

INDIGENT CARE DISCUSSION (Draft 2)

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The issues surrounding indigent health care are numerous, ranging from moral and ethical to economic and political. Together they occupy a seemingly overwhelming challenge to our societal values, institutions, and, in some respects, current structure for redress. The immense scope of the problem has contributed to an attitude of helplessness textured by such comments as "the need for a broad societal address". Increasingly, recognition of the enormity of the problem has served as a convenient scapegoat for inactivity without first discerning what each individual and institution could contribute singly and, through unity of effort, collectively.

For two very different reasons, it is difficult to fully understand the AAMC's reluctance to become an effective contributor to resolving, where possible, certain aspects of the problem. First, the AAMC is involved in (or has plans for) analyzing the contributions that academic medicine can make in such socially pervasive areas as AIDS, minority recruitment issues, development of women faculty, and international medical education. All of these areas represent tough problem areas laden with cultural values and difficult institutional barriers. Second, many teaching hospitals and medical education institutions are currently supplying a great deal of indigent patient care and, in

some, rely on the indigent for the teaching of medical students and residents.

During the past year some discussion has arisen within various quarters within the AAMC, particularly the OSR-Ad Board about the scope of the problem and areas in which the AAMC could potentially contribute in confronting the indigent care problem if the decision was made to devote some effort. In September, 1986 a proposal was drafted by the deans of the Central Region for consideration by the AAMC. (See attachment A). At the January, 1987 meeting there was extensive discussion of the paper and no resolution for activity. In fact, the concensus was for deliberate inactivity.

Dr. Jim Bentley at the 1987 April OSR Ad Board meeting gave an overview of the questions facing leaders concerned about the care of indigent patients during a time of shrinking resources for health care overall. He described the distribution of indigent patients as heavily skewed, with most of these patients in public general hospitals, and teaching hospitals as the next major source of care. Dr. Bentley divided his description of indigent patients into several categories: the long-term chronically ill, young mothers and children with no insurance, alcoholics and drug addicts, and those who are

simply poor. He also discussed the avenues currently being examined to address problems with indigent care including:

- a) national health insurance
- b) improving the health care delivery system in general (e.g., projects at the U. of Penn and Johns Hopkins are examining the effects of patients with no primary provider)
- c) legislative efforts to make health care benefits a requirement of employment
- d) a large variety of state efforts.

Dr. Bentley concluded with thoughts about how many tiers Americans will allow in their health care system and about medical educators' examining their dependence on poor patients to teach.

At the 1987 June OSR meeting Mr. David Moore reviewed the current legislation for health benefits for the uninsured. There was consensus that all persons should have access to health care.

During the 1987 September OSR meeting, a proposal for stimulating activity within the AAMC was considered. There was a feeling that a problem exists and that the status quo within the AAMC has been goodwill characterized by little activity.

The OSR Program at the Annual Meeting focused on service and to a great extent on many of the issues surrounding indigent care. Additionally, to either confirm or negate our suspicion and bias that a problem exists,

information was collected through a very informal questionnaire and informal discussions about medical students' and residents' experience with two issues relating to indigent care in teaching hospitals. The first suspicion we held was discrepancies in supervision by faculty exist between indigent and non-indigent patients. The second related to our perceptions on discrepancies in the "quality of care" delivered between the two groups. Listed for your perusal in Appendix B is a summation of comments from the survey we used at the Annual Meeting. This was intended solely as a way to get a broader perspective of medical students' views and experiences. It is not intended as anything even approaching a valid representation of the indigent care problem from student perspectives. However, it did confirm our suspicion that the problem is widespread and cement our resolve to keep it before us an agenda item. We feel that Medical Academia occupies a privileged position in our society and concomitant with that trust comes an obligation to serve society. One, we do not feel, we are currently addressing to our full capacity even within the bounds of our own institutions.

The growing seriousness of the problem both in an ethical and moral context and in every substantive context together with the danger of political over-reaction (particularly given the recent events in New York and California) requires prompt, comprehensive and thoughtful assessment by each of our societal institutions (e.g.,

professional societies, educational institutions) as to the possibility of new or enhanced roles that they might undertake for the public good. Unquestionably, academic medical centers carry a major responsibility for such analysis and possible actions. Furthermore, the unique and ethical character of the problems posed by the growing inequities in medical care suggests that the Association should thoroughly explore every possibility for appropriate collective activities.

Therefore the following question is posed for discussion:

How could the Association respond to the growing problems for our society posed by the increasing discrepancies in health care delivery, i.e. indigent care?

As a springboard for discussion a few ideas are listed below.

1. Valid assessment of the problem in academic medical institutions. A valid questionnaire could better delineate the scope and magnitude of the problem and highlight approaches for improving the situation. At present there are some efforts to do this. For instance the IOM is currently involved in such an effort. How could we contribute? This might be an area in which certain foundations might wish to

contribute money for an assessment of the problems and possible solutions.

2. Legislative efforts- The AAMC has been supportive of initiatives such as the Medicaid and the National Health Service Corps Reauthorization. But, what else could be done? Why not take a pro-active approach? For example, given that this is the year for reauthorization of Title VII, why not advocate for support of training of future experts in attacking the problem, e.g. MD/MPH funding.

3. Clearing house of activities- Why not devote some resources to developing and/or expanding the AAMC's ability to serve as a clearing house of activities to include, specifically, initiatives in dealing with indigent care? For instance, this could include educational projects, health service innovations, and state initiatives and activities.

4. Interfacing with other groups- Why not join forces with other organizations that have had a long history of active involvement with issues related to indigent care. In particular perhaps we could interact intimately with groups concerned with health services research and prevention-related activities e.g., the American Public Health Association and the Centers for Disease Control?

5. Medical Education: supervision and attitude. An example from the survey will illustrate this point. One student reported an attending asking a group of students after 20 minute chart rounds (one of three per week) "Are there any up-town patients that I need to stop and see on my way out". In this we all recognize the need for improved supervision of students and housestaff to be more than sitting around a table chatting about all the patients for twenty minutes a day. Also important is the subliminal message that is transmitted to students that it is alright to treat patients differently based on their economic circumstances rather than their medical situation. As a third year student I had the pleasure of working in an ambulatory pediatric clinic specifically set up for indigent patients and effective teaching of medical students. The program is structured such that there is excellent supervision of six medical students by a full-time faculty member and a senior resident. The goals of the program are to provide quality care and solid teaching in an ambulatory setting. This program costs money. Just as a library is considered a necessary part of an educational institution so should the quality of teaching in an educational setting. Neither make money.

6. Institutional committment- Many students have initiated a variety of student-run programs for indigent patients with the quality ebbing with the flow of commitment of a changing student body. Therefore, we well recognize the need for an institutional committment in order for there to be long-lasting quality care. One example can serve to illustrate the beginning of an institution's committment. Recently at the University of Texas Health Science Center at Houston a Vice-President for Indigent Care was created to analyze in what concrete ways the institution can contribute.

7. Task Force on Physician Supply- Until the question of need or demand is addressed, it will not be possible to adequately predict future supply of physicians. The Task Force could develop two models for projecting demand/need by using data from the National Center for Health Statistics. One model would be built on assumptions of the current health care delivery system. The second model would be built on assumptions of a delivery system which included the 35 million people currently underserved, uninsured, or underinsured. Using the Graduation Questionnaire data, a second research effort which could analyze one aspect of why students don't locate in economically underserved areas. Currently there is no known relation between indebtedness and specialty choice. However, to date

there has not been a study of indebtedness and the decision to serve in an economically underserved area. Data from the Graduation Questionnaire would allow that hypothesis to be tested.

8. Annual Meeting Theme- Academic medical institutions will continue to be in the midst of issues associated with the indigent care question. Therefore, it might behoove us to take some time to address it over the course of a few days when all of the constituents of the AAMC could discuss what aspects of the problem impact them and what they are doing to address the problem and how they feel the AAMC could contribute. This could be done through a properly designed questionnaire.

The above is merely a brief outline meant to sharpen focus, heighten dialogue and, hopefully, spark activity. The problem is broad and will require community of minds and efforts to solve. I hope that, though we have a packed agenda, we will be able to plan an approach to keeping this issue before us.

APPENDIX B

The MSI and MSII were grouped as basic science students. The MSIII and MSIV were grouped as clinical students. Comments were taken verbatim from the returned questionnaires. Where appropriate, a few editorial changes were made e.g. verb tense, proper pronouns. However, the tenor of the comments were unaffected.

Once again, this is a very unscientific attempt at gathering information. For instance, the timing of the questionnaire during the meeting lent itself to inadequate response rate. Second, it is not a random sample of anything- school, students, type of institution. In fact the people who returned the survey either at the meeting or mailed it in were probably more keenly interested in the subject than those who did not take the time. It was intended solely as a mechanism to gather more widespread anecdotal information. However, there are two things which appear to be fairly consistent. First, there are at least, in some institutions, a discrepancy in supervision between paying and public patients. Second, from the students' perspective, there does not seem to be a gross difference in such a loosely defined entity called quality of care.

1. Discrepancies of supervision and attitude experienced either by the student or other students at their school.

	NO	YES
Basic science students	8 (73%)	3 (27%)
Clinical students	6 (18%)	27 (82%)

COMMENTS

BASIC SCIENCE STUDENTS

1. Mayo Medical School- Professor telling students 'We only collect 20 cents on the dollar on these patients' referring to welfare patients in anesthesia.

2. Univ. Washington at Seattle- Statements that 'One or two vets must die in the training of every good doctor'. Patients called dirtbags and turfed to the street.

CLINICAL STUDENTS

1. New York Medical College- Private patients received more contact by attendings than public patients

2. University of Texas- Attendings deliver private patients' babies and residents do the public patients. This is often generalizable to other clinical settings.

3. Baylor- At V.A. in general surgery, the attending rounded on a ward of about 35 patients only twice in the course of a month. Even the fourth and fifth year residents seldom saw patients more than a minute a day. Public patients are viewed as less important and considered lucky to receive free care.

4. Tulane- At Charity Hospital it is basically the medical student who delivers a lot of the care to patients.

5. University of South Florida- VA particularly has a reputation as being of a standard of care well below that required at other hospitals.

6. Hahnemann- Certain patient populations have been placed in a twilight zone who get discriminated against as far as attention i.e. less patient contact and less discussion.

7. Albert Einstein- Some attendings believe that combative IVDA are not worth taking care of. However, other attendings are committed to the care of all patients and try to

maintain an open and positive outlook on their care.

8. Vanderbilt- Public patients are managed primarily by the residents with the faculty for consultation while private patients are more directly managed by attendings.

9. UCSF- Public patients are more utilized as teaching material. Less information about procedures is given to them. Consent is often taken for granted given their public patient status. Derogatory statements and discrepancies and discriminations along cultural differences.

10. University of Alabama- Medical students deliver Medicaid babies.

11. U-Conn- Attendings at the VA basically do not see patients and medical students do all the procedures although the residents do supervise well.

12. USC- Students perform procedures on public patients which they are not allowed to perform on private patients. Less of an effort is made by housestaff and attendings to explain disease and medical care to public patients.

13. Stanford- Not a major problem at Stanford and affiliated hospitals but only VIP patients that donate money to Stanford receive VIP treatment.

14. Eastern Virginia- In obstetrics we are more receptive to paying patients requests and patient education.

15. Jefferson- Frequently PGY1 and PGY2 are the only physician public patients see. I have run into residents who seem to be more rushed and have less respect for public patients. These attitudes are especially apparent in the public clinics versus patients in the private office visits. Private patients are given options for birth control methods. Public patients are given prescriptions for birth control pills. There is an attitude that public patients are not as smart as private patients. They do not get all of their questions answered thoroughly. Clinic patients with hgb as low as 7 were discharged from the hospital but private patients were kept in the hospital until their Hgb was at a normal level.

16. Washington University- All options are not available for those without good insurance.

17. Cornell- Attitudes toward indigent patients in labor have been less than ideal. Husbands or fathers are not allowed into the delivery or labor room without Lamaze certification. Much less support available during labor.

18. New York Medical College-

There is generally much less of a 'proprietary attitude' on the part of the attending physicians in the care of sevice patients- most management decisions are left in the hands of the housestaff while private patients are nearly considered 'hands off' to all except the attending. At private hospitals young indigents are referred to as 'dirt bags' and treated accordingly; they are grudgingly given adequate treatment. Surprisingly the results lead to fewer complications as the indigent patients are not as 'overtreated' as the privates. Private patients often receive more attention from the attendings, in fact some private patients are 'untouchable', particularly on OB. Indigent patients may have all of their care delivered by the housestaff and students. They may not even be seen by an

attending. This is routine at inner city hospitals.

19. Mayo- Completely egalitarian between paying and non-paying.

2. Discrepancies in types or numbers of tests experienced by the student or other students at their school.

	NO	YES
Basic science students	3 (27%)	8 (73%)
Clinical students	24 (80%)	6 (20%)

COMMENTS

BASIC SCIENCE STUDENTS

1. Ponce School of Medicine- Private patients received more tests.
2. Univ. of Washington- People in a position to sue have additional tests ordered.

CLINICAL STUDENTS

1. University of Southern California- More tests ordered for public patients. The county picks up the tab. It's called the medical student work-up.

2. University of Alabama- We ordered more tests in public patients. Patients with insurance have fewer to keep costs down.

3. Tulane- We order more tests in public patients because the state is paying for it.

4. University of Texas- Outpatient indigent care setting fewer tests were ordered secondary to budget limitations.

5. Mayo- Fewer extravagant tests to rule out rare disorders.

6. University of Miami- Financial limitations dictate diagnostic tests.

7. SUNY-Syracuse- Internal medicine order more tests without questioning risk/benefit ratio whereas Family Practice I learned the opposite.

8. The poor receive good medical care at Columbia but without the amenities that the privates receive.