M, a middle-aged patient who ran out of her diabetes medications a few months ago. She requests a refill. As you explore why she waited so long, you find out that she cannot always afford the copayment for them, and, even when she has the funds, she does not have reliable transportation. She tells you that she now has headaches and tearfully describes her difficulty sleeping. Scanning through her chart, you see that no one has offered her a mammogram or Pap smear in the past 5 years. As you gather your thoughts, you wonder how you can address all of her medical and nonmedical issues.

Who Are the Underserved?

The U. S. Census Bureau has reported that 50.7 million Americans (16.7 percent of the population) did not have health insurance in 2009 [1]. Previous studies have demonstrated that patients without health insurance are less likely to receive recommended preventive measures and screening and have poorer outcomes for chronic illnesses such as diabetes mellitus, cardiovascular disease, and cancer [2].

Moreover, certain urban and rural communities (designated as Health Profession Shortage Areas or Medically Underserved Areas by the federal Health Resources and Services Administration [3]) lack primary medical care, primary care physicians, and other health resources. Finally, factors such as transportation difficulties [4], limited health literacy [5], lack of fluency in English [6], low income level, and low education level [7] contribute to the designation of “underserved.”

Who Cares for the Underserved?

A number of physicians care for the underserved by practicing full time in public health systems and community health centers [8]. Other physicians volunteer part-time in local free clinics [9]. However, it is important to realize that a significant amount of care for the underserved is provided by physicians in private practice who treat Medicaid patients or provide charity care to patients who are unable to pay [10].

The American Medical Association defines the responsibilities of all physicians as follows:

Each physician has an obligation to share in providing care to the indigent.... All physicians should work to ensure that the needs of the

poor in their communities are met. Caring for the poor should become a normal part of the physician's overall service to patients [11].

Some medical students may have great interest in caring for the underserved, while others may not. The purpose of this paper is to encourage all medical students to take advantage of opportunities offered in medical school to learn to care for members of this population, since they will have a professional obligation to do so.

What Skills Are Needed?

Physicians who care for the underserved must have a number of skills, including ability to recognize that the patient may have unexpressed needs, an appreciation of local epidemiological factors, knowledge of community resources, and a willingness to take on the role of the patient's advocate [12]. Other necessary skills include the ability to listen to and communicate with patients who are from other cultures or speak other languages, to demonstrate respect towards all patients, and to help them overcome the barriers of the health care system [13]. Physicians who treat underserved patients in the urban ambulatory setting must be prepared to manage chronic medical conditions, emotional issues, lifestyle counseling, and a greater number of problems per visit than those delivering care in other circumstances [14].

How Can I Prepare?

Required courses and clerkships. Most medical students care for the underserved in various rotations that occur in teaching hospitals or their medical schools [15]. While you will learn a great deal about different medical conditions (potentially in advanced stages of presentation), there is much more to learn than that. Take the time to get to know your patients, their family situations, their cultural identities, social situations, the barriers and challenges they face in dealing with their illnesses, and any other factors that may have contributed to the hospitalization. These hospital-based encounters can also help you learn to advocate for patients and help them navigate through the health care system. While less time is spent in medical school in the ambulatory setting, similar opportunities to learn to care for underserved patients occur through the family medicine and other required primary care clerkships.

Some schools have reorganized the preclinical courses and clinical clerkships in their 4-year curriculum to include experiences that prepare all of their students to care for patients whose socioeconomic status is low or who are in public insurance programs [16, 17]. The David Geffen School of Medicine at UCLA in partnership with Charles R. Drew University jointly offers a specific 4-year curriculum to train qualified applicants to care for the underserved, and this program has reported that a higher percentage of graduates from its first 10 years practice in underserved settings than graduates of a traditional curriculum at UCLA [18, 19].

Service-learning opportunities. Seifer notes that the Health Professional Schools in Service to the Nation (HPSISN) defines service learning as “a structured learning experience that combines community service with explicit learning objectives,

preparation and reflection” and enables students to “provide direct community service but also to learn about the context in which service is provided, the connection between their service and their academic coursework, and their roles as citizens” [20].

Some schools offer service learning through required courses such as family medicine clerkships [21]. Students who participate in the project learn how community organizations address the barriers and challenges in underserved care.

Other schools provide service learning through electives. A frequently offered opportunity is participation in student-run volunteer clinics that care for homeless and underserved populations [22, 23]. In addition to providing opportunities for clinical learning, these volunteer experiences give students the opportunity to develop leadership skills and experience in organizing the health care delivery of the clinic to meet the patients’ needs.

Electives and longitudinal tracks/pathways. Some schools have 4-year longitudinal tracks or pathways on underserved care for students with strong interest in this area. These tracks or pathways typically include didactic seminars, clinical care of patients in an underserved setting, and community-based projects [24-27]. Other schools have tracks or special electives that focus on rural practice and report a higher proportion of graduates practicing in rural settings than traditional curricula [28-30].

Extracurricular opportunities. Finally, there are extracurricular programs that help students learn more about delivering care in underserved areas. One example is the Albert Schweitzer Fellowship program, which has chapters in many American cities [31]. Students selected for this program conduct a health service project in the community, developing leadership skills and gaining experience in conducting community projects.

Motivation to Care for the Underserved

Studies have identified positive factors that motivate physicians and help them maintain an interest in caring for the underserved. These factors include the desire to make a difference, the creativity to address multiple issues with limited resources, flexibility, the ability to work with others as a team, and the commitment to serve a specific community or population group [32, 33]. In addition, a number of physicians practice in underserved settings because they view their work as a calling, a “deeply felt motivation for work that goes beyond the satisfaction of the worker’s material and social needs” [34].

Conclusion

What is your calling as a physician? Some of you know that you are called to care for the underserved. Others may be unsure about your calling or what type of practice setting you will choose in the future. No matter what your interest or calling is, you will most likely have patients like Ms. M in the future. If you are not prepared to care for her, who will?

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THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinion on Physicians' Duty to the Poor

Opinion 9.065 - Caring for the Poor

Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should be a regular part of the physician's practice schedule.

In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity.

Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as seeing indigent patients in their offices at no cost or at reduced cost, serving at freestanding or hospital clinics that treat the poor, and participating in government programs that provide health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless.

In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge, and prestige to designing and lobbying at all levels for better programs to provide care for the poor.

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CLINICAL PEARL

Diagnosis and Treatment of Community-Acquired Pneumonia in Children and Adults

Yu-Hsiang “Clara” Lin, MD, and Anoop Agrawal, MD

Community-acquired pneumonia (CAP) is a commonly diagnosed illness, defined as “an acute infection of the pulmonary parenchyma that has been acquired outside the hospital” [1]. The etiology of CAP frequently goes unidentified because it is difficult to obtain a direct sample of the infected tissue for culture. This may pose a challenge in diagnosing and treating CAP. Although adults with CAP typically present with cough, fever, sputum production, and pleuritic chest pain, along with the presence of an acute infiltrate on chest radiograph [2], the wide spectrum of presentation among children can make diagnosing them difficult. While CAP can manifest as an acute febrile illness with clinical decompensation in some children, a small percentage of pediatric patients under 5 years of age may simply have fever and abdominal pain without respiratory distress [3]. This article will review current clinical guidelines for the diagnosis and treatment of community-acquired pneumonia in previously healthy children and adults; aspiration and nonbacterial pneumonia will not be included in the discussion.

Children between 60 days and 18 Years of Age (Who Have Not Been Hospitalized within 7 Days of Presentation)

Diagnosis. History taking and a complete physical exam are critical to diagnose CAP in children. History of the patient should include the age of the child, type of symptoms and date of onset, immunization status (particularly *Streptococcus pneumoniae* and influenza), possibility of aspiration, and recent exposure to tuberculosis. The complete physical exam, including vital signs, can often help determine the severity of pneumonia. Severely ill children should be evaluated for signs of parapneumonic effusion or empyema, including dyspnea, dry cough, pleuritic chest pain, frictional rub on auscultation, or diminished breath sounds. In less acutely ill children, the following combinations of clinical findings are the most predictive of severe CAP [3]:

- In infants less than 12 months of age: nasal flaring and oxygen saturation (SpO₂) less than 96 percent on room air and respiratory rate above 50 and intercostal retractions.
- In children 1 to 5 years of age: SpO₂ less than 96 percent and respiratory rate above 40.
- In children greater than 5 years of age: SpO₂ less than 96 percent and respiratory rate above 30.

Further laboratory tests and imaging studies such as a chest x-ray should be ordered based only on clinical findings and a high index of suspicion [3]. In children,

complete blood count (CBC) should be considered only if this additional information can help determine the use of antibiotics, since the value of CBC for children with signs and symptoms of pneumonia has not been strongly supported by evidence. Typically white blood cell count is 15,000 per mm or more in bacterial infections [3]. In the Texas Children's Hospital 2009 CAP clinical guideline, blood cultures are not generally recommended for an otherwise uncomplicated bacterial pneumonia, especially in the outpatient setting. It can be helpful for children with more severe disease, however, if collected before antibiotics are administered. A tuberculin skin test should be conducted if travel and history suggest possible exposure to tuberculosis, and a pertussis polymerase chain reaction (PCR) can be obtained from nasopharyngeal swab for children with coughs lasting more than 2 weeks.

Treatment. In general, antibiotic therapy should not be delayed while awaiting laboratory test results. Choice of antibiotic therapy should take into consideration the treatment setting (inpatient or outpatient), and the age of the child, both of which can influence the causal organism and its susceptibility to treatment. Most uncomplicated pneumonias in otherwise healthy children can be managed with outpatient therapy. Indications for hospitalization include severe dehydration, inability to tolerate oral rehydration or medication, moderate-to-severe respiratory distress, altered mental status, oxygen requirement, poor compliance or lack of follow-up after discharge, or unsuccessful outpatient management [3].

In the outpatient setting, high-dose amoxicillin (80-100mg per kg per day) has been demonstrated to be a reasonable option for CAP, since *Streptococcus pneumoniae* is a common pathogen (the most common in some age groups) among children. According to the Texas Children's Hospital clinical guideline, outpatient treatment differs by age group:

- Children 3 months to 2 years of age: high-dose amoxicillin for 10 days to provide coverage for *Streptococcus pneumoniae*. Children younger than 2 years who cannot tolerate oral medications should be treated with one intramuscular dose of ceftriaxone at 50 mg per kg.
- Children between 2 and 5 years of age: high-dose amoxicillin for 10 days plus a macrolide for atypical pathogens. Amoxicillin monotherapy can be considered if there is less concern about atypical pathogens, but a second antibiotic should be added if there is no response after 24-48 hours of monotherapy.
- Children older than 5 years: high-dose amoxicillin for 10 days plus a macrolide.

In an inpatient, non-ICU setting, recommended therapy according to age groups is:

- 3 months to 2 years of age: ampicillin or cefotaxime to provide coverage for *Streptococcus pneumoniae*.
- Between 2 and 5 years of age: ampicillin or cefotaxime with a macrolide if needed to cover for *Streptococcus pneumoniae* and atypical pathogens.
- Older than 5 years: ampicillin or cefotaxime with a macrolide if needed to cover for *Streptococcus pneumoniae* and atypical pathogens.

Children in transition to oral antibiotics should receive at least 10 days of antibiotics when clinical improvement is demonstrated with the given therapy.

Antibiotic therapy should be used in accordance with the antibiogram and the susceptibility/resistance pattern of *Streptococcus pneumoniae* observed in each specific hospital. Special considerations and appropriate treatment guidelines apply to children with complicated pneumonia or pleural effusions, those who require intensive care, and those who demonstrate no clinical improvement on the suggested therapy.

Adults Older than 18 Years (Who Have Not Been Hospitalized within 7 Days of Presentation)

Diagnosis. In adults, CAP typically presents as a constellation of suggestive features including cough, fever, sputum production, and pleuritic chest pain, along with the presence of an acute infiltrate on chest radiograph, with or without microbiological data [2]. As in children, the management and prognosis of CAP in adults depend on the initial assessment of severity of illness. Once again, history and physical examination are important parts of the evaluation. If there is infiltrate on the chest x-ray of an otherwise healthy adult, community-acquired pneumonia should be strongly considered.

When evaluating adults with CAP, prognostic models (e.g., PORT Severity Index or CURB-65) can be helpful in determining the severity and therefore treatment setting of illness [4]. According to the Infectious Disease Society of America (IDSA) 2010 clinical practice guideline for CAP, criteria for severe CAP include but are not limited to rapid respiratory rate (more than 30 breaths per minute), hypoxemia, uremia, altered sensorium, leukopenia, hypotension requiring fluids or vasopressors, and multilobar infiltrates. Inpatient admission and discharge criteria should also take into consideration compliance and support on an outpatient basis [2].

With the exception of chest radiograph, most other laboratory tests in adults with strong clinical suggestion of CAP are optional in the outpatient setting. The IDSA guidelines include specific indications of more extensive diagnostic testing such as blood culture, sputum culture, urine legionella and pneumococcal antigen testing, and fungal and tuberculosis studies [4].

Treatment. As in children, antibiotic therapy should not be delayed while awaiting laboratory test results and should take into consideration the treatment setting. For outpatient treatment of adults without comorbidities, a macrolide or doxycycline is an acceptable first-line treatment. In adults with comorbidities such as diabetes, malignancy, chronic obstructive pulmonary disease, or other chronic medical conditions, either a respiratory fluoroquinolone (such as moxifloxacin, gemifloxacin, or levofloxacin) or an advanced macrolide (azithromycin or clarithromycin) can be used as monotherapy [2, 4]. Beta-lactams (such as high-dose amoxicillin or amoxicillin-clavulanate) with a macrolide can also be used. In regions with a 25 percent or higher infection rate with high-level macrolide-resistant *Streptococcus*

pneumoniae, patients with or without comorbidities should be treated with a respiratory fluoroquinolone or combination therapy of a beta-lactam agent and a macrolide, as stated above [2, 4].

In an inpatient setting, the clinician should consult the antibiogram of the specific hospital for susceptibility and resistance pattern of common CAP pathogens. The first-line treatment of adult CAP in the medical ward should consist of monotherapy with a respiratory fluoroquinolone or, for some patients, a combination of an advanced macrolide with a beta-lactam agent such as cefotaxime, ceftriaxone, ampicillin, or ertapenem. If pseudomonal infection is a specific concern, antipseudomonal beta-lactams such as ceftazidime, imipenem, meropenem, or piperacillin-tazobactam should be given in combination with ciprofloxacin or levofloxacin [2, 4].

As always, special consideration should be applied to patients with complicated pneumonia or evidence of pleural effusion, or patients requiring intensive care.

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HEALTH LAW

Medical-Legal Partnerships

Rebecca L. Huston, MD, MPH, Susan Zinn, JD, and Sylvia Leal-Castanon, MD

You are a pediatrician, halfway through a busy morning clinic. You walk into an exam room to see 9-year-old Sarah, whose asthma you have treated for years, and her mother. Initially, Sarah's health was very unstable, requiring numerous hospitalizations. By working closely with her family, you were able to get her asthma under control.

In the past 6 months, however, Sarah has had three emergency department visits and two hospitalizations for asthma. You are confident that the family is compliant with the treatment plan, and your medical management has been comprehensive: allergy testing, pulmonary function tests, asthma education classes, appropriate medications—and yet, Sarah's asthma is not controlled. You dig deeper and identify several problems. First, Sarah and her family rent an apartment that is infested with cockroaches. The family keeps their apartment meticulously but there is trash in the hallways, and an often-overfilled dumpster sits against the outside wall. There is also a water leak from the apartment above theirs that has led to mold growth on one wall. Sarah's mother has tried repeatedly to get the landlord to address these problems, to no avail.

A second problem is that Sarah has lost her Medicaid. Her mother submitted the renewal application 2 months ago but has not heard back. The family is unable to purchase Sarah's medications. Finally, Sarah's school has threatened to take her family to court because of excessive school absences this year. In this case, you realize that fixing Sarah's problems will take a lot more than the latest and best asthma medications. Sarah needs a specialist—not a pulmonologist or allergist, but a lawyer. If you work with a medical-legal partnership (MLP), Sarah and her mother can walk right down your hallway and meet with a lawyer who can address these problems.

The National Center for Medical-Legal Partnership defines MLP as

a health care and legal services delivery model that aims to improve the health and well-being of vulnerable individuals, children and families by integrating legal assistance into the medical setting. MLPs address social determinants of health and seek to eliminate barriers to health care in order to help vulnerable populations meet their basic needs and stay healthy [1].

The first MLP was developed by Barry Zuckerman, MD, at Boston Medical Center in 1993, and the model is used in 225 hospitals and health centers in 38 states. In 2010, more than 13,000 individuals and families received legal assistance through MLPs, and more than 10,000 health care professionals received training on the MLP model. MLP has been endorsed by the American Medical Association and the American Bar Association [2, 3].

MLPs focus on three key activities. First, they provide legal assistance in the health care setting. Legal professionals meet with families to identify and address those circumstances affecting their health that are amenable to legal intervention. Second, MLPs work to transform health care practice by educating health care professionals about the significance of social determinants of health. Third, MLPs work toward policy change by addressing local, state, and federal laws and regulations that can stand in the way of maintaining good health.

As physicians, accurately diagnosing our patients' problems and providing the latest evidence-based management of their physical problems can seem challenging enough. We must go deeper, however, to better understand the underlying causes of our patients' illnesses and the reasons why they sometimes do not respond to our medications. Often the answer is found by taking a detailed social history.

Increasing attention is being paid to the social determinants of illness. A 2009 review in *Pediatrics* emphasized the strong link between problems in the social and physical environments and the risk for childhood asthma [4]. There is also evidence that the origins of adult conditions can be traced back to childhood [5]—researchers have found strong associations between early childhood adverse experiences and environments and adult diseases such as coronary artery disease, chronic lung disease, cancer, alcoholism, depression, and drug abuse. Few physicians make house calls anymore, so we must delve deeper in our history taking to fully understand the circumstances that may be influencing our patients' health. It is also important for us to develop collaborative relationships with other professionals in our community. Typically, these other professionals will be in the health care field, but sometimes what our patients really need is a lawyer.

According to a 2009 report from the Legal Services Corporation, the average low-income household in the United States had 1.3-3.0 legal needs per year [6]. These needs included problems related to housing, consumer protection, family law, employment, health care, and government benefits. Typically, legal assistance was received for fewer than 20 percent of these problems.

Unsafe housing conditions and inappropriate denials of government benefits are common examples of legal problems that can directly affect the health of our patients. Through direct access to legal advice while in the hospital or clinic, our patients get the assistance they need. Data show that MLPs can increase access to health care and improve the patient's and family's sense of well-being [7].

Assistance with benefit denials can also significantly improve reimbursement to health care facilities, which can help defray the cost of the program [8].

So let's get back to Sarah. Her mother receives legal assistance from the MLP in your clinic. Two telephone calls from the MLP lawyer are enough to get the landlord to address the cockroach and mold problem and to get Sarah's Medicaid reinstated. The lawyer then goes with the mother to Sarah's school. School personnel agree to accept Sarah's medically excused absences and to work with her mother to help Sarah catch up on school work that she missed. Sarah's mother is ecstatic and Sarah's asthma management gets back on track.

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POLICY FORUM

Student-Run Clinics—A Short-Term Solution to a Systemic Problem

Erwin C. Wang, MHA, Megan Prior, Jenny M. Van Kirk, Stephen A. Sarmiento, Margaret M. Burke, MS, Christine Oh, MS, Eileen S. Moore, MD, and Stephen Ray Mitchell, MD

More than 23 years have elapsed since David Hilfiker discussed the “medical abandonment of the poor” [1]. In “Unconscious on a Corner,” Dr. Hilfiker told the story of Mr. W, who received weeks of treatment at a Washington, D.C., intensive care unit. His physicians failed to diagnose his dementia during this time, giving him instructions and a treatment plan that he would never be able to follow.

Instead, Mr. W was released from the hospital to seek refuge at a poorly kept overnight homeless shelter, from which he would be forced to leave in the morning. He had to forage for food and struggle through his conditions. He endured poor health while suffering through the unnavigable system faced by so many of Washington’s poor.

The health care environment of the city Dr. Hilfiker described was one in which many were denied access to essential medical services due to a lack of health insurance. Today, scores of Washingtonians all too closely resemble Mr. W: a homeless woman with hypertension needing medications and caring for three small children or a young man searching unsuccessfully for HIV testing and smoking cessation counseling.

The problem of access to health care services described by Dr. Hilfiker in 1987 has changed. Today, 11 percent of Washingtonians are uninsured; the national average is 17 percent. Despite having a significant number of people enrolled in both private and public insurance programs, the district still has one of the highest HIV rates in the world, a life expectancy lower than that in all 50 U.S. states, and the highest infant mortality rate in the nation [2, 3].

The problem in D.C. is no longer a lack of health insurance; it is a shortage of physicians who will treat the underserved and a lack of hospitals and clinics in less affluent areas of the city. A 2006 survey performed by Georgetown University medical students found that only 59 percent of Washington physician practices accepted Medicaid patients (M. Young, T. O’Toole, and E. Moore, unpublished data: survey of DC clinics on Medicaid participation).

Another study evaluating insurance status in Washington found that 44 percent of publicly insured adults visited the emergency room in a 1-year period while only 20

percent of employer-insured adults did [4]. Even those with insurance are forced to use expensive, less efficient forms of care. Indeed, access to insurance coverage does not necessarily mean access to appropriate medical care.

Local and federal governments have worked tirelessly to address these challenges. Advocacy groups and policy experts have supported such new health care delivery models as patient-centered medical homes and accountable care organizations, which both aim in their own way to enhance primary care, encourage evidence-based practice, and reward quality outcomes [5].

How these solutions will be implemented or whether they will even be successful is still being debated. Some policy experts suggest that there is a potential for health care disparities to be unintentionally exacerbated by these health care delivery models [6]. Who will respond to the pressing health conditions of the underserved now?

While policies and infrastructure attempt to catch up, *physicians* can act now. As Dr. Hilfiker describes, many physician resist putting themselves in someplace unfamiliar, practicing in an alien culture or environment. Hilfiker writes, “the nature of the healer’s work is to be with the wounded in their suffering” [1].

Still, many physicians have answered this call. Several organizations work to place physicians in underserved areas. The HOYA Clinic was founded in 2006 by Georgetown University students and physicians to assist the homeless population of Southeast Washington. Many of the thousands of homeless people in Washington are sheltered at the D.C. General Emergency Family Shelter, where our clinic is located. The facility is equipped with electronic medical records, e-prescribing, access to laboratory testing, and an organized primary care pharmacy.

Twenty-five physicians, including some in private practice, 20 nurses, and 654 students have volunteered at the HOYA Clinic over the past year, with strong support from Georgetown University Hospital and MedStar Health, an integrated health system in the mid-Atlantic region. These volunteers attempt not only to fix acute medical problems but also to build a culture of change.

Dozens of local medical societies and physician groups across the U.S. have taken up similar callings to aid the underserved in their local communities. Organizations such as Project Access and the Washington Archdiocese Health Care Network, which was mentioned in Dr. Hilfiker’s article and is now in its thirtieth year of existence, have formed networks of specialists that perform expensive services for indigent individuals at little to no cost [7]. These physicians welcome a few patients every month or year and offer desperately needed, tremendously costly specialty care, providing what they hope is a temporary solution to a larger problem.

Pending legal challenges, the Patient Protection and Affordable Care Act aims to enable millions of Americans to gain health insurance, supplement federal loan

repayment programs, and change reimbursement schemes. However, more policy shifts offering financial incentives may be needed to encourage physicians, especially those in primary care, to work with indigent populations [8]. This temporary solution of physician volunteers may become more permanent after all.

Moreover, leaders from Project Access and similar groups fear a decline in the availability of clinicians to indigent populations because of possible significant increases in the number of Medicaid enrollees combined with falling payment rates. One study indicates that health care practices and clinics that do not currently accept Medicaid patients are not likely to do so in the future when more Americans are insured through Medicaid under the Patient Protection and Affordable Care Act [9].

Due to the economic downturn, quickly decreasing state Medicaid funds will directly affect those who work with the underserved [10, 11]. The community health centers and safety net systems are experienced in case management and language translation for their populations of patients and will need to treat even more patients with fewer resources, adapting to new health care delivery models, and maintaining quality [12].

These conditions threaten access to care for acute conditions; a greater threat exists in the need for treatment of chronic conditions. People with chronic illness require reliable, regular access to medical care, particularly from primary care physicians, to achieve better outcomes. Thus, many believe that greater action is needed to draw more primary care physicians to work with the underserved [8].

Physicians must advocate for the underserved. Dr. Hilfiker asks if it would be so difficult for those in private medicine to allocate some small percentage of their patient count to the underserved. Doctors today of course have new challenges. Physicians, especially those in primary care, are not earning salaries as generous as those of their predecessors, medical education debt is increasing, and payers are continuing to cut into physician reimbursements.

Yet, how do these burdens compare to those of our most indigent populations? Do the challenges physicians face relieve them of their professional duty to care for the most underserved, and often sickest, patients?

Health policy experts will continue to debate how to address the maldistribution of physicians. Rather than relying on financial incentives, perhaps more immediate success could come from appealing to the social imperative that first drew physicians to the medical field.

As Martin Luther King Jr. wrote in his “Letter from a Birmingham Jail,” those with the power to do so must act to preserve human rights and human dignity. As he said, “justice too long delayed is justice denied” [13].

Ideally, this justice would be achieved voluntarily; certain policies and requirements can and do assist efforts to attain it. Georgetown University requires its medical

students to perform 20 hours of community service before graduating, and many fulfill this prerequisite at the HOYA Clinic. This modest requirement is intended to instill in us as future physicians a spirit of service and dedication to the underserved. How can we promote that sentiment among current physicians? Will we too, as future physicians, even those who have volunteered at HOYA Clinic, drift away from caring for indigent populations despite the enormity of their plight?

As coordinators of the HOYA Clinic, we have witnessed the desire, drive, and determination to make positive changes for the benefit of the less fortunate. This sentiment shared by so many students, nurses, and physicians at Georgetown and elsewhere offers promise for more change to come. We hope that all health care providers will renew their commitment to aid the underserved and ensure justice for all we serve.

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MEDICINE AND SOCIETY

Beyond Charity—Social Justice and Health Care

Justin M. List, MD, MAR

The passage of the Affordable Care Act in 2010 took a step towards ensuring that every citizen in the United States has access to affordable health care. Still, the current system contains a number of health coverage and treatment gaps for those living in poverty. Physicians who treat patients without insurance and who cannot pay often do so under the term “charity care.” But the charity care model, for all its good intent, is severely limited as an approach to resolving the problem of the underserved. A better conceptual approach to securing care for uninsured individuals in the United States is a social justice framework, and incentives for achieving social justice may be different from those that induce physicians to deliver charity care.

Loosely defined, charity care entails physician care provided to patients for free or at significantly reduced payment rates. Physicians who deliver charity care may earn less than their peers with better-insured patient panels. Some include patients on Medicaid in the term “charity care,” since Medicaid’s payment for physician services is lower than that of Medicare and private insurance. The term itself is not without controversy. Charity implies the performance of a good deed or action, particularly to the needy. Although its definition denotes generosity, it is often construed as connoting “self-sacrifice.” That is, the term as often used focuses on the benevolence of the doer, e.g., physician, rather than on systemic injustice experienced by the receiver, e.g., the needy patient, in the case of health insurance in the United States.

An emphasis on charity reflects attention on fixing short-term needs rather than on addressing systemic inequities that create an environment in which charity is necessary. Sociologist Janet Poppendieck explains this concept by arguing that “the resurgence of charity is at once a symptom and a cause of our society’s failure to face up to and deal with the erosion of equality. It is a symptom in that it stems, in part at least, from an abandonment of our hopes for the elimination of poverty” [1]. The applicability of this critique to charity care medicine is probably limited; addressing the medical needs of the poor is not incompatible with addressing their social needs. Social justice asks physicians to advance professional values by calling for a critique and reversal of systemic factors that create an environment where charity care finds need. At the very least, as physician Paul Farmer writes, “charity medicine should avoid, at all costs, the temptation to ignore or hide the causes of excess suffering among the poor” [2].

Social justice is defined as a just distribution of goods within society and examines the relationships between groups and individuals that influence the distribution of

goods. Such work entails advocating both for the poor on an individual level and for solutions to the structural barriers that deny them access to affordable, adequate health care. As educator and theorist Paulo Freire puts it, “True generosity consists precisely in fighting to destroy the causes which nourish false charity” [3]. A social-justice approach nourishes the “true generosity” for which Freire argues. While different, charity medicine and social-justice work can be seen as part of a comprehensive solution to the problem of the uninsured and underinsured. Are the motives for engaging in charity care and social-justice work the same? The answer to that question depends on why and how physicians engage with the underserved.

Motives for Providing Charity Care

A simplistic way to explore physician motives to provide charity care is to consider them ranging along a continuum from altruism at one end to self-interest at the other. In reality, they do not fall on such a linear continuum but rather reflect a web of various influences. For some, knowledge of the health disparities in the United States engenders a commitment to charity care. A sense of justice (and injustice) informed by personal experiences, reflection, medical education and training, and peer influences functions as a strong motivator to engage the underserved. Religious and other humanistic beliefs also motivate a number of physicians to provide charity care despite financial disincentives to do so.

Psychological motives may also be at play for physicians who practice charity care. It may be the case that physicians derive added personal and professional satisfaction from caring for patients at the margins of society, although this can erode over time, given the difficulties of caring for impoverished patients living in precarious conditions, and especially if physicians feel their work is not valued by society at large.

Practicing some charity care medicine may confer a sense of redemption, duty fulfilled, or guilt assuaged. It is conceivable, for example, that a physician who maintains a panel of wealthier patients would feel drawn to delivering episodic charity care. The social-justice question we must pose to that physician is: Are you willing to advocate for changes to the medical system that creates the need for you to take on charity patient cases in the first place? If the answer is “no,” one could argue that the physician is passively complicit with a health care arrangement in which charity care is the only chance underserved patients have at receiving health care.

Beyond Charity Care

Will the same range of motives—from altruism to self-interest—that prompt physicians to provide charity care move them to social justice work? Although a number of considerations factor into answering that question, the answer is most likely “no.” Ever-increasing medical educational debt, lower payments for primary care services than for specialty procedures, growing costs for maintaining individual and group medical practices, widening wealth disparities in the U.S. leading to more uninsured patients, and population shifts toward urban centers are a few of the reasons altruism and self-interest will not necessarily lead doctors to social-justice

work. In truth, many of these factors may perpetuate the need for charity care, as physicians worry about their own financial solvency in addition to that of their patients. A social-justice framework requires that physicians speak out against the forces that continue to make meaningful, truly universal health care unattainable, even when to do so temporarily contradicts their own financial interests.

Acknowledging that financial incentives, such as loan repayment or increased salaries for those who provide primary care and work in resource-poor areas, may be needed to narrow or close the gaps in access does not necessarily reflect poorly on the state of medicine's professional conscience. Doing so merely recognizes the practical fact that physicians face barriers to caring for the underserved in contemporary America from the moment they learn of the lower remuneration physicians receive for such care. The current payment system encourages physicians to practice medicine in any sector of the health care field other than primary care for the underserved, one of the areas in which they are most needed [4].

The political will to ensure that every citizen has adequate access to affordable care has not yet arrived in the United States, despite the fact that every other high-income country has such a system. A society free of charity care, with a fundamental respect for human dignity, would allow the medical profession to maximize patient care. Ridding U.S. society of the need for charity medicine would free physicians to spend more time and energy on patient care, instead of being forced to balance charity care with making ends meet in a medical practice. Taking a social-justice approach to health disparities may be the best way to achieve this. It requires physicians to take the lead.

At the heart of the social-justice approach to ensuring care for the underserved is the need for physicians, collectively and individually, to be agents of social change. Physicians have enormous opportunity to see how poverty, lack of insurance, and other determinants of health impact their patients and to advocate based on this knowledge. Yet there is an insidious temptation for physicians to feel victimized by other decision makers in the health care system who seem to reap more financial benefits, and that feeling can compromise physicians' sense of empowerment as agents of change for disenfranchised patients. I have discussed the many disincentives to caring for underserved patients, but, at the end of the day, physicians have significantly more influential social and political cachet than their underserved patients. To be sure, there is much work to be done in the area of physician remuneration to reduce physicians' sense of disenfranchisement. But social justice demands that physicians actively advocate for social change in patient care that eclipses the continued need for charity care.

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HISTORY OF MEDICINE

Catholic Hospitals and the Safety Net

Marcy Doderer

The tradition of Catholic hospitals is a long one, stretching back to medieval Europe and beyond. Hospitals run by religious orders were among the first in the United States. Catholic hospitals, because of their mission and their preferential treatment of the poor, are a significant, even essential part of today's health care safety net.

Catholic facilities operate in all 50 states, employ more than 750,000 people, and provide acute care, skilled nursing, hospice, home health, assisted living, and senior housing services. According to the Catholic Health Association, Catholic hospitals account for approximately 13 percent of all hospitals in the United States and deliver care to one in six patients hospitalized in the United States each year. This translates into nearly 19 million emergency room visits and over 5.6 million hospital admissions a year. In addition, with more than one-third of Catholic hospitals located in rural or underserved areas, many Catholic facilities often provide a higher percentage of public health and specialty services—such as psychiatric services, dental care, crisis prevention, and cancer screening—than other hospitals [1].

The role of Catholic hospitals in their particular communities varies widely according to the needs and the configuration of the local health system. It can be said in general, however, that Catholic hospitals provide a great deal of free or poorly compensated inpatient care and primary care services through clinics and medical outreach programs for the uninsured. Often, Catholic hospitals become known as a “provider of last resort” for uninsured and underinsured citizens [2]. This leads to a continual balancing act, as the hospitals strive to meet their missions while remaining financially viable.

The role Catholic hospitals play in providing care for underserved populations is illustrated by San Antonio-based CHRISTUS Santa Rosa Health System, a member of CHRISTUS Health and the only nonprofit, nongovernmental health system in the area. Founded by the Sisters of Charity of the Incarnate Word of San Antonio in 1869, with a special concern for the underserved, CHRISTUS Santa Rosa now comprises four adult community hospitals and one academic children's hospital that treat large numbers of disadvantaged patients. At the Children's Hospital, more than 80 percent of the patients are either on Medicaid or uninsured. In 2010, CHRISTUS Santa Rosa Health System provided more than \$33.9 million worth of uncompensated care.

CHRISTUS also works to improve community health through outreach efforts. The health system operates mobile mammography and pediatric clinics and school-based clinics and supports other primary care services with both financial and human resources to improve access to care. In addition, CHRISTUS leaders actively participate in a wide variety of advocacy and collaborative efforts at the local, state, and federal levels to impact public policy decisions regarding health care. In 2010, the system directed more than \$28.7 million to programs like those described above aimed at improving access to care in the San Antonio community. Like many Catholic hospitals, CHRISTUS faces a growing number of uninsured or underinsured patients, declining payment rates, and escalating costs.

The Catholic Health Association envisions a health care system in which unequal access to care is no longer a burden the poor must bear. Ultimately, leaders in Catholic health care hope to influence public policy so that the limited federal and state dollars can most profoundly impact the health care needs of the nation's most vulnerable citizens.

Though the ideals are high, Catholic hospitals fully recognize that resources are not endless and sustainable systems are needed to improve the health of our nation. Catholic hospitals will continue to serve their communities through the preferential option for the poor, the vulnerable, and the underserved and also spur change to improve the health care delivery system for all.

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MEDICAL NARRATIVE

Rebuilding Medicine

Corey Hebert, MD

The date was September 5th, 2005. Catastrophic devastation surrounded me. I sat on the steps of my office building and gazed upon a formerly fully occupied parking lot that had been transformed into a makeshift triage center for the American Red Cross relief effort in New Orleans. We had no electricity and no clean drinking water, and heinous images of dead bodies were far too often on the news. I was scared and worried that New Orleans as I had known it was gone forever. How could a city and its people rebound from this level of destruction?

My own healing process began by working to improve the health of the children and families who still called New Orleans home. Many others began their healing process much the same way—by getting down to the business of rebuilding the city brick by brick.

Fast forward 5 years. A Super Bowl victory, NBA playoff appearances, a blossoming independent school system, educated young entrepreneurs everywhere you look, and construction underway on state-of-the-art VA and teaching hospitals to rival those anywhere in the world. What was needed in New Orleans is what we need in medicine: renewed engagement. Doctors today need to care about their patients and their profession as much as New Orleans' citizens care about getting their city back on its feet.

As New Orleans was brought low after Katrina, the culture of health care in America today is broken. Our payor-payee system is dictated by financial motivations, not concern for the patients. Our hospital systems overlap and duplicate services, wasting millions of dollars on obsolete routines. Our medical institutions of higher learning have forced the best and brightest to shun primary care as a practice area for fear that they may not be able to pay back their student loans. The United States now faces a shortage of primary care doctors, and huge numbers of our patients suffer from preventable illnesses—childhood obesity, hypertension, and diabetes. The profession—not the mere job of medicine, but why it all matters—is in danger of being lost. Organized medicine can do for the profession what rebuilders did for New Orleans; all we have to do is bring people back to it.

First, New Orleans had to improve communications between local and state governments, the lack of which resulted in catastrophic and deadly logistical failures. Without good communication all systems fail. The medical profession is suffering from insufficient communication on many levels. There is a poisonous lack of

respect between members of the different health care professions that keeps everyone from working together. And the proprietary, commercial nature of electronic medical record systems mean that communication among hospitals and other care delivery sites, especially across state lines, is patchy at best. A cohesive, reform-minded center to the profession could demand better coordination among commercial interests that would bring together the disparate parts of the health care delivery system.

The next step New Orleans undertook was repairing the physical surroundings. As Malcolm Gladwell chronicles in *The Tipping Point*, the crime rate in New York City dropped precipitously due in part to a concerted effort to cover the graffiti that plagued the city. This project was undertaken according to the Broken Windows theory, which holds that “crime is the inevitable result of disorder. If a window is broken and left unrepaired, people walking by will conclude that no one cares and no one is in charge. Soon, more windows will be broken, and the sense of anarchy will spread...sending a signal that anything goes” [1].

The city center of medicine is the hospital—the hub of both the care of patients and the training of new physicians. And our medical facilities—especially those that serve the most vulnerable people in America—are in disrepair; they are not fit for the worst of our enemies. Let’s examine what doctors trained in these surroundings are learning. They see the poorest, most marginalized people waiting enormous lengths of time only to be pushed through like cattle. The staff is often overworked, underpaid, and not particularly respectful of the patients. I believe this is leaving trainees with the view that it is fine to give underserved people sub-par care because they have no choice, and the medical profession doesn’t have any responsibility to make conditions better. Upgrading the physical surroundings in which doctors learn and underserved patients are cared for will send the message that these missions are important and worth investing in.

Which brings me to the third step that had to be taken to revitalize New Orleans: the recruitment of visionary leaders to help rebuild the city. This very critical move has put New Orleans in the forefront of the charter school movement, the movie production industry, and cutting-edge entrepreneurial action. The medical profession needs strong, honorable leadership to make progress. And organized medicine has been that force in the past. The model works, but the profession is turning away from it. Wariness that it might hamper individual physician autonomy, concerns about the time commitment and the cost, and just plain apathy have made physicians reluctant to be a part of organized medicine. This will not do. Young, enthusiastic, visionary, and idealistic physicians must work within organized medicine to make the health care system honorable once again.

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