A Modest Proposal

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Originally published in "Medical Education"

In the US health care system, uninsured people face multiple barriers to adequate care. This personal essay reflects on the effect that caring for these patients can have on a Year 1 medical student. The experience of 1 student with his first patient spurs a call to action to the medical community as it strives to lead the debate and shape the solution to providing care to the uninsured. As the student ponders the problem, his observations may uncover a universal challenge that all providers must resolve for themselves.

My first patient at the community health clinic was a middle-aged man with concern written all over his face. I had just completed Year 1 of medical school and had armed myself with a tool-belt of clinical pearls and examination manoeuvres. I gathered a complete history with confidence. As I reported the findings to the attending doctor, we came to the conclusion that this man needed a colonoscopy. His family history of colon and oesophageal cancer made this an obvious step. Not so fast. I found that a set number of gastroenterology referrals are allotted per year and my patient was not eligible because he did not have a positive faecal occult blood screening. Little did I know that the US Preventive Services Task Force (USPSTF) Grade A recommendation does not apply to the uninsured.

We work in a special community clinic. Our clinic was set up with a mission to serve the uninsured and the uninsurable. When any of our patients get Medicaid or Medicare, they are no longer eligible for our services. In fact, if any of our patients obtain any type of health care coverage, they are referred to the private providers in this community. Our patients by definition cannot afford their medications; so most medications are purchased at a discount pharmacy that is part of our clinic. Our patients can barely afford the $5 they are asked to contribute.

Many individuals donate their time and expertise to our under-served – the uninsured. Hundreds of local specialists have agreed to see a certain number of our uninsured patients free of charge though a volunteer referral network. There are also a few full-time providers, as well as an army of volunteers from my local medical school. Our medical community would not deny anyone life-saving treatment, regardless of his or her ability to pay. We are grateful for the time that these doctors donate. This is an enormous step in the right direction, but unfortunately the need is much greater than that which they – on their own –can meet.

What can we, as providers, do? I may have a plausible solution. Perhaps all non-surgical specialty providers could see 2 uninsured patients per day. If each provider works 180–200 days per year, this would generate an average of 360–400 available slots per year per specialist. I suspect there are at least 2 providers in every specialty within our region so this should give ample opportunity for an uninsured patient to be re-evaluated. Even if we cut that number in half, to only 1 patient per day, this would mean almost 200 available referrals per year, per provider. Perhaps, instead of a sales or income tax to help these patients, a "services tax" could become a part of the practice of medicine. I truly believe that most doctors want to help underserved patient populations, but they may not know how.

Patients who require surgery or invasive diagnostic procedures present another problem. If a surgeon or diagnostician saw 2 uninsured patients per week for 40 weeks per year, 80 procedures per specialist would be available. This is considerably more than the number available now. I realize that hospitals would have to be involved for a plan like this to succeed. Although this suggestion involves some cost and the use of resources, this is a small price to pay for preventing death and disability in these uninsured patients.

Unfortunately, adenocarcinomas or myocardial infarctions don't wait to check who your insurance provider is before they rear their ugly heads. The burden lies on us, as present and future providers of medical care, to follow through where opportunities for the uninsured are limited. We must be-

come the champions of these patients if we want to improve their health outcomes. If not, we are at risk of doing harm.

I have observed that the system in place for these individuals is fragmented at best. For too many of these patients, compliance with strict treatment regimens for their chronic pathologies may take a backseat to finding their next meal or fulfilling other survival needs. How can a doctor reconcile his or her work with that line of thinking? Is that proven combination therapy really going to work if our patients can't obtain it?

I came to medical school naive to the plight of the uninsured. Having no experience of being uninsured myself, I had no clue about the types of barriers that might confront someone in need of care. I chose my medical college, in part, because of its stated mission to serve under-served populations within my state. As I move forward in my career I have cautious optimism towards the future of the uninsured. I intend to seek residency and employment at a public or community hospital. I want to work in clinics located in underserved communities and contribute wherever the mission takes me. I also see the need to recruit others to my vision. If we all contribute, uninsured patients, medical providers and students will all be the better for it. And to think, it all started with 1 patient who just needed a screening colonoscopy...

Illustration By Zach Folzenlogen