

Virtual Mentor

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Clinical Case

How Good Is Good Enough?

Commentaries by G. Caleb Alexander, MD, MS, and Robert C. Bowman, MD

Dr Benson is a primary care physician practicing in a town of 5000 people. He often manages patients with complex medical issues and prides himself on his ability to stay current on advances in medical treatment. Each year he exceeds his continuing medical education (CME) requirements, is well respected among his colleagues, and is often consulted by other physicians for difficult cases.

Last week Dr Benson received a troubling phone call from Sandy, the mother of one of his patients. He has known the patient, Carla, since she was a child. She was always what he thought of privately as a “difficult” patient, and during her adolescence he spent a great deal of time helping her through a substance abuse problem and a bout of major depression. Carla is now 24. Sandy called Dr Benson to tell him that Carla’s behavior had grown increasingly erratic over the past several weeks; she lost her apartment and moved back home, has maxed-out her credit cards, and does not seem to be sleeping more than 2 or 3 hours a night. Following the conversation with her mother, Dr Benson asked Carla to come in and visit with him. Dr Benson suspected that Carla was abusing drugs again, but acknowledged that she could have a psychiatric disorder.

After talking with Carla, who insists that she has been “clean” for several years, performing a thorough physical exam, ordering lab work, and asking Carla to consent to a urine drug screen, Dr Benson thinks he is seeing an acute manic episode. Dr Benson gets Carla’s permission to have her mother come in from the waiting room so they can all discuss the diagnosis.

With Sandy present he explains what he believes to be the diagnosis, but says that a definitive diagnosis for such a serious disorder should be made by a psychiatrist.

“Where do we have to go to see a psychiatrist?” Carla’s mother asks.

Dr Benson explains that the nearest one is in the city, 100 miles away.

“We can’t get there.” Sandy cries. “The car broke last week and we don’t have any money to fix it, and nobody’s going to drive Carla 100 miles for a doctor’s appointment. Can’t you just give her something?”

Dr Benson hesitates. He has managed patients with bipolar disorder who were sent to him already stabilized on their medications, but he has never diagnosed and started a patient such as this on a new regimen, and, moreover, he does not track the constantly changing literature in psychiatry and neuropharmacology. He also knows that, even if Carla sees a psychiatrist in the city for a diagnosis, she will not be able to make the long trip on a regular basis for follow-up appointments.

Commentary 1

by G. Caleb Alexander, MD, MS

Deborah Tannen, a sociolinguist, writes about the “Heinz dilemma,” a hypothetical scenario used to evaluate developmental stages of moral reasoning [1]. In the scenario, a man’s wife is dying, but he can save her life by stealing a drug that he cannot afford to buy from a pharmacy. The question—should he steal the drug?—is posed to 2 children. The 2 address the dilemma in very different ways—1 concludes that it may be okay to steal the drug and offers a rationale based on rules and rights. This child states that the man should steal because, even though stealing is wrong, letting someone die a preventable death is even more wrong, and thus stealing can be justified in this setting. The second child answers by trying to accommodate the man’s needs without requiring dishonesty. Maybe the pharmacist could help the man, for example, or maybe the husband could pay the pharmacist back at a later date, and so on.

Intuitive reactions to the dilemma that Dr Benson faces may be close to 1 of these 2 paths of moral resolution. Some may argue that the physician should treat the patient while others may argue that to do so without specific psychiatric consultation or support would be unwise and that there must be other ways around the immediate predicament the physician faces.

Regardless of the path one chooses, the dilemma that Dr Benson faces should be familiar to many physicians. Although it may seem unlikely that patients’ access to care can be limited by geographic boundaries, such barriers are ubiquitous and unavoidable, in the United States and elsewhere [2]. In fact, outside of urban areas in developed countries, where other barriers to care are prevalent, difficulty accessing specialists and medical technologies may be the rule, rather than the exception. And in some ways, the predicament faced by Dr Benson is quite similar to other situations physicians routinely face. On the one hand, there is the aspirational ethic to treat all patients with an equally high standard of care. On the other hand, such a goal may at times conflict with physicians’ responsibility to be wise stewards of societal resources [3] or with financial constraints placed on patients and physicians [4].

How then should physicians, in general, and Dr Benson, in particular, navigate situations where a patient needs treatment that is not readily available? Answers to several clinical questions can help guide a physician through this process. First, what is the incremental benefit of the optimal treatment over the one that is more readily available? In this case, how likely is it that a psychiatrist’s evaluation would yield a different conclusion than Dr Benson’s? Second, what steps can be taken to narrow the gap between the likely safety and efficacy of the optimal and that of the second-best

treatments? Might a phone consultation, for example, provide a minimally acceptable means for obtaining a psychiatric consultation? Third, how comfortable are Dr Benson and the patient with the anticipated plan of care? Given that Dr Benson is “well-respected among his colleagues,” it is likely that he has the clinical acumen to help assess the probable incremental benefit of optimal treatment over the one he can provide. Principles of informed consent, important in any setting, become especially powerful where there are “tough calls,” such as whether a marginally more risky management approach is acceptable because of its greater feasibility. Finally, a less clinical question: how much additional effort is required to obtain the first-line therapy? In this case, 10 miles versus 100 miles versus 1000 miles may make a big difference.

Arguing that physicians should never stray from optimal care creates a world of moral idealism divorced from clinical reality—a reality that for many precludes access to state-of-the-art specialists and medical facilities. Just as a t-shirt may be used as a tourniquet, or a stick as a splint, physicians and patients may be required to decide whether or not an available therapy is good enough. This case provides an extreme example. However, in more subtle ways, physicians do so all the time—rationing, by any other name...[\[5\]](#).

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Commentary 2

by Robert C. Bowman, MD

The broad scope of rural practice allows physicians to encounter patients of all ages and in a wide variety of clinical and financial situations. There is a multidimensional aspect to rural-based care that integrates knowledge of medicine, relationships, finance, and health care systems. A challenging patient such as Carla, the person described in this case, requires the physician to have as much interpersonal skill as medical expertise.

This case is further complicated by a patient who is:

1. Unpredictable,
2. Limited in ability to care for herself,
3. Diagnosed with a complex illness, and
4. Living in a setting with limited mental health resources.

Although Carla's diagnosis falls within a narrow range of possibilities, the most likely of which are drug abuse relapse and bipolar disorder, the treatments vary widely, and the wrong one could worsen her condition. Moreover, many pharmacotherapies have significant side effects and costs that can make adherence difficult. The risks of treating a case like Carla's are considerable, given that the threat of harm she poses to herself and others is moderate as assessed by Dr Benson. Had this been a high-risk case, emergency transport to a psychiatric facility would have been necessary.

The assistance of a third party (the patient's mother, Sandy) is an essential element in this case, but it also complicates matters since Sandy's interests, concerns, and relationship with her daughter must be fully ascertained. Based on her reaction to Carla's latest behavior and the patient's previous history, it is possible that Sandy is experiencing a significant degree of "caregiver burnout."

Given the resources available in their town, Dr Benson might consider taking the following steps.

First, he must secure permission to discuss Carla's case with other health care professionals. Next, he should call the nearest psychiatrist and, at the same time, ask his own staff to pursue transportation options with the local senior center, a church group, or another community resource. While he waits for the psychiatrist to return the call, Dr Benson can investigate his clinical suspicions by reviewing diagnostic criteria, possible treatment options, and other information for patients with bipolar disorder.

Another concern is that Carla is at risk of "falling through the cracks" due to her financial and insurance situation. Her greatest difficulties revolve around affordable care and access to medications. If there is a "sliding scale" fee system at a local clinic or pharmacy, Dr Benson can explore this option on Carla's behalf. As with primary care, the physician and his staff must gain the patient's trust, help her to anticipate side effects of any medications she is prescribed, and work through the challenges that each stage of treatment brings. Again, the clinical advantage lies with an experienced medical group that knows their patients and their community, as well as their medicine.

When the psychiatrist returns Dr Benson's call, the 2 can fully discuss Carla's case, and the psychiatrist can suggest treatment. With Carla's consent, an evaluation with the psychiatrist should be scheduled for a time when she can be transported. In a situation like this, where setting up and keeping regular appointments is difficult, it may be appropriate for Dr Benson to start Carla on a pharmacological regimen based on the advice of the psychiatrist even before her first psychiatric appointment. In addition to

the psychotropic drugs, an example of a possible plan of care might include counseling at a local mental health center twice a week with periodic visits to the psychiatrist for overall symptom management. If the psychiatrist is willing to accept Carla's case, some of these follow-ups might require travel 100 miles to the city, and some might take place when the psychiatrist is supervising at the local mental health center. No matter what the doctors agree to, consent must be given either by Carla, if she is deemed competent, or her mother before any decisions are made.

It is possible that an easier care plan might be available for Carla and Dr Benson. Integrated care clinics—the latest trend in rural mental health care—have mental health specialists on-site, either on a part- or full-time basis. Besides effectively merging mental health into overall health, this arrangement helps remove the stigma of going from a small town to an urban mental health facility for care. Two competing primary care offices in Moose Lake, Minnesota, for example, have even employed a psychiatrist to assist with care.

It is not uncommon for rural physicians to provide care outside of their specialties, though it must be acknowledged that patient care might be compromised by the rural physician's lack of specific training. This absence can involve either lack of depth (primary care) or lack of breadth (specialists), hence, a physician's recognizing his or her own limitations is a key aspect of quality care. Fortunately for Carla, behavioral issues are a common part of primary care training, although, as this case illustrates, care for mental illness can quickly exceed the scope of most physicians.

According to rural health researcher Jack Gellar at the University of North Dakota, the "safety net" for mental health patients in rural areas is primary care. With each patient and each passing day, rural primary care physicians extend their abilities to care for more complex patients.

Robert C. Bowman, MD, has directed rural medical education efforts at 2 medical schools and 2 national associations—the National Rural Health Association and the Society of Teachers of Family Medicine—since he began his initial rural practice in Nowata, Oklahoma.

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