Medical Ethics

By Jonathan Evans, MD, MPH, CMD

When Long-Term Caregivers Have Ethical Obligations

The Case

A 73-year-old woman was admitted to a skilled nursing facility following a 4-month hospital stay. Nine months earlier, she had moved to the United States from India to be near her daughter (a physical therapist and a U.S. citizen) and grandchildren. Thereafter, the elder woman worked full-time for an office-cleaning company. One evening, on her way home from work, she was struck by a car and suffered multiple fractures, intracranial hemorrhage, and pulmonary hemorrhage.

The patient had no health insurance. She was not eligible for Medicare, having immigrated after age 65. The driver who struck her was not ticketed. The driver's automobile insurer therefore did not pay for any of the patient's medical care. She was transported from the accident scene to a public hospital that received federal and state funds to provide indigent care.

In the hospital, she underwent surgery, prolonged mechanical ventilation, tracheostomy, and percutaneous gastrostomy placement. She was started on 23 new medications. After 4 months, she remained profoundly impaired cognitively but was deemed medically stable for discharge. She was, however, minimally conscious, bedbound, fed through the gastrostomy tube (with the tracheostomy still in place), burdened by several hospital-acquired pressure ulcers, and requiring total care.

Two area nursing facilities (one for-profit and one not-for-profit) offered to admit the patient and provide services billed to the family at the state's Medicaid rate (about $5,000 monthly).

The patient was admitted to the not-for-profit facility and assigned to the facility's medical director as her attending physician. She remained in the facility for 6 months, during which time she was seen by her new physician 12 or more times (without pay).

Once several psychoactive medications were discontinued, the patient's mental status quickly improved to the point where she could sit up and feed herself, but she needed help with all other activities of daily living. When she was physically able to travel, her family brought her back to India, where she was admitted to a nursing facility.

Discussion

While lack of health insurance and access to care are huge issues for the nation, they have been rather unusual problems for physicians practicing in nursing facilities.

Nevertheless, there are a number of circumstances in which a patient, such as the one described in this case, is admitted to a nursing facility and the facility gets paid, but the physician (or other licensed independent practitioner) does not.

The situation raises a number of ethical questions: Does a doctor have a moral obligation to provide free care? Can or should a nursing home physician refuse to accept responsibility for a patient who cannot pay? Should physicians be held to a different standard than hospitals or nursing facilities? Should primary care physicians be held to a higher standard than, say, a gastroenterologist, dermatologist, or plastic surgeon?

It is also worth noting that the patient in this case was a tax-paying, law-abiding, gainfully employed, legal immigrant.

Beneficence – Health care providers have an obligation to do good. Therefore, physicians and others should be willing to provide free care within our means whenever necessary. Even primary care physicians make substantially more than the average American worker.

Specialists should not be held to a lower ethical standard than primary care physicians. On the contrary, because their incomes are generally higher, it is even less burdensome for an average gastroenterologist, dermatologist, or plastic surgeon to provide free care.

Many physicians and some nursing facilities do not participate in Medicare or Medicaid. That is to say, they are not willing to be paid less than they feel they deserve. And many hospitals do not provide elective care to patients who cannot pay. The cruel irony is that the single largest risk for becoming destitute in America is the development of a serious medical condition.

Justice – Medical education is largely funded by tax dollars. Residency training is almost exclusively on the taxpayers' tab. Hospitals generally receive favorable tax treatment regardless of their for-profit status. Thus, society as a whole contributes a lot to the health care delivery system. The ethical principle of justice therefore requires that society share in the benefit. Providing free care is one way of "paying back," although the burden is not shared equally and is considered discretionary.

Professionalism – The values that define our professional work require us to do the best we can for each patient we have, not to ration care one patient at a time and limit its benefit according to how charitable we feel or the patient's ability to pay. For us to maintain our professional integrity, the needs of the patient must come first, and we must always strive to do the best we can for each patient.

The misgivings that individual providers may have about being obligated to provide free care are the same as the misgivings that our society has. Society believes that it is unethical to allow someone to die because they are too poor to pay for emergency care. Federal law (the Emergency Medical Treatment and Labor Act) requires all hospitals to provide emergency treatment to stabilize a patient. There is no national consensus, however, regarding the moral obligation to provide additional and potentially life-saving treatment. In this regard, society's current approach is neither morally nor logically consistent.

Free Isn't Really Free

Many institutions that routinely provide indigent care do so by contract or by statute. Directly or indirectly, they are paid to do so, even if the compensation is inadequate. Ultimately, the cost of indigent care is shifted to insured patients and taxpayers.

Of course, all of us pay in other ways when care of uneven quality is meted out based upon what individual providers deem that various patients deserve, rather than what each needs. The result is irrational rationing.

Our society is conflicted about our moral obligations to one another. As health care providers, we should not be. All of us should work toward universal access to care, and provide free care when necessary.

Dr. Evans is a full-time long-term care physician in Charlottesville, Va., and medical director of two skilled nursing facilities. He is AMDA's president-elect and serves on the Caring for the Ages Editorial Advisory Board. You can comment on this and other columns at www.caringfortheages.com, under "Views."