Concurrent Care: An Ethical Issue for Family Physicians

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Caring for a critically ill patient is a challenging task for both the health care team and the patient's family. When a lack of organization of the patient's care occurs, this difficult situation is made even worse. Organization of health care for the critically ill patient is loaded with ethical questions. We use the following case as a basis to discuss the issues surrounding referral, consultation, and care of the patient.

A Case in Point

The patient was a 70-year-old man who was admitted to the coronary intensive care unit on June 18 with diagnoses of diabetes mellitus and congestive heart failure. Myocardial infarction had been ruled out. The patient was under the care of a family physician, who requested a cardiologist to consult on the case. On the following day, the patient was transferred to the progressive care unit.

A nephrologist was consulted on June 20 to evaluate progressive renal failure. The patient was returned to the coronary intensive care unit on June 21 for insertion of a Swan-Ganz catheter, after which dialysis was begun.

A transesophageal echocardiogram was completed on June 24 to evaluate valvular function. Dialysis and cardiac catheterization were done on June 26. Dialysis was performed again on July 2 and 3.

On the afternoon of July 4, a neurological consultation was completed. On the patient's record the neurologist noted, "Mr Johnson is not competent to make good decisions about his care, but he is consistent in his wishes and seems to grasp the consequences of his refusal of any more dialysis. In addition, Mr Johnson appears to have a valid legal document that expresses his wishes to discontinue treatment. It would appear to me that his wishes must be honored."

Several days later, a patient care conference was held in Mr Johnson's room. Besides Mr Johnson, the cardiologist and the nephrologist were present. Mr Johnson's five children were also present, one of whom held a durable power of attorney for health care for Mr Johnson. The patient's pastor and several nurses were also present. None of the family members had ever met the cardiologist or the nephrologist. Mr Johnson's family physician was not in attendance. In fact, the family expressed that they had not known which doctor to call to ask about their father's condition.

During that patient care conference, the cardiologist stated that Mr Johnson was competent (the cardiologist apparently had not read the neurologist's comments). Mr Johnson repeated his refusal to have dialysis performed anymore. The nephrologist then informed Mr Johnson that refusing to have dialysis would most likely result in his death.

Mr Johnson's children did not agree with their father's decision. After some discussion, Mr Johnson changed his mind and agreed to continue with the dialysis for at least 6 weeks.

When surgery was scheduled for placement of hemodialysis access for acute and chronic renal failure, Mr Johnson refused to consent. After the surgeon discussed the procedure with Mr Johnson, the patient still refused to consent. The next day the nephrologist spoke with Mr Johnson, but the patient was adamant about not wanting any more dialysis.

A few days later the cardiologist spoke with Mr Johnson and the son who held durable power of attorney for health care, and all agreed that establishing a "No Code" status for Mr Johnson was appropriate. After the No Code status was written on the chart, Mr Johnson was transferred to a medical bed. His family physician saw Mr Johnson from time to time during his admission and until Mr Johnson was discharged on August 3.

After spending some time at home, Mr Johnson changed his mind about having dialysis. He realized that

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the nephrologist's prognosis of death without it was, in fact, correct. Mr Johnson was readmitted to the hospital and received the recommended dialysis. The nephrologist commented that patients do have the right to change their minds.

Discussion

We believe that a number of ethical errors were made in the handling of this case. These ethical errors arose primarily because of the failure of the family physician to remain an active member of the health care team and because of the failure of the subspecialists to keep the family physician involved.

Referral of a patient to a subspecialist is a complex social interaction between a physician, patient, and the subspecialist. Care of the critically ill is often complex because multiple referrals are necessary. A "collusion of anonymity"[1] occurs when neither the referring physician nor the consultants accept ultimate responsibility for managing the patient's care. Inappropriate decisions often are made when this happens. The problem is amplified when the family physician consults with a variety of specialists. The consultation process should not be a ritual of "passing the buck," but an integral part of the family physician's commitment to continuous care and the patient-physician relationship. If the consultation does not provide what the family physician perceives to be meaningful or useful information, then additional consultations should be obtained until the problem is resolved. The term *primary physician* implies having the main as well as the initial responsibility for the patient.

The first and most obvious error that occurred in the treatment of Mr Johnson was that his family physician served only as physician of first contact. There may have been reasons, however, why the family physician abdicated his responsibility. One reason may have been because he could not be reimbursed for his services.[2] Medicare reimbursement for "concurrent care" is denied when there is a specialist and a generalist on the same case supervising care for the same diagnosis. When this occurs, the specialist will be reimbursed but the generalist will not.

Such a policy for reimbursement, at least in this case, violates a fundamental principle of medical ethics established by the American Medical Association[3]: "The medical profession has long subscribed to a body of ethical statements developed primarily *for the benefit of the patient*" [emphasis added]. Mr Johnson was treated unethically because no physician was interested primarily in *Mr Johnson's* benefit. The family physician failed to live up to his responsibilities because he did not attend the family conference and because he did not assume primary responsibility for Mr Johnson's care. The subspecialists failed to live up to their responsibilities because they did not include the family physician in the family conference and because they apparently ignored the advance directive on Mr Johnson's chart.

The issue of reimbursement raises another concern. For the family physician to refuse to care for Mr Johnson or to reduce the level of his care is to misconstrue the fundamental nature of the physician-patient relationship. The physician-patient relationship is not primarily an economic one based on fees for services. Such a view perceives the relationship as a contract.[4] We believe that the physician-patient relationship should be viewed as a covenant.[5,6] A contract model of a relationship is based on each party's own self-interests, even though the interests of others might be served as well. A covenant model of a relationship, however, is based on trust and the notion of one party having a "calling" to help the other party. Such a covenant model is clearly present in the Hippocratic oath.

The practice of family physicians abdicating their responsibilities to specialists is quite prevalent in the hospital where Mr Johnson was a patient. In a recent 3-month period, only 7 patients of a total of 83 had a family physician as the attending physician. The remaining 76 were under the care of one or more subspecialists. The areas surveyed included intensive care, coronary care, and progressive care units. According to the nurses in those units, Mr Johnson's case is not atypical.

Family physicians should not abdicate their responsibility for their critically ill patients and should continue to function as coordinators of medical care for these patients. The family physician must therefore not only be an astute medical diagnostician, but also be cognizant of the patient's rights and of the decision-making process as it occurs. In Mr Johnson's case, the cardiologist did not even know that an advance directive had been documented in the patient's chart. Neither did the cardiologist know that the neurologist had concluded that Mr Johnson was not competent. The family physician should have been actively involved not only in the development of Mr Johnson's advance directive but also in ensuring that it was honored.

The second error that occurred in Mr Johnson's case was that the family conference was conducted unethically. The cardiologist said that Mr Johnson was competent, but then he let Mr Johnson's family persuade Mr Johnson to continue the dialysis. That Mr Johnson quickly changed his mind when the family was no longer present strongly suggests that he was manipulated by both his family and the health care team. Such manipulation is a violation of a patient's right of self-determina-

tion and is inconsistent with basic human dignity. The cardiologist was treating Mr Johnson's heart, but apparently he was not treating Mr Johnson.

There are several solutions for the ethical issues that arise in cases like Mr Johnson's. One short-term solution would be to have hospitals reimburse family physicians when their patients are in critical care areas and require subspecialist care. The hospital in which Mr Johnson was a patient has considered assuming that responsibility. We believe that this problem cannot be solved by individual institutions, however, but requires a system-wide solution.

A second solution, but surely a much more long-term one, would be to change the reimbursement regulations. There is some rationale for not paying two physicians for performing essentially the same service, but in Mr Johnson's case, the family physician would not have duplicated the services provided by either subspecialist by serving as the coordinator of care. Each subspecialist treated a specific organ and the specific problems associated with that organ. The ultimate message behind current regulations is that a physician can be reimbursed for caring for a part of a body but not for taking care of a *person*. Such a reimbursement philosophy encourages a "pieces and parts" approach to medicine; it does not encourage treating the whole person. In fact, it implicitly discourages such treatment.

A third solution would be to change the political climate in hospitals so that subspecialists would act only as consultants in such cases and not usurp the role of the primary care physician. Such a solution might have some bearing on medical fees as well, with subspecialists reimbursed only for consulting on the case.

A fourth solution would be to modify the medical school curriculum so that it encourages greater cooperation and respect between prospective family practice physicians and prospective subspecialists. Such a modification would address such issues as who is responsible for a patient requiring critical care and how to coordinate care when multiple specialists are involved.

A fifth solution would be for organized medicine to address not only the medical and legal components of the physician-patient relationship but the ethical ones as well. We believe that medical students and residents are given very little education and relatively little precepting in the ethical practice of medicine.

References

1. Rakel R. Essentials of family practice. Philadelphia: WB Saunders, 1993.
2. Medicare B Bulletin 89-07, 1989; 7–9.
3. Council on Ethical and Judicial Affairs. Current opinions. Chicago: American Medical Association, 1989:ix.
4. Brody H. The physician/patient relationship. In: Veatch RM, ed. Medical ethics. Boston: Jones & Bartlett, 1989:67–91.
5. May WF. The physicians covenant: images of the healer in medical ethics. Philadelphia: Westminister Press, 1983.
6. May WF. The beleaguered professional: the public obligations of the professional. Kennedy Inst Ethics J 1992; 2:25–41.