# The ethical issue of cherry picking patients

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## CASE SCENARIO

Dr Miller is a cosmetic dermatologist at the only dermatology clinic for 120 miles. His partners include a Mohs surgeon and a dermatopathologist. The office employs physician extenders to care for the general dermatology patients. A physician assistant (PA) pulls Dr Miller into an examination room asking for guidance on a patient. The patient Justin is a 14-year-old boy with a 6-month history of biopsy-proven alopecia areata (AA) involving 30% of his scalp. Justin's mother relays Justin's stress over his appearance due to bullying and his resultant absenteeism from school. There has been no improvement despite compliance with the PA's prescription of topical triamcinolone 0.1% ointment every other day to the affected areas of his scalp for 3 months. Both patient and mother are wary of intralesional corticosteroid injections or systemic immunomodulating medications.

Dr Miller and his partners have not managed general dermatology cases, such as AA, in the several years since they began limiting their personal practices to their respective subspecialties, supported by their PA's and outside referrals. As Dr Miller and his partners are not routinely engaged in direct supervision of their midlevel providers, the PAs have an implicit understanding that time-consuming or difficult cases should be referred to university dermatologists. Such a practice setup, staffed with multiple physician extenders—expected to emphasize lucrative procedures but bereft of appropriate supervision—has received national attention in the press.[1] Dr Miller suggests that the university practice, although a considerable distance away, would be better suited to serve Justin. The patient and his mother indicate their strong preference to be treated at this office in their hometown. The mother vocalizes that going to the university practice would be a hardship due to the long drive, difficulty getting time off from work, and Justin missing more school days.

**Dr Miller should:**

**A.** Refer Justin to the university dermatology practice for care.
**B.** Refer Justin to the university dermatology practice for a consultation and offer to subsequently implement the university's plan of care at his practice.
**C.** Ask Justin to return to the clinic in 1 week, affording Dr Miller time to read about potential therapies and to call a colleague for therapeutic advice, if needed.
**D.** Advise Justin that therapy is unlikely to work, especially because he has already failed topical triamcinolone ointment.

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## DISCUSSION

The dermatologist in our vignette has effectively limited his practice to cosmetic dermatology to the near exclusion of general dermatology for many years. In theory, Dr Miller supervises his physician extenders who care for the practice's general dermatology patients; in reality, he only administratively signs off on their work. His group has historically undertreated or referred out the more time-consuming, moderately complex general dermatology patients. To maximize its profit, the practice prioritizes patients with straightforward conditions that can be easily managed with short office visits or those needing lucrative procedures. For example, patients with scarring acne return to their referring physician with only a simple, nonpersonalized topical therapy (freeing Dr Miller's office from the time involved in prescribing systemic antibiotics or isotretinoin); patients with severe psoriasis are dispensed only midpotency topical corticosteroids. On the other hand, patients with a history of actinic damage, skin cancers, or cosmetic concerns return frequently for numerous biopsies, excisions, Mohs surgeries, and cosmetic procedures. This has allowed Dr Miller and his partners to focus on their strengths and passions in their respective subspecialty areas, which has been more efficient and financially rewarding. Because of this routine, moderately complex medical dermatology cases are now outside of Dr Miller's comfort zone and hinder his practice's workflow. It would require Dr Miller to invest time in reviewing evidence-based literature to appropriately treat this patient. Although Dr Miller might feel insecure regarding his ability to provide Justin the standard of care for AA, he trained in general dermatology, became board-certified, and should, therefore, be able to treat AA after reading appropriate current literature or consulting a colleague.

The ethical principles of beneficence and dignity apply to this case. Beneficence dictates that Dr Miller must place his patient's interests first and help this patient to the best of his ability. The diagnosis is straightforward and established. Several commonly used therapies, including topical immunotherapy and high-potency topical corticosteroids with or without minoxidil, could be undertaken if the family refuses intralesional corticosteroid injections.[2] Alternatively, Dr Miller could explore the nature of Justin's reluctance toward intralesional therapy and proactively address possible anxiety about pain with a prescription for a topical anesthetic. Dr Miller is advocating referring this patient to a distant clinic without a clear patient-centered reason.

The dignity of the patient should also be considered. Dr Miller should explore and respect Justin's personal experiences with this challenging disease. Justin has suffered from bullying, a common occurrence in children of all ages with AA.[3] Patients with scalp involvement tend to have low health-related quality-of-life scores.[4] Justin might also feel rejected as a result of today's encounter, much like an unwanted customer, especially after spending the past 3 months anticipating the care of a dermatologist.

Routinely undertreating patients and referring some out to the distant university practice reflects poorly on the honesty and integrity of Dr Miller's practice. Unless Justin's case is unresponsive to adequate, available therapy, or diagnostic uncertainty arises that Dr Miller cannot resolve, the physician's motivation for referring him elsewhere for treatment will be unclear to the patient. There are many reasons why established patients may be referred to a university practice; however, referral elsewhere to streamline the practice's financially-driven workflow is both dishonest and unethical. Presumably, the practice's website and office promotional material imply that prospective patients will benefit from the expertise of qualified dermatologists. Patients like Justin who are unknowingly undertreated for months or years might eventually feel their time and money was dishonestly procured. For practices advertising general dermatology care with dermatology physician extenders, a board-certified dermatologist should be willing and able to provide general dermatologic care—at minimum, via direct, on-site supervision—to all of their patients.[5]

Dr Miller should also consider the potential negative impact of his practice style on each affected party. First, refusing to treat Justin is likely to intensify any anxiety, isolation, and psychosocial distress he is experiencing as a result of his condition. Second, as a result of this practice model, his community loses access to high-quality general dermatologic care. The brunt of general dermatology care falls upon his PAs, placing them in a difficult position without adequate supervision to optimize patient safety, enhance patient satisfaction, and excel in their professional growth and development. Displacing complete control of dermatologic care to physician extenders without appropriate oversight is bad for patient care, might increase medicolegal risks, and has a potentially negative impact on the specialty of dermatology. Last, Dr Miller's inability to adequately supervise his PAs and care for common skin diseases must surely affect his professional self-worth, not to mention the

image he projects to his patients, staff, and colleagues. He must ask himself whether he still considers himself to be a dermatologist and is capable of taking care of dermatologic diseases.

## ANALYSIS OF CASE SCENARIO

Dr Miller's practice has an established physician–patient relationship with Justin. Option A unjustly displaces Justin's potentially time-intensive care to another practice, disregarding the family's expressed preference. Option A also suggests that Dr Miller is not competent to assume care for many routine dermatologic problems, which are, therefore, delegated to his physician extenders. Option B may be appropriate in certain cases, but not as routine practice by a clinic advertising a board-certified dermatologist. Option D is ethically and therapeutically inappropriate, as several potential therapies remain in the dermatologist's armamentarium. Option C is best, as it emphasizes the patient's dignity and the physician's responsibility to maintain expertise in general dermatology, in addition to his subspecialty.

Treating this common dermatology condition would require Dr Miller to spend some time reviewing current treatment options with a textbook, online references, or colleague. Even though evidence for efficacy of the treatment options presented is not striking, they are all safe treatments without black box warnings. By selecting option C, Dr Miller will be adhering to accepted medical ethical standards, including the professional obligation to engage in lifelong learning and to promote access to care.

## BOTTOM LINE

If dermatologists depend on new and referred general dermatology patients to support their practice's preferred emphases, they still have a responsibility to competently and adequately care for those patients' needs. Dermatologists who hire physician extenders to directly care for their patients are still ethically and vicariously responsible for routine dermatology treatment decisions. A reputation for effectively treating common dermatologic conditions will not only demonstrate concern for their immediate community but will also enhance the reputation of the community of dermatologists who advertise themselves as Fellows of the American Academy of Dermatology.

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