Patient screening common among Nova Scotia FPs

'Meet-and-greet' sessions are permissible, but ethically risky

BY PAULINE ANDERSON
Halifax

Dr. Emily Marshall (PhD) knows what it's like to be turned down by a family physician. In fact, it happened to her not just once, but on multiple occasions.

When she moved to Halifax from Vancouver, it took Dr. Marshall, who is now an assistant professor in the department of family medicine at Dalhousie University, three years to find a family doctor who would accept her as a patient. And that was only after she attended a so-called "meet-and-greet" session with her prospective provider, before which she recalls being "really nervous."

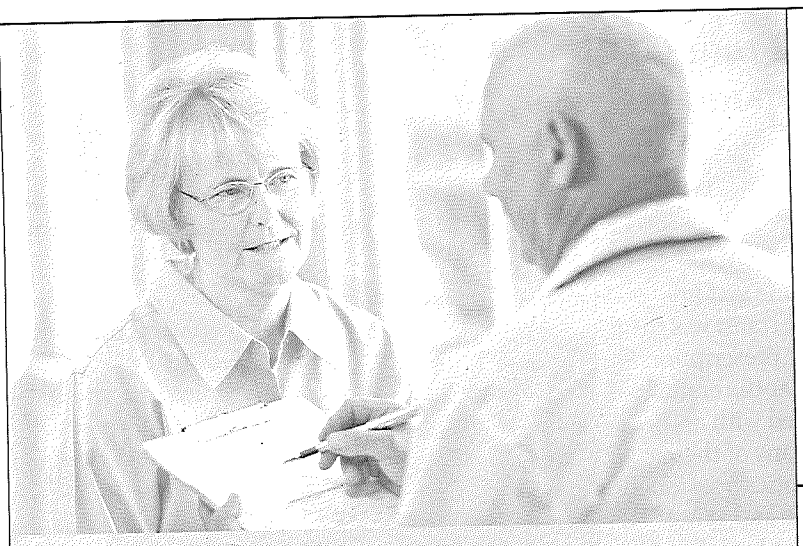
Even though meet-and-greets are being discouraged in many parts of the country, and there's mounting concern they are being used to screen unwanted or difficult patients, such sessions are being held by almost one-third of primary-care physicians in Nova Scotia, a new survey shows.

"My concern is that meetings like this can be interpreted by the public as discriminatory, regardless of the true intentions of the health-care provider," said Dr. Marshall, who led the study and presented it recently at the North American Primary Care Research Group meeting in New York.

"I suspect the vast majority of these (meetings) are innocently done by doctors trying to make sure that there's a good fit with a patient, but I also think that the potential is there for it to be unethically applied and to leave the most vulnerable people at risk of not finding a regular provider."

Dr. Marshall and her colleagues surveyed primary-care practices across Nova Scotia. They asked about whether the practice was accepting new patients and if it wasn't, whether there were ever any exceptions. Of 741 practices, they got completed surveys from 628 providers, including 589 family physicians and 39 nurse practitioners. This represented a response rate of 85%. The survey is part of the Models and Access to Primary Care in Nova Scotia (MAAP-NS) study.

According to the survey, 29.2% of respondents said they require a screening appointment for new patients and 44.3% of these providers reported that on at least one occasion they didn't continue to see a patient after such a meeting. At the same time, though, 36.9% of providers requiring a meet-and-greet reported that a patient subsequently decided not to continue in the practice on at least one occasion.



College policy states that practitioners should not screen out patients with more difficult health concerns.

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'Ethical quandary'

Dr. Marshall said she was "surprised" by the "higher than expected" rate of doctors asking patients to come in for some type of screening appointment.

What happens during these pre-acceptance visits? "It's a bit of a black box," commented Dr. Marshall. "Different clinicians have different perspectives on this. Some think it's a sacred thing to be able to meet with patients, to get to know them and build that relationship, and to make sure it's a good fit; others see this as a real ethical quandary."

There have been increasing reports in the media about this meet-and-greet practice and even some court cases challenging it, said Dr. Marshall.

In the current climate where fewer physicians are accepting new patients, some patients fear they won't find a regular provider. "I worry that it would lead to patients potentially not disclosing their actual health concerns or their risk behaviours" for example, their smoking or gambling habits, said Dr. Marshall.

"I can't find a lot of reasons why you would need to screen people out," added Dr. Marshall, who wondered why the initial meeting with patients can't be done after accepting them into the practice.

According to the Nova Scotia Human Rights Act, doctors can't discriminate based on, for example, age, gender, race, sexual orientation or disability. However, they can refuse a patient whose needs are beyond the scope of their practice. Doctors in teaching hospitals can also deny accepting patients who refuse to be seen by medical students, according to Dr. Marshall.

Some provincial colleges of physicians and surgeons have taken a strong stand on this issue. For example, according to Dr. Marshall, after holding a public consultation on the matter, the Ontario college issued a statement saying that doctors should provide care on a first-come, first-served basis and that there should be no meet-and-greet sessions "as it's too challenging to know whether they are being done ethically."

College policy

The College of Physicians and Surgeons of Nova Scotia also advocates accepting patients on a first-come, first-served basis. In a statement on its website, it says that while initial appointments and health status questionnaires are acceptable practice for physicians to get to know new patients and to learn of their health concerns and history, "these may not be used to select 'easy patients' and/or to screen out those with more difficult health concerns, such as chronic or terminal disease."

The college's policy, according to registrar Dr. Gus Grant, provides "clear guidance" for physicians. "Meet-and-greet interviews are permissible, but obviously fraught with potential problems."

The new study is "an eye opener," he said. "It certainly gives us in the regulatory world pause."

He added that it's helpful to know the prevalence of the meet-and-greet practice. "It gives us an opportunity to repeat the message and underscore the importance of the ethics that must underpin the meet-and-greet meeting."

What's unfortunately not immediately apparent from the study, though, are the reasons for the results, he said. As well, he added, the study doesn't indicate "what the right number should be in a perfect world."

The survey also found that doctors do make exceptions on accepting new patients when it comes to family members.

Unhelpful offices

Dr. Marshall also presented the results of another survey that is part of the MAAP-NS study. Investigators called 394 family

practices and acted out scenarios that represented two socioeconomic circumstances (the caller had just moved to take up a new job at a bank or the caller had been told to call by a welfare worker), and two types of patients (the caller needed a doctor for regular care or the caller needed an appointment because their asthma was acting up).

Dr. Marshall noted it was difficult to even reach some doctors' offices by phone. Callers were unable to reach 25 offices, despite five attempts.

"Meetings like this can be interpreted by the public as discriminatory."

—Dr. Emily Marshall (PhD)

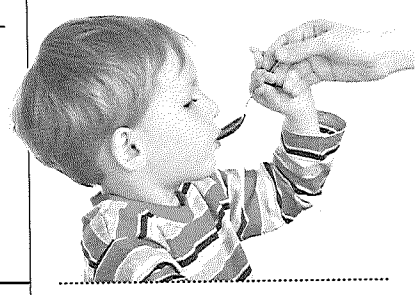
From those that did respond, the investigators found that socioeconomic status and the presence of a chronic condition were not correlated with being offered an appointment. However, only 24.4% of offices provided further assistance to those not offered an appointment, and of these, 60.6% were patients of higher and 39.4% lower socioeconomic status.

"Provider offices could do a lot more to support orphaned patients," said Dr. Marshall. "They could refer them to walk-in clinics and regional health authorities who have phone lines to help place these patients, but these resources were rarely shared at all and they were less frequently shared if you were of low socioeconomic status.

"Our callers were often made to feel like they were a hassle to the person they were calling." MP

Clinical Pearls

Dose by weight in kids—and write it down



Using a child's age for dosing is an easy way to get it wrong.

ONE OF MY PATIENTS showed me a picture from her phone of her 11-year-old son at soccer practice standing with another friend of the same age. Her son was a full two heads taller than his friend and about that larger in girth, too. Conversely, my son was denied access to several rides at a travelling fair this summer when the top of his head failed to reach the procrustean two-year-old height marker—he was two-and-three-quarter years old at the time.

These two examples illustrate why I insist on writing children's weights onto the prescriptions that I write for them. Dosing by age is an easy way to over- or undermedicate our pediatric patients. There is too much variability in size between children of identical ages for me to feel comfortable with rules of thumb like "this number of teaspoons for this number of years of age." I calculate scripts by milligrams per kilogram and keep a bathroom scale in my office to capture each child's weight. I write it onto their prescription so that the pharmacist can double check my calculation as an additional safety feature, math not being my strong point at the end of a hectic day.

How many cases of "amoxil allergy" might be due to overdosing I cannot say, but as the father of modern toxicology, Paracelsus, said: "The dose makes the poison."—*Dr. Ramon Salazar, family physician, Wolfville, N.S.*

Want to share a clinical tip from your practice? Please limit the text to approximately 200 words and email it to andrew.skelly@medicalpost.rogers.com.

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