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KEY WORDS

PANDEMIC FLU
DUTY TO SERVE
CANCER SCREENING

HEALTH CARE
PREVENTION
SCREENING

A DUTY TO SERVE?

WHAT CAN WE LEARN FROM PANDEMIC LEGISLATION? Two states, Maryland and South Carolina, have enacted laws that authorize license revocations, fines, or even imprisonment for health care providers who disobey public health officials' orders to work during public health emergencies.(1) These penalties would apply even to providers whose occupations do not ordinarily encompass clinical responsibilities, or to providers who are not currently part of the workforce, for example, physicians or nurses who are taking time off from work to care for their children.

Be afraid. Be very afraid.

It is a fair question to ask--Who are these idiots and why are they doing this? Let's think about it for a moment.

First of all, we're talking about a **pandemic** situation where, for physicians, the workplace becomes 'abnormally dangerous' which traditionally provides an exception to usual duty to work statutes. Individuals can usually be excused from performing contractual obligations because of health dangers that were not foreseeable at the time any contract was entered.

It turns out that the basis for the specific laws here is the **Model State Emergency Health Powers Act (MSEHPA)**, which authorizes public health officials to order providers 'to assist in the performance of vaccination, treatment, examination or testing of any individual as a condition of licensure, authorization, or the ability to continue to function as a health care provider in this State.' This hardly seems specific enough to extend it to the unique circumstances of pandemic avian influenza. The authors of this editorial in **JAMA** (Dr. Reis and Attorney Coleman) argue cogently against any such extension of this law on the basis of both ethics and judicial tradition. Their argument runs like this:

'Some scholars maintain that HCPs, or at least physicians, implicitly have accepted an obligation to treat patients during a pandemic as part of a "social contract" between society and the medical profession. The claim is that "society grants the medical professions special social status and certain privileges" in exchange for the profession's implicit agreement "to promote society's health... However, the fact that physicians have social obligations does not mean that they must fulfill those obligations by risking their lives. Many physicians provide other valuable forms of

community service, such as by working in medically underserved areas or providing free care to indigent patients.

'Physicians may enjoy high societal status in part because the public expects physicians to act altruistically...[but] expectations alone do not normally create enforceable obligations...

'However, even the most ardent proponents of the duty to rescue generally agree that individuals should not be penalized solely because of public expectations about the profession in general...The law should not single out HCPs for drastic penalties like license revocations or imprisonment when other individuals whose contributions are equally important are free to refuse to work without similar repercussions.'

COMMENT: These rules are coming from a bunch of legislators who, I am sure, will not be coming into work during the pandemic. On their behalf, it can be said that, in fact, they **should not** come into work. The primary public health measure during a pandemic is **quarantine** and the **avoidance of public gatherings**. I have argued elsewhere that the same is true for physicians. **In a pandemic situation, your office should not be open**; they will just be death magnets. The worst thing you can do is to bring influenza patients together with non-influenza patients. **The major role for physicians is to educate and lead the public in preparation (adequate supplies of food, water, medicine, etc.) and basic hygiene and quarantine measures**. Emergent non-influenza care should be done at home. House calls will be back in fashion again.

The same logic applies to the **hospitals**, which will become death houses and open morgues as all local morgue capacity is filled early in the epidemic. The only chance that patients already in the hospital have is if you keep patients with influenza away. Following basic principles of triage, patients with severe influenza will be the lowest medical priority because there is so little you can do for them. For all the other savable patients the number one concern is to keep them away from the flu, if at all possible.

My fear is that **the above designed legislation would tend to compel physicians to show up in exactly the wrong places to do any good and at the risk of their lives**. My personal belief is that **I am willing to accept some risk to my life in the practice of medical care that is well designed and clearly effective; this, of course, is a very rare occurrence in the US--even rarer than global pandemics**. I am completely unwilling to risk my life in the pursuit of high-risk and inherently doomed activity. My suggestion is that all physicians figure out now where they stand on this issue so they are appropriately prepared when their local legislators begin trying to take this decision away from them.

There is another game going on here as well--passing legislation that can pass regardless of whether it will have any positive effect in order to distract attention from the real issues--the lack of any capacity for an informed, coordinated, efficient system response in this country. Instead of legislating disaster preparedness plans congressmen are content merely to punish the usual suspects after the disaster is well in hindsight.

Ultimately, the game goes on at yet another level as well. If you think about it, the idea that a physician would be severely penalized for refusing to risk his or her life pointlessly in the delivery of futile care is ludicrous. It is especially so since there

is no similar duty to provide care that we know to be both needed and effective. **In this country there is no penalty for not insuring that children have adequate food, immunizations, or health care and no duty to provide medicines or mend the bones of people who can't work.** No one speaks of forfeiture of medical licenses or jail time when specialists refuse care to the poor. Why would we possibly care whether physicians go to work in a pandemic? **In terms of a US health care status report card, physicians are doing very little that is truly useful, effective, or properly matched to the problem right now.** They will do even less in the pandemic situation. Why haven't legislators noticed?

Of course, one of the very few potential benefits of a pandemic crisis, if more such legislation passes, will be to end the relative oversupply of specialists in American medicine.

ADDRESSING PATIENT CANCER SCREENING PREFERENCES: Here in Santa Rosa we are currently getting ready for our new **Electronic Medical Record**. The champions are now leading us through the exercise of agreeing upon alerts for preventive medicine. I have noticed a small conceptual problem with this.

Aggressively implemented alert systems have the potential to turbo power the typical American **hamster** (read 'physician') into **Hyper-Hamster-Space**. As the phone companies have so effectively taught us, a list of seven digits or items are about as much as most of us can attend to at any one moment. To have 169 different protocols, as some would suggest, is to attend to none of them. **If you are serious about any health priorities, no rational list would go above 7.** But which seven? Ah, there's the rub. We need some consolidation. So, when the question came up about cancer prevention strategies, I suggested that we devise a **single alert--"Have you discussed cancer concerns with the patient?"** Period. End of system-enforced cancer screening.

Of course, one would like to see responsive behavior that was a little more systematic, and I have a modest proposal. [But be careful not to overlook the irony.] Cancer prevention is daunting stuff. There is such a proliferation of options and a pandemic of guidelines, mostly of the egghead academic type or the blatant commercial interest variety. Physicians everywhere, every time the issue comes up, bemoan the fact of having to go through all this stuff again, as each new year brings on another bumper crop of tests and procedures to newly afflict an unsuspecting (and mostly undiseased) population.

I figure I could save the US at least \$179,000,000. There are approximately 112,000 family physicians or GPs in the US (Department of Labor, Bureau of Labor Statistics). Let's assume they have to go through the whole list of cancer options covered below at least once by the time a patient reaches 50. This is bad enough. It would take at least an hour to go through all this stuff once, and I suspect much more. **The real killer is that you have to do it all over again next year and each year for the next 20 years or so.** The essence of my proposal is simple. **Let's just have the discussion once, do it right, and never do it again.** By eliminating 1 hour waste for 20 years for 112,000 physicians (2.24 Million hours) I have saved the health care system--at a not-unreasonable estimate of \$80/hour--around \$179 million without counting inflation, which will make it much more. The form I have produced

below accomplishes this. It took me about 2 hours to do. \$179 million return on 2 hours work is not shabby!

PATIENT CANCER SCREENING PREFERENCES FORM

Are there any cancers you are concerned about?

YES

NO

NO - DON'T ASK AGAIN*

Breast cancer

cancer

cancer

Cervical cancer

Lung cancer

Prostate cancer

: _____

* signature required: _____

Are you interested in safe, general methods for the prevention of all types of cancer?
YES NO

If yes, discuss the following:

GENERAL PREVENTION FOR ALL CANCERS [50-60% REDUCTION IN ALL-CAUSE MORTALITY (vs. testing for early detection of each)]

diet (or 5 servings of fruits &

vegetables each day)

Healthy lifestyle

exercise (20 minutes of walking a day)

of smoking

Mediterranean or Okinawan diet

relaxation or stress-reduction

Are you interested in other methods for reducing risks of specific, individual cancers?
YES NO

If YES, review the **CANCER-RISK SELF-ASSESSMENT** information at the end of this document and then **select your desired actions below and how often you would like it checked (frequency)**. [You should be aware that none of them have been shown to reduce overall (all-cause) mortality. They have only been shown to lead to moderate reductions (typically in the order of 33%) in your risk of dying of that one specific cancer.]

ACTION OPTIONS

FREQUENCY OPTIONS

WOMEN

cancer

Pap smear

Every 1 2 or 3 years

There are currently available a number of very expensive, not-covered-by-your-insurance, genetic tests. Are you interested in any of these?

Breast cancer

Colon cancer

Ovarian cancer

Sure as shooting, there are going to be many more such tests being marketed in the future. Do you want to be notified of them as they become available?

YES

NO

WRAPPING IT UP: Having just reviewed all of these options, don't you think this is all a little ridiculous to consider for cancers for which you are at very low risk. Aren't you ready to admit that it really makes more sense just to go back to the healthy lifestyle measures and to can all this cancer screening testing which is just going to make your life miserable with its inevitable false positives, false negatives, and procedural complications?

I'm convinced. Let's go back to lifestyle.

I'm not convinced. Sign me up for every available test. Please send a certified letter to my attorney whenever new tests become available.

I'm inherently wishy-washy about my cancer screening preferences, please repeat this discussion with me every: 1 2 3 4 5 years.

Self-Assessment of Cancer Risks

Cancer is a concern to everyone. This is especially true if someone in your family or among your close friends has had cancer. The general risk of developing cancer in the US is about 0.4% per year. For the most part interventions against cancer and various attempts to prevent the different kinds have had only equivocal effectiveness. In fact, none of them have yet to be proven to actually increase life expectancy. This is an area in which it is particularly important to be an informed consumer. Essential in order to do anything intelligent to mitigate your personal cancer risk is to systematically appraise your personal situation and determine what factors may put you at increased risk for specific cancers.

A wonderfully practical article on this topic appeared in the *British Medical Journal*. (1) There Janusz Jankowski and Emma Boulton presented a systematic approach to assessing personal cancer risk with respect to a variety of cancers using an alphabet-based memory aid--**ABCDEFGHIJK**. The point is, unless you are at specifically increased risk of developing a specific cancer, there is little point in aggressive general cancer screening technology.

Alcohol consumption > 3 units a day: predisposes to squamous cancers, especially cancer of the bladder and esophagus.

Body Mass Index > 25 and certainly > 30: predisposes to all solid cancers. If you don't know your BMI, see the free calculator at: <http://www.nhlbisupport.com/bmi/> .

Cigarette smoking at any level (even passive smoking): predisposes to bladder cancer, lung cancer, head and neck cancer, esophageal cancer, and oropharyngeal cancers.

Diet, especially one that is high in fat: predisposes to all solid cancers.

Exercising < 30 minutes a day: predisposes to all solid cancers.

Family history of cancer: (in at least one first degree relative (e.g., brother, sister, mother, father, son, daughter) and at least 3 people in two or more generations): predisposes to inherited cancer syndromes, including breast cancer, colorectal cancer, diffuse gastric cancer, ovarian cancer, prostate cancer, and uterine cancer.

Genital health (sexually transmitted infections): predisposes to cervical cancer and penile cancer.

Health promoting drugs that may decrease global cancer risks (but need a careful risk benefit analysis): colonic adenomas can be treated with low dose aspirin but can have serious side effects; hormone replacement therapy is linked with breast cancer)

Intense sunburn: predisposes to melanoma.

Job related factors: lung cancer (exposure to asbestos and particulates), skin cancer (contact with arsenic)

Known disease associations: colorectal cancer has predisposing mucosal pathology-adenomas, celiac disease, ulcerative colitis.

The actions they recommend for physicians at the time of a routine check-up are:

1. Review history for any symptoms of cancers of concern (e.g. bleeding in the rectum, altered bowel habits, weight loss) [remembering, as discussed in a recent issue, that most of these red flags do NOT turn out to be cancer]
2. Educate the patient that early investigation of cancer symptoms increases the chances of cancer being successfully treated, but that most of such symptoms are not in fact due to cancer.
3. **Emphasize the importance of a good diet.** A patient should eat at least 5 portions of fruit and vegetables each day and cut down on fat, salt, and added sugar.
4. **Explain that many cancers are preventable through lifestyle modification.** Help the patient strategize as to what modification to tackle first-smoking, exercise, dietary modification, or alcohol consumption.
5. If the patient is serious about lifestyle modification, counsel about the advantages and options of various support methods for assisting behavioral change.
6. Offer objective advice about the risks of medical interventions such as x-rays, Pap smears, endoscopic examinations (sigmoidoscopy, colonoscopy, endoscopic esophagoscopy, gastroscopy and duodenoscopy (EGAD)), mammography, Pap smears and additional interventions (e.g. *ThinPrep*, HPV testing), and fecal occult blood testing (FOBT). The authors state, "***Most people asking about the risk of cancer won't develop it, and in about 10% of people anxiety levels will be raised needlessly.***"
7. Provide as much objective (non-cancer society and non-specialty society sponsored) information and web-links as appropriate.

COMMENT: The real advantage to this approach is to **document a patient's preferences for once and for all and never to have to go through the painful discussion part of it again.** Of course, the patient can still defeat you by specifically asking you to review their options on a recurring basis, but most will not. ***If you can***

just avoid the discussion, who really cares about how often they get any tests, right?

So I tried this form and these ideas out on my residents here--a very bright, capable group. They were not interested. The idea of ever having this full discussion was so obviously painful that it could not even be considered. It turns out that their (for at least some) approach was just to **do everything for everybody in order to avoid having the discussion and to avoid a guilty conscience and medical malpractice nightmares**. This, of course, is the worst possible outcome, although one that the 'system' obviously encourages.

Personally, I can't imagine doing anything to anybody without their understanding why I would want to do it and what the likely value to them would be. In a case of an obviously dubious test (like the PSA), I just couldn't do it unless they begged me. (Very few have ever done this.) If patients ask me my opinion, I just say that I don't believe the case for doing any of them is very good, and I would be perfectly happy to pass on all of them. If you feel the need to do **just one**, then I think the **Pap smear** is the obvious choice (*but don't use ThinPrep, don't do HPV testing, don't test more than every 3 years, don't respond to anything other than HSIL, and don't do it on men*). I also tell them quite emphatically, **if they want to do something effective for all cancer prevention, nothing is better than lifestyle**, and it is not clear that adding any other testing confers any additional absolute benefit.

But there is one more supreme irony here. Look at this form with its staggering complexity, open-endedness (always more tests), and its low utility. Most of us are only doing it because we think someone else wants us to do it (not realizing that there is no one there to notice or care--attorneys excepted, of course). [We should not care about the attorneys because our malpractice premiums are all paid up. **Malpractice premiums are the price we pay in order to be able to do the right thing** without worrying about litigation. To pay this premium and deliberately do the wrong thing is an absurdity of a higher order.]

In our clinic we serve **a mostly underserved population, who generally have no right to adequate nutrition, immunizations, basic health care or medicines, not even to functionally necessary specialty consultations, surgeries, or treatments; yet they have the clear right, once they make it into our offices, to either have a discussion about countless, generally nonsensical [to their life situation] options for cancer screening, or simply to have as many of these tests ordered as their insurer (usually Medicaid) will allow.** They have no right to testing or services that are actually necessary for function. **Doesn't this strike anyone as absurd?**

We have real health care problems in this country. Cancer screening is not really one of them. **At this point we should be considering legislation to fine or imprison all the doctors and all the legislators who fail to show up for the real job at hand.**

REFERENCES:

1. Coleman CH, Reis A. Potential penalties for health care professionals who refuse to work during a pandemic. JAMA 2008; 299: 1471-3.

2. Jankowski J, Boulton E. 10-Minute Consultation: Cancer Prevention. *British Medical Journal* 2005; 331: 618