

Customer Disservice?

Humming a little tune as I rounded the corner and headed down the homestretch of my afternoon in the office, I plucked a chart from the wall outside of room 14. Carol Todd, a woman of 48, had come to see me about “cellulitis of the scalp.” My nurse had scrawled a question mark after her history, and then an exclamation point. I shot a quizzical look into the nurses’ pod at her. She rolled her eyes at me and mouthed the words, “You’ll see.” I knocked on the door and entered the examination room.

Mrs. Todd, a short, stout woman, pursed her bright red lips into a scowl as she saw me. I introduced myself, welcoming her to our clinic. She brushed me off with a dismissive wave of her hand. “Are you really old enough to be a doctor? You look just like a kid.” I started to answer something about medical school, residency, years of experience, but she just shrugged at my response and snapped, “I’m in a hurry, doctor, so if you wouldn’t mind I’d like to get to my problem. I spent 30 minutes in your waiting room surrounded by coughing people, and I’m in no mood for small talk.” I sat back in my chair and asked her to describe her symptoms. “I don’t have symptoms, I have cellulitis. Didn’t the nurse tell you? It should be right there in the chart. I made her write it down.” Her finger jabbed impatiently at the chart I held in my hand. I swallowed down a little smile as it threatened to spread across my lips and instead asked her to tell me about her “cellulitis.” I made a mental note to ask her about her medications—would they include haloperidol or fluphenazine?

“Well, I started having a headache yesterday, and now there are bumps on my head. Here, you feel them,” she demanded. I wheeled myself warily forward and dutifully palpated her scalp. Nothing. “Do you feel them?” she asked impatiently. “Here, you’re feeling in the wrong place. Feel *there*.” She grabbed my hand, clamping it down over a stretch of perfectly flat scalp. “Now do you feel it?”

Again, I detected nothing but normal scalp. I nodded sagely anyway. “Yes . . . I think I feel them now. I see what you are talking about,” I said.

I asked her some questions about her history. She had no fevers, scratches, or unusual exposures. There was no history of hiking or tick bites, and she was feeling generally well. Her scalp wasn’t warm or tender. I couldn’t find a shred of evidence to convince me that she had an infection, or any other disease state for that matter. She took no psychotropic medications. I tried my best diplomatic voice, the one I usually reserve for fights with family members. “What would you like to do about it, Mrs. Todd?” I asked evenly.

She raised her eyebrows, which were penciled in high arches on her forehead. “What do you mean?” she asked incredulously. “You’re the doctor. I’m paying you. I want you to tell me what to do about it!”

I started in on my viral illness speech, and then told her about how unnecessary I thought antibiotics were. I

explained in depth about the lymphatic system and allowed that she could have been feeling enlarged lymph nodes in her scalp. “Maybe you have an upper respiratory virus, or a sinus infection that is just beginning. Maybe this is the first sign. You must come right back in if you are feeling sick.”

I listened attentively as she told me of her history of other infections for another 10 minutes. But things went from bad to worse. She persisted: “The last time they gave me Z-something, that five-day thing. It worked fine. Maybe you should give me that.”

I shook my head no and replied, “I don’t think that would be the right thing in your case, Mrs. Todd.”

“You mean you’re not going to give me an antibiotic?” she asked. “I wasted all that time for nothing.”

I nodded apologetically. “I’m really sorry for all of your inconvenience. I hope you understand that I just want to do what I think is best for your condition,” I added as she readied herself to leave.

That was not the last I heard from Mrs. Todd. Two weeks later, I found a small yellow envelope in my mail cubby. It was stamped “Confidential,” never a good sign. It came from the customer service office, a new department in our hospital system. An official-looking form explained that a patient had complained about my care. A photocopy of the complaint was included. Mrs. Todd had written about her wait and my failure to diagnose her cellulitis. Undeterred by my explanations that afternoon, she had gone to the emergency department, waited again, paid again, and eventually emerged with a diagnosis of cellulitis and her prescription for azithromycin. She held me responsible for both of the waits. “Please refund my charge for the office visit and my charges from the ER,” she wrote. “I should have been diagnosed correctly by Dr. Glazer in the first place.” She enclosed both bills, the totals circled and underlined with copious red ink. An accompanying hospital-generated form letter urged me to contact our customer service representative immediately.

I called from my clinic that day. The representative listened impatiently to my description of the encounter. “Yes, doctor, I am a nurse myself. I have read your note. You wrote that there was no evidence to support a diagnosis of infection. That’s all very good. But now we’ll have to waive the cost of her care.” She paused and then went on, “What would make all of our lives simpler is if you would just do what the patient wants. Is it really such a big deal to give her an antibiotic? The ER doctor did, and she was happy with him.”

I replied by asking pointedly, “Don’t we have a problem with antibiotic resistance here at our hospital?”

She countered with, “What’s that got to do with anything? She will get the antibiotics anyway, and you might as well not make her unhappy about doing it.”

Three days later I again paused to read a chart outside an examination room door. “Cough, sore throat for 5 days.

Diagnosed with bronchitis,” the nurse’s narrative read. “Started on [clarithromycin] 3 days ago. No better. Wants something stronger.” I sighed, my mind’s eye conjuring Mrs. Todd’s loopy handwriting on her letter of complaint and the hospital bills with their accusatory slashes of red ink. Then, cowed by the imperatives of customer service, I reached into my pocket for my prescription pad.

James L. Glazer, MD
Maine Medical Center
Portland, Maine 04101

Requests for Single Reprints: James L. Glazer, MD, Maine Medical Center, 272 Congress Street, Portland, ME 04101; e-mail, glazej@mmc.org.

Editor’s Note: In February 2002, *Annals of Internal Medicine* and *Lancet* published the *Charter on Medical Professionalism*. The American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine developed the Charter to provide an ethical framework to guide physicians as they practice in the world of 21st-century medicine. In an effort to help our readers remember the principles of the Charter and apply them, *Annals* is publishing a series of commentaries to accompany selected *On Being a Doctor* and *On Being a Patient* essays. We’re grateful to Dr. Troyan A. Brennan for his contribution to this series.

COMMENTARY

This vignette raises what is arguably the key question of our era in medicine: Does providing cost-effective care inevitably conflict with serving the interests of the customer/patient? For me, the answer is clearly no, but the question is critical. As cost control comes to play an ever larger role in our health care system, we will find the emerging commitment of our profession to cost-effective practice to be the most important ethical and political issue that we face as individual practitioners.

As a background for my comments, the story is missing a few elements. First, this patient did not have a previous relationship with Dr. Glazer. Our paradigm for primary care is that the doctor serves not only as the provider of technical services for the patient but also as the confidant of a much-valued friend. Would this story have turned out differently if these two had known each other for years? Almost certainly. Second, the customer service representative’s reaction is a bit of a caricature: Most of our colleagues in administration are more high-minded than she. Someone needs to talk with her, because she is just plain wrong.

But the vignette nicely presents a serious problem: Do we have an ethical/professional commitment to treat all patients in a cost-effective *and* high-quality fashion, no matter what their desires? The increasingly prevalent rhetoric of patient as customer or consumer, which is driven by those who wish to bring more market incentives to health care, brings with it the notion of the customer always being right. More informed, more aggressive patients can and do assert their customer rights to the kind of care they want. Should doctors cede their authority to the patient in low-stakes situations, such as antibiotic-seeking behavior?

The answer is no, resoundingly no. Providing patients with more information so that they can make better health

care decisions is the right thing to do. But prescribing unnecessary antibiotics clearly puts the patient at risk for side effects with no offsetting medical benefit—so in the case described here, quality suffered.

Perhaps more important, this prescription put at risk the welfare of patients as a class. First, every use of antibiotics contributes to selecting antibiotic-resistant bacteria. Second, and more important, providing unnecessary care shows a failure to understand that the costs of such care will be distributed eventually to the rest of society. We as a profession have long refused to recognize that our actions in an individual case result in costs to society. But as health care cost inflation leaves more people without health insurance, we, as responsible professionals, must broaden our perspective.

The logic of the preceding argument hinges on one controversial step: that we are not only advocates for our individual patients but also stewards of a responsible health care system, as stated in the Charter on Medical Professionalism (1). This claim would have had few adherents 15 years ago. Now, the resonance of the physician charter with the profession indicates that more and more doctors accept a dual commitment, to social justice and to patients. In “Customer Disservice,” the duties line up—it was poor-quality care and socially irresponsible to provide unnecessary antibiotics. In this circumstance, the physician should have recognized the professional challenge, tried to educate the customer service representative, and continued to fight the good fight—providing care that was necessary, sufficient, and in line with accepted standards of medical practice. I believe that more physicians are accepting the dual obligation to the patient and to society. We will need their commitment to professional values as we try to make our increasingly irrational health care system work for all patients.

Troyan A. Brennan, MD
Brigham and Women’s Hospital
Boston, MA 02445

Potential Financial Conflicts of Interest: Dr. Brennan is an executive at a physician group and is the chair of the American Board of Internal Medicine.

Reference

1. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002;136:243-6. [PMID: 11827500]

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