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OVERUTILIZATION AND UNDERUTILIZATION OF PREVENTIVE SERVICES IN ELDERLY POPULATIONS: A CONUNDRUM

Freeman L. Farrow, MD, JD*

INTRODUCTION

What is health? Ivan Illich has defined "health" as "an everyday word that is used to designate the intensity with which individuals cope with their internal states and their environmental conditions."¹ A simpler definition of health for the purposes of disease prevention discussion is the state of one's mental and physiological function. One can have good health or poor health. Perfect health is seen as optimal mental and physiological function of one's body.² While perfect health may be a goal, good health is some state of better bodily function that falls short of this ideal. An operational definition of good health is more optimal mental and physiological function of one's body as compared to some normative scale.³ In

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1. IVAN ILLICH, *MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH* 7 (1976).

2. WORLD HEALTH ORG., *THE FIRST TEN YEARS OF THE WORLD HEALTH ORGANIZATION* 459 (1958).

3. For purposes of this article's discussion, the comparison is between elderly and younger populations within the United States.

medical and lay circles alike, what is considered good health for an average seventy-year-old adult is not the same as what is accepted as good health for a five-year-old child. Indeed, what is good health for a five-year-old, may be considered excellent health for an elderly individual. Reverse the comparison, however, and you have an ill child. To determine what is good health in elderly populations, David Keenie suggests that "health" in these populations be described as "a multidimensional matrix of three interwoven components: the absence of disease (including disease symptomatology and iatrogenic⁴ disease); an optimal functional status; and an adequate system of social support."⁵ This article concentrates on the prevention of disease as a method to optimize functional status, and the incidence and effectiveness of prevention measures in elderly populations. This article concludes that preventive medical services are both over- and underutilized in the nation's elderly population, and that attempts to legislate policies to mandate more appropriate use of preventive services in elders necessarily involve difficult issues related to patient education and autonomy, intrusion on the sanctity of the physician-patient relationship, the potential criminalization of medicine, and the necessary lag of legal developments in relation to medical innovations.

In the first section, this article examines preventive medicine and how it is applied and misapplied in elderly populations. In the second section, the article discusses the roll of cost in determining elderly populations' access to screening services, and whether decreasing cost may lead to increasing overuse of screening in these populations. The third section explores situations of overutilization and underutilization of screening in elderly populations, and provides examples of

4. "Iatrogenic disorder: Any adverse mental or physical condition induced in a patient by effects of treatment by a physician or surgeon. Term implies that such effects could have been avoided by proper and judicious care on the part of the physician." *TABER'S CYCLOPEDIA MEDICAL DICTIONARY* 703 (Clayton L. Thomas ed., 14th ed. 1981).

5. DAVID C. KEENIE, *PREVENTIVE CARE FOR ELDERLY PEOPLE* 14 (1993).

potential adverse patient consequences resulting from either. It also questions the effects physicians' personal and professional interests may have in determining whether over or under screening situations occur, and the physicians' concerns (professional, ethical, legal, personal) contributing to, rather than alleviating, the problem of proper decision making with respect to what preventive services should occur for individual elders. The article concludes that patient autonomy, freedom of determination within the physician-patient relationship, and potential criminalization of medical practice through imposition of external mandates are issues that must be addressed in improving the appropriateness of medical screening within elderly populations.

PREVENTION IN MEDICINE

Why the difference in optimal function between age groups? Because we are beings with finite life spans. We have expiration dates. We die. In the process of living to old age – a moving target over the course of the past century at least⁶– our bodies and minds lose capacity to function optimally and progress to total senescence.⁷ This process can be slow or fast, but it will progress over time. Intervening in this progression to expiration are diseases, ailments, injuries, and afflictions, which tend to speed loss of functional capacity and approach to death.

So what is prevention in medicine? What prevention is depends upon the definitional framework and the patient population considered. Prevention can be defined, however, as any intervention that delays disease or slows its progression,

6. See, e.g., U.S. DEP'T OF HEALTH & HUMAN SERVS. ET AL., HEALTH, UNITED STATES, 2008, 203 – Table 26 (2009), available at www.cdc.gov/nchs/data/hus/hus08.pdf (demonstrating continuing extension of life expectancy across demographic groups).

7. See, e.g., PHYSIOLOGICAL BASIS OF AGING AND GERIATRICS 26 (Paola S. Timiras ed., 3d ed. 2003) (comparing the natural aging process of humans and other species); see generally L. Hayflick & P. S. Moorhead, *The Serial Cultivation of Human Diploid Cell Strains*, 25 EXPERIMENTAL CELL RES. 585 (1961) (discussing cellular biological basis of senescence and death from old age).

and can be thought of as one aspect of health promotion in individual patients.⁸ Prevention comes in three forms: primary, secondary, and tertiary.⁹ Primary prevention attempts to prevent disease from occurring (e.g., through immunization).¹⁰ Secondary prevention attempts to minimize the effect of disease (e.g., through colorectal cancer screening).¹¹ Tertiary prevention attempts to "slow progression or reduce disability" caused by manifest disease.¹² The goals of preventive care and health screening are to improve health promotion through reduced morbidity, mortality, and suffering by targeting common, potentially preventable, and treatable illnesses and ailments.¹³ Screening and prevention are also aimed at decreasing healthcare costs.¹⁴ Michael Myers notes that thinking has developed that considers old age as a medical thing, a contagious disease to be cured or conquered rather than as a natural latter stage of human life to be understood and embraced.¹⁵ This thinking may explain the focus in some quarters on primary prevention, as opposed to secondary and tertiary prevention, in considering the health care of elderly populations. Sidestepping the evidence of savings in healthcare

8. Laurie Mallery & Kenneth Rockwood, *Preventive Care for the Elderly*, 38 CANADIAN FAM. PHYSICIAN 2371, 2371 (1992).

9. See, e.g., Nat'l Library of Med., Medical Subject Headings, MeSH Descriptor Data (2009), available at http://www.nlm.nih.gov/cgi/mesh/2009/MB_cgi?mode=&term=Preventive+Medicine (giving definition of "preventive medicine"); see also *id.*, available at http://www.nlm.nih.gov/cgi/mesh/2009/MB_cgi?mode=&term=Primary+Prevention (giving definition of "primary prevention"); see also *id.*, available at http://www.nlm.nih.gov/cgi/mesh/2009/MB_cgi?mode=&term=Secondary+Prevention (giving definition of "secondary prevention"); see also *id.*, available at http://www.nlm.nih.gov/cgi/mesh/2009/MB_cgi?mode=&term=Tertiary+Prevention (giving definition of "tertiary prevention").

10. Mallery & Rockwood, *supra* note 8, at 2371.

11. *Id.*

12. *Id.*

13. *Id.*

14. TRUST FOR AM.'S HEALTH, PREVENTION FOR A HEALTHIER AMERICA: INVESTMENTS IN DISEASE PREVENTION YIELD SIGNIFICANT SAVINGS, STRONGER COMMUNITIES, 3 (2009), available at <http://healthyamericans.org/reports/prevention08/Prevention08.pdf>.

15. See Michael J. Myers, *Old Lawyers, Blue Eyes, and the Medicalization of Aging*, 11 MARQ. ELDER'S ADVISOR L. REV. 105, 105-06 (2009).

costs through primary prevention, physicians Mallery and Rockwood argue that in elderly populations preventive care should emphasize secondary and tertiary prevention because prevention of morbidity and of functional impairment from ailments that are inevitable and incurable in later life should receive more emphasis in these populations.¹⁶ Their position that within elderly populations, preventive medicine should focus more on prevention of morbidity and of functional impairment (preserving or increasing quality of life for elderly patients) is based on expected greater prevalence of medical ailments and afflictions in these populations compared with younger populations.¹⁷

Irrespective of the basis for preventive medicine, recommendations in elderly populations sometimes suffer from the lack of significant numbers of elderly participants in research studies and from undue and narrow focus on early disease detection and prevention of mortality.¹⁸ Moreover, with significant percentages of both healthy and frail sub-populations, the elderly population is not homogeneous.¹⁹ Elders exhibit great diversity in their presentation of disease and high variability in health, physical function, and cognitive abilities.²⁰ In addition, the elderly population is physiologically

16. Mallery & Rockwood, *supra* note 8, at 2371-72.

17. *Id.* at 2378; *see also* LINDA P. FRIED, HEALTH PROMOTION FOR OLDER ADULTS: WHAT IS THE POTENTIAL? 11 (2000) (stressing the importance of secondary and tertiary prevention in elderly populations).

18. INST. MED., EXTENDING LIFE, ENHANCING LIFE: A NATIONAL RESEARCH AGENDA ON AGING 100 (Edmund T. Lonergan, ed., 1991).

19. *See* Adam G. Golden et al., *Prescribed Medications for Geriatric Patients in the Managed Care Setting*, 6 AM. J. MANAGED CARE 610, 610, 614 (2000) (discussing differing recommendations for health care interventions for varying portions of the elderly population); Barry Simkin, *Even Frail Elderly Patients Can Benefit From Exercise*, GERIATRIC TIMES (2002), <http://www.cmellc.com/geriatrictimes/g020831.html> (stating that the elderly population must be considered to be heterogeneous).

20. *See* Lisa C. Hutchison, *Health and Public Policy as It Affects Seniors*, in PHARMACOTHERAPY SELF-ASSESSMENT PROGRAM 71, 72-73 (5th ed., 2002), *available at* <http://www.accp.com/docs/bookstore/psap/p5b04sample02.pdf> (discussing diversity of elders in multiple categories including health status, financial assets, activity, and disability); *see also* Mallery & Rockwood, *supra* note 8, at 2372.

different than the younger populations from which prevention study participants are often drawn.²¹ Elderly persons are more likely to live with chronic disease or disability and with multiple disabilities simultaneously manifesting.²²

Chronic illness incidence increases with age.²³ Cost of health care for persons suffering from chronic illness account for a large proportion of national health care expenditures.²⁴ Health trends of elderly persons include both longer life and poorer health during that extended life.²⁵ Though seemingly counterintuitive, support for this statement is evidenced in decreased mortality rates at younger ages, increasing elderly population, and increasing prevalence of chronic conditions in

21. OFFICE OF TECH. ASSESSMENT, U.S. CONGRESS, TECHNOLOGY AND AGING IN AMERICA 121, 123, 128-29, (1985) (discussing typical use of young men in medical research studies, resulting in extrapolation and lack of direct evidentiary support for application of study results to elderly populations).

22. FRIED, *supra* note 17, at 2-3, 11 (discussing the greater incidence and prevalence of chronic diseases and ailments in elderly populations compared with younger populations).

23. Dorothy P. Rice, *The Characteristics and Health of the Elderly*, in CARING FOR THE ELDERLY: RESHAPING HEALTH POLICY 3, 11 (Carl Eisdorfer et al. eds., 1989).

24. See Henry J. Kaiser Family Found., *U.S. Healthcare Costs: Background Brief*, KAISEREDU.ORG, http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358 (last visited Nov. 2, 2010)

- Chronic disease – The nature of health care in the U.S. has changed dramatically over the past century with longer life spans and greater prevalence of chronic illnesses. This has placed tremendous demands on the health care system, particularly an increased need for treatment of ongoing illnesses and long-term care services such as nursing homes; it is estimated that health care costs for chronic disease treatment account for over 75% of national health expenditures. (Citation omitted.)
- Aging of the population – Health expenses rise with age and as the baby boomers are now in their middle years, some say that caring for this growing population has raised costs. This trend will continue as the baby boomers will begin qualifying for Medicare in 2011 and many of the costs are shifted to the public sector. However, experts agree that aging of the population contributes minimally to the high growth rate of health care spending. (Citation omitted.)

Id.

25. See, e.g., Am. Geriatrics Soc'y Found. for Health in Aging, *Trends in the Elderly Population*, AGING IN THE KNOW, http://www.healthinaging.org/agingintheknow/chapters_print_ch_trial.asp?ch=2 (last visited Nov. 2, 2010).

the elderly.²⁶

Care driven by screening recommendations and treatment mandates, while beneficial to some elders, has created for others situations in which patients may be over-screened and over-treated, and thus placed at greater risk of morbidity and mortality due to medical intervention. The concept of *primum non nocere* is well known to physicians.²⁷ The mandate of this medical concept may be difficult to meet, however, where the very medical interventions meant to protect and improve the health of patients are potentially detrimental. Still, other elderly patients continue to receive inadequate screening and preventive intervention for a variety of reasons.²⁸

HEALTH CARE COSTS' AFFECT ON SCREENING ELDERS

Prior to recent enactment of the Patient Protection and Affordable Care Act by the House, creating a national complex of affordable health care insurance,²⁹ Congressional Budget Office (CBO) projections predicted that federal spending on Medicare and Medicaid would grow from four percent of gross domestic product (GDP) in 2007, to nine percent of GDP in 2032, to nineteen percent of GDP in 2082.³⁰ Over this period, the United States population will become substantially older.³¹

26. Rice, *supra* note 23, at 11-12.

27. "First, do no harm." Medical principal that a patient's medical condition should not be made worse because of having visited a physician. TABER'S CYCLOPEDIA MEDICAL DICTIONARY, *supra* note 4, at 1160.

28. See Mary C. Spalding & Sean C. Sebesta, *Geriatric Screening and Preventive Care*, 78 AM. FAM. PHYSICIAN 206, 208 (2008) (discussing factors contributing to inadequate and inappropriate screening in various elderly sub-populations); Am. Geriatric Soc'y Ethics Comm., *Health Screening Decisions for Older Adults: AGS Position Paper*, 51 J. AM. GERIATRICS SOC'Y 270, 270-71 (2003) (addressing how to screen elderly adults appropriately).

29. See generally The Patient Protection and Affordable Care Act of 2010 H.R. 3590, Pub. L. No. 111-148, 124 Stat. 119, 111th Cong. (2010) (to be codified throughout 42 U.S. Code).

30. CONG. BUDGET OFFICE, ACCOUNTING FOR SOURCES OF PROJECTED GROWTH IN FEDERAL SPENDING ON MEDICARE AND MEDICAID 1 (2008), available at http://www.cbo.gov/ftpdocs/93xx/doc9316/05-29SourcesHealthCostGrowth_Brief.pdf.

31. *Id.* at 2.

More than half of the predicted increase in Medicare and Medicaid spending is attributable to rising costs per beneficiary rather than rising numbers of beneficiaries.³² Per person health care costs are rising more rapidly than per capita GDP.³³ Whether the Patient Protection and Affordable Care Act will have the promised effect of slowing the rate of rising health care costs, including rising Medicare and Medicaid costs, and actually provide effective and sufficient health care coverage to more Americans remains to be seen.³⁴

One question the legislation raises is whether, with increased, less costly medical care coverage, the incidence of inappropriate health screening services and unnecessary preventive interventions in the elderly will rise. Inappropriate health screening and preventive care can occur either through failure to provide necessary care or through provision of unnecessary care.

USE OF SCREENING WITHOUT EVIDENCE OF BENEFIT

If we shift our medical focus to increasing quality of life rather than simply increasing length of life for the elderly, we may begin to approach medical screening and prevention in elderly populations from a more realistic viewpoint, a viewpoint more in line with what patients need. To facilitate such a change in the medical realm, the medico-legal paradigm must also shift. If a physician may be successfully prosecuted for medical negligence or malpractice simply because the physician failed to follow recommended prevailing medical screening or preventive services guidelines in a particular patient who happens to incur morbidity from the screened-for event, the likelihood of physicians adopting a more measured response to screening and prevention is slim.

Phillip E. Crunk and Alex Yui-Huen Kwan list “health care,

32. *Id.* at 1.

33. *Id.*

34. Affordable Health Care for America Act, H.R. 3962, 111th Cong. (2009).

education, nutrition, housing, physical and mental well-being, and economic security" as considerations "in forming the complex of factors necessary for improvement in the quality of life" for elders, whether in the United States or abroad.³⁵ These considerations are of course intertwined. Higher status in a combination of these categories correlates positively with higher socioeconomic status. The better one's socioeconomic status, the more resources one may have at one's disposal to demand and pay for health care. Whether the demanded healthcare is necessary or beneficial, is another matter.

Various private and governmental groups such as the American Cancer Society, the American Medical Association, and the United States Preventive Services Task Force (USPSTF) provide research-based recommendations for medical screening, disease prevention, and treatment.³⁶ The evidentiary basis for implementation of these recommendations in elderly populations, however, is at times tenuous.³⁷

In their 2000 book on Health Promotion for the Elderly, researchers Keller and Fleury note that various models utilized

35. Phillip E. Crunk & Alex Yui-Huen Kwan, *The Elderly Who Live Alone: A Cross-Cultural Analysis of the Elderly in Hong Kong and the United States*, in INTERNATIONAL PERSPECTIVES ON HEALTHCARE FOR THE ELDERLY 127, 131 (G. Harry Stopp, Jr. ed., 1994).

36. See generally AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, GUIDE TO CLINICAL PREVENTIVE SERVICES 2010-2011 (2010), available at <http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf> (providing USPSTF screening recommendations); CTRS. FOR DISEASE CONTROL AND PREVENTION, PROMOTING PREVENTIVE SERVICES FOR ADULTS 50-64: COMMUNITY AND CLINICAL PARTNERSHIPS (2009), available at <http://www.cdc.gov/aging/pdf/promoting-preventive-services.pdf> (providing CDC, AARP, and AMA screening recommendations); *American Cancer Society Guidelines for the Early Detection of Cancer*, AM. CANCER SOC'Y, <http://www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer> (last visited Nov. 2, 2010) (providing ACS screening recommendations).

37. See, e.g., Carolyn Clancy, Acting Director, AHRQ, AHRQ's Role in Evidence-Based Preventive Health Care Services, Testimony Before House Subcommittee on Oversight and Investigation, Committee on Energy and Commerce (May 23, 2002), available at <http://www.ahrq.gov/news/test52302.htm> (noting the paucity of scientifically rigorous studies, and paucity of research subjects in rigorous studies, from which conclusions are drawn regarding screening recommendations).

in development of health promotion interventions, including preventive care, have both merits and weaknesses.³⁸ Keller and Fleury note that little attention is paid to how to promote behaviors that keep elders healthy and reduce disability in senior years, yet *decrease* use of medical services.³⁹ When life expectancy is but another 10 years or so, how important is it to get a particular screening such as prostate specific antigen?

OVER SCREENING

Challenges for physicians caring for elderly patients with multiple chronic ailments are choosing what to treat, what to screen for, and what to do about new problems found.⁴⁰ Presented for consideration are the following two hypothetical, but very realistic, elderly patients:

Ms. Smith is a sixty-five year-old black woman who is morbidly obese, has class IV congestive heart failure with hypoxemic, obstructive sleep apnea (she is on oxygen at all times), uncontrolled diabetes mellitus, poorly controlled hypertension, and high cholesterol. She does not smoke or drink alcohol. She does not exercise because she can't tolerate it and her joints hurt all the time.

Mr. Jones is a seventy-five year-old white man with no apparent health problems. He is slim, and walks approximately two miles per day for exercise.

Both Ms. Smith and Mr. Jones are retired. Both are Medicare recipients.

What best promotes health in these patients? Should they receive any health screening or preventive health care? If so, should it be the same? What health screening? What preventive health care? Do the answers change if either of the patients has

38. COLLEEN KELLER & JULIE FLEURY, *HEALTH PROMOTION FOR THE ELDERLY* ix (2000).

39. *Id.* at 129.

40. See, e.g., Siri Carpenter, *Treating an Illness is One Thing. What About a Patient with Many?*, N.Y. TIMES, Mar. 31, 2009, at D1 (discussing the challenges inherent in treating elderly patients with multiple chronic illnesses).

only a high school education, has no Internet access, and is computer illiterate? The answers to these questions are multivariate, and complex. While certain health screenings may be beneficial to both, others are unnecessary and potentially detrimental. General screening guidelines based on age, gender, and even race may be useful, but blind obedience to these guidelines by health care providers will not provide these patients with optimal health care.

Ms. Smith may have already exceeded her life expectancy, given her medical condition. Accordingly, a reasonable physician may choose to forego certain recommended screenings. USPSTF recommendations, however, state that she and all sixty-five-year-old persons should undergo routine colon cancer screenings.⁴¹ Considering her medical condition, colon cancer screening is inappropriate. Ms. Smith is not a candidate for surgery because the very procedure meant to save her from the ravages of colon cancer is more likely than not to kill her given her general medical status.

Considering his medical condition, Mr. Jones may be expected to live less than eleven additional years.⁴² Is it reasonable to screen him for every preventable ailment because he can tolerate the procedures? In either instance, truly informed consent to screening proposed by medical providers and knowledge of what screening may be reasonably medically necessary may not be possible.

General use of prostate specific antigen (PSA) assay is another example of inappropriately utilized screening and prevention measures. In March 2010, Richard Ablin, the very researcher who discovered PSA in 1970, spoke out against routine use of the test for prostate cancer screening, stating that "[t]he test's popularity has led to a hugely expensive public health disaster."⁴³ Ablin proceeded to detail the misuse and

41. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *supra* note 36, at 36.

42. NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2008 203 (2009) available at [http://www.cdc.gov/nchs/data/08.pdf#026](http://www.cdc.gov/nchs/data/hus/08.pdf#026).

43. Richard J. Ablin, *The Great Prostate Mistake*, N.Y. TIMES, Mar. 10, 2010, at

abuse of the test for health screening purposes.⁴⁴ American men have a sixteen percent lifetime chance of being diagnosed with prostate cancer.⁴⁵ Yet, they have only a three percent chance of dying from prostate cancer.⁴⁶ Because of the slow growth nature of most prostate cancers, prostate cancer is more likely to be an incidental finding on autopsy than it is to be found a cause of death.⁴⁷ Yet, the test is still seen by some physicians and patients alike as an essential part of adult male health screening.⁴⁸

PSA testing in the United States costs more than \$3 billion.⁴⁹ This testing is paid for primarily through Medicare and Veterans Administration funds because most men receiving the test are seniors.⁵⁰ The test "reveals [only] how much of the prostate antigen a man has in his blood," and that amount alone does not correlate with mortality risk from cancer.⁵¹ There are numerous causes for elevated prostate antigen, such as infection or use of common drugs like ibuprofen.⁵² Men without any elevation in PSA may still have prostate cancer.⁵³ The morbidity and early mortality of men with elevated PSA may be increased due to medical intervention and treatment based on the test results rather than any actual disease. Men are often persuaded to have prostate biopsies, then prostate surgery, radiation therapy, or other damaging treatments on the basis of an elevated PSA.⁵⁴ These interventions often result in significant morbidity, including decreased sexual function and urine control problems,

A27.

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*

48. See, e.g., *Prostate-Specific Antigen (PSA) Test*, NAT'L CANCER INST. (Mar. 18, 2009), <http://www.cancer.gov/cancertopics/factsheet/Detection/PSA> (noting that physicians differ on their recommendations for PSA screening, with some physicians being in favor of testing in their patient populations).

49. Ablin, *supra* note 42.

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.*

without any significant proven decrease in mortality or other benefit to patients' lives.⁵⁵ The American Cancer Society has urged caution in using the test.⁵⁶ The United States Preventive Services Task Force has recommended against PSA screening for men aged seventy-five or older, and "concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years."⁵⁷ Yet, PSA screening is still routinely used in men without known pre-existing prostate cancer (i.e., for screening rather than disease progression or remission tracking purposes).⁵⁸ Why? Ablin believes the test's use is linked to pharmaceutical companies advocating for use of the tests and advocacy groups naively pushing for men to get screened as a preventive measure aimed at increasing prostate cancer awareness.⁵⁹ These and other factors may indeed contribute to the costly misuse of the PSA screening test. So why are we still screening? Patient, physician, and media factors contribute to this.⁶⁰

An important point here, however, is that even when PSA is determined to have been useful in screening for prostate cancer in a given individual man, there is no statistical evidence that the test is useful per se in preventing morbidity or mortality due to the condition.⁶¹ In fact, there is evidence that certainly

55. *Id.*

56. See Am. Cancer Soc'y, *Prostate Cancer: Can Prostate Cancer Be Found Early?*, CANCER.ORG, <http://www.cancer.org/cancer/prostatecancer/detailedguide/prostate-cancer-detection> (last visited Nov. 2, 2010).

57. U.S. Preventive Services Task Force, *Screening for Prostate Cancer: U.S. Preventive Services Task Force Recommendation Statement*, 149 ANNALS INTERNAL MED. 185, 185 (2008).

58. Ablin, *supra* note 42.

59. *Id.*

60. See, e.g., NAT'L CANCER INST., *supra* note 47 (noting that physicians differ on their recommendations for PSA screening, and failing to provide – as an NIH information site – any clear guidance on PSA testing issues).

61. See Spalding & Sebesta, *supra* note 28, at 213 (stating "[i]t is unlikely that men with a life expectancy of less than 10 years will receive benefit from . . . [prostate cancer] screening"); Russell Harris & Kathleen N. Lohr, *Screening for Prostate Cancer: An Update of the Evidence for the U.S. Preventive Services Task Force*, 137 ANNALS INTERNAL MED. 917, 917-24 (2002).

morbidity and perhaps mortality are increased because of unnecessary medical interventions performed due to PSA testing.⁶² The use of PSA assay for screening purpose is just one example of over screening in an attempt to increase longevity.

UNDER SCREENING

An example of under screening that profoundly affects health promotion is the lack of medical provider screening of patients for sufficient "health literacy."⁶³ Health literacy can be defined as "[t]he degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."⁶⁴ These skills are needed to communicate with healthcare providers effectively for one's own medical benefit.⁶⁵ Patients with poor health literacy report worse health status and have less understanding of their medical conditions and treatment.⁶⁶ Poor health literacy may increase the risk of hospitalization.⁶⁷ Failure to screen for lack of ability to understand, cooperate in, and facilitate one's own better health care, decreases the effectiveness of medical intervention. If a provider fails to determine that certain patients have insufficient health literacy, the provider is unlikely to tailor patient intervention and explanation of therapy, if any, to the patient's level of understanding. This leads to poor health promotion in these patients.

Elderly patients constitute one of the patient populations most likely to have a high percentage of health illiteracy.⁶⁸ Even

62. Ablin, *supra* note 42.

63. Ad. Hoc. Comm. On Health Literacy for the Council on Scientific Affairs, Am. Med. Ass'n, *Health Literacy: Report of the Council on Scientific Affairs*, 281 JAMA 552, 554 (1999).

64. *Definition of Health Literacy*, LITERACY ASSISTANCE CENTER, <http://www.lacnyc.org/resources/healthlit/definition.htm> (last visited Nov. 3, 2010) (citing Healthy People 2010 definition of health literacy).

65. *Id.*

66. Am. Med. Ass'n, *supra* note 62, at 553-54.

67. *Id.* at 554.

68. *Rhode Island Addresses the Costly Issue of Health Illiteracy*, TODAY'S HEALTHCARE COSTS (Blue Cross Blue Shield of Rhode Island) Oct. 2006, at 2,

if an elderly patient has sufficient health literacy, the patient's culture and socioeconomic status, the medical provider's culture and socioeconomic status, medical provider paternalism, and other factors may affect all aspects of medical care, particularly with respect to prevention and screening services.⁶⁹ Nonetheless, the less health literacy a patient exhibits, the more likely the inappropriate imposition or withholding of prevention and screening services.⁷⁰ The combination of lack of sufficient health literacy with poor socioeconomic status leads to a much greater likelihood of inappropriate medical intervention.⁷¹ Does improved health literacy necessarily increase effective care, or does it create a group of more demanding patients? Hopefully, the former.

Cultural, socioeconomic, and societal conditions affect various seniors' motivation to change health habits.⁷² Physicians should consider four areas in targeting patient interventions: 1) appropriate health assessments, 2) lifestyle changes used to achieve health promotion and disease prevention outcomes, 3) culturally sensitive efforts to achieve better health promotion and disease prevention, and 4) application of interventions in a manner sensitive to socially and economically disadvantaged

available at https://www.bcbsri.com/BCBSRIWeb/pdf/THC/THC_October_2006.pdf (analyzing data from a 2003 national assessment of adult literacy conducted by the U.S. Department of Education and data from National Academy on an Aging Society estimates of increased health care costs attributable to health illiteracy in the elderly, which demonstrate that health illiteracy contributes to increased health care costs without a concomitant increase in the effectiveness of that care).

69. See Daniel Fu-Chang Tsai, *Personhood and Autonomy in Multicultural Health Care Settings*, 10 AM. MED. ASS'N. J. ETHICS 171, 174 (2008) (stating that paternalism can override patient autonomy in medical decision making and discussing how differences in patient and physician socio-cultural values can adversely affect prevention and directed screening care decisions).

70. Blue Cross Blue Shield, *supra* note 67, at 2 (stating that adults with lower health literacy averaged more hospital stays and long hospital stays than their more literate counterparts, and that because of this poor health literacy, attempts at prevention fail more often).

71. *Id.* (showing that adults living below the poverty level had lower average health literacy than adults living above the poverty threshold, and that being a member of a minority group exacerbated this effect – leading to more and longer hospital stays compared with more literate adults).

72. KELLER & FLEURY, *supra* note 38, at 129.

populations.⁷³ It is questionable how often these areas are considered by providers in determining patient care, as opposed to cost constraints, insurance status, time constraints, or subjective valuation of patient worth.⁷⁴ Physicians must be able to relate to patients to reach them, to communicate with them effectively, and to conscript them into improving their own care.⁷⁵ Simultaneously, physician paternalism must be curbed.⁷⁶

Elderly patients must be empowered to self-determine health promotion preventative and interventionist medical screening and therapies.⁷⁷ Sensitivity to a patient's cultural and socioeconomic particulars will aid physicians in assessing not only what prevention and intervention are needed, but also the most effective mechanisms through which to educate the patient and obtain patient buy-in and ownership of the prevention and screening.⁷⁸ Patients heavily involved in religious groups, community center activities and clubs, or extended family networks are more likely to trust and accept recommendations of health care professionals working through those organizations to deliver health information and education to patients.⁷⁹ Health recommendations may not be followed if too costly, without local or convenient access, or perceived as less pressing than other life concerns such as food and shelter.⁸⁰

73. *Id.* at 129-30.

74. See Denis A. Cortese & Jeffrey O. Korsmo, *Putting U.S. Health Care On The Right Track*, 361 NEW ENG. J. MED. 1326, 1326-27 (2009) (discussing incentive programs through which to reverse these poor patient care practices).

75. John M. Travaline et al., *Patient-Physician Communication: Why and How*, 105 J. AM. OSTEOPATHIC ASS'N. 13, 15-16 (2005) (stating that physician tailoring of medical information delivery to the educational needs of individual patients, while encouraging patient queries and feedback, will improve patient comprehension and better overall medical care).

76. *Id.* at 13 (discussing improvement of patient care through avoidance of paternalism).

77. KELLER & FLEURY, *supra* note 38, at 132.

78. *Id.* at 131-32.

79. *Id.* at 131-33.

80. See, e.g., Susannah M. Bernheim et al., *Influence of Patients' Socioeconomic Status on Clinical Management Decisions: A Qualitative Study*, 6 ANNALS FAM. MED. 53, 53-59 (2008) (noting that issues concomitant to low socioeconomic status interfere with patient ability to comply with and maximize medical management, and negatively affect physician treatment decisions with respect to patients in this

Although preventive care may be a public health priority, it is often not an individual provider priority or even an individual patient priority. If a particular patient has a 'leave well enough alone' attitude, that patient will decline even the most carefully explained and encouraged preventive care or testing. Should such a patient's autonomy and personal bodily integrity be interfered with through legislation mandating preventive services interventions? Personal privacy principles dictate when a physician can intervene in or override a patient's wishes with respect to receipt of medical care.⁸¹ Should medical providers be permitted or obligated to ignore patient autonomy for cost and life saving reasons? Requiring physicians to provide specific preventive services to seniors creates an environment of interference with the practice of medicine and necessary privacy, intimacy, and flexibility of medical decision-making in the physician-patient relationship.⁸²

PHYSICIAN ISSUES

There are legal issues with screening or not screening. When a physician screens for an ailment, receives confirmation of the ailment, and then does not treat the patient for the ailment, physicians may be liable for malpractice.⁸³ On the other

population); Tim E. Byers et al., *The Impact of Socioeconomic Status on Survival After Cancer in the United States: Findings from the National Program of Cancer Registries Patterns of Care Study*, 113 *CANCER* 582, 582-89 (2008) (observing that low socioeconomic patient status led to later presentation for medical intervention with more advanced disease, and poorer post intervention outcomes – particularly in minority populations).

81. See, e.g., *Coulter v. Thomas*, 33 S.W.3d 522, 524-25 (Ky. 2000) (reviewing under battery, rather than informed consent principles, physician's refusal to remove blood pressure cuff as patient requested); *Gragg v. Calandra*, 696 N.E.2d 1282, 1287 (Ill. App. Ct. 1998) (reviewing under battery, rather than informed consent principles, allegation that open heart surgery and maintenance of patient on life support were conducted without patient or family consent).

82. See KEENIE, *supra* note 5, at 265-69 (noting that elderly populations are heterogeneous, and include individuals with "widely varying" health status and disability, health care values, and thoughts and desires regarding future health care; asserting that although preventive medicine strategies are important, they must be personalized for each individual patient – respecting the autonomy of person).

83. See, e.g., Richard M. Hoffman & Steven B. Zeliadt, *The Cautionary Tale of PSA*

hand, not screening a patient when one "should" screen may also place a physician in a position of liability.⁸⁴ Determining when one should screen, test, or provide preventive intervention is sometimes a difficult question, and often the gravamen of after the fact disputes in medical negligence and malpractice litigation.⁸⁵ Fears of medical malpractice claims for negligence, under treatment, and outright malpractice often lead physicians to take a shotgun approach to medical screening and prevention as a form of defensive medicine.⁸⁶ Aside from increasing potential morbidity in this patient population, the approach clearly increases medical spending.⁸⁷

There is a constant tug-of-war between formalized regulations and necessary flexibility of providing medical care to individual patients.⁸⁸ Should the recommendations promulgated by private and governmental organizations for preventive

Testing, 170 ARCHIVES OF INTERNAL MED. 1262, 1262-63 (2010) (discussing prostate cancer screening controversy and possible approaches physicians may take to avoid liability in this area, given the current medical malpractice milieu; commenting on Yu Hsuan Shao et al., *Risk Profiles and Treatment Patterns Among Men Diagnosed as Having Prostate Cancer and a Prostate-Specific Antigen Level Below 4.0 ng/mL*, 170 ARCHIVES OF INTERNAL MED. 1256 (2010)).

84. See *id.*

85. See, e.g., Cheryl R. Herman et al., *Fundamentals of Clinical Research for Radiologists, Screening for Preclinical Disease: Test and Disease Characteristics*, 179 AM. J. ROENTGENOLOGY 825, 827-28, 830 (2002) (discussing challenges of selecting appropriate screening tests, and the appropriate timing of tests to best determine optimal treatment and reduce selection bias and physician treatment bias due to liability concerns); see also Ann W. Latner, *When a Doctor Snubs PSA Screening*, CORTLANDT FORUM (Nov. 17, 2008), <http://www.cortlandtforum.com/when-a-doctor-snubs-psa-screening/article/121112> (discussing sample case of physician who decided, without patient consultation, to forego PSA testing in patient who later suffered significant physical morbidity from unusual but aggressive prostate cancer – physician subject to liability in after the fact dispute regarding the medical decision making).

86. See Kenneth DeVille, *Act First and Look Up the Law Afterward?: Medical Malpractice and the Ethics of Defensive Medicine*, 19 THEORETICAL MED. BIOETHICS 569, 580 (1998) (examining the phenomenon of defensive medicine and the problematic aspects of physicians' attempts to maintain the safest legal position possible).

87. Troyen A. Brennan et al., *Liability, Patient Safety, and Defensive Medicine: What Does the Future Hold?*, in MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 93, 109-12 (William M. Sage & Rogan Kersh eds., 2006) (examining the practice of defensive medicine, and the extent to which it increases health care costs).

88. See, e.g., Alan L. Hillman, *Managing the Physician: Rules Versus Incentives*, 10 HEALTH AFFAIRS 138, 141-42 (Winter 1991).

preventive services for elderly persons be enforced as requirements that physicians must meet in caring for their patients?⁸⁹ Moreover, should every medical ailment or affliction that can be prevented, be prevented?⁹⁰ There are potential problems with these approaches to encouraging better preventive care for elders.

Legislatures' enactment of statutes often lags behind medical developments and innovations.⁹¹ Moreover, time and again in medical history, what once was ideal practice was later shown to be inappropriate and obsolete based upon new technologies, new evidence, and new beliefs amongst medical researchers and medical providers.⁹² Physician liability tied strictly to national or other screening and treatment recommendations will stifle medical care and drive care costs up through defensive medicine practices.⁹³ Criminalization of medical practice will be a deterrent to provision of appropriate health care.⁹⁴ Patients may be harmed in the process, through receipt of unnecessary and harmful interventions.⁹⁵ Physicians

89. See, e.g., Kimberly S.H. Yarnall et al., *Family Physicians As Team Leaders: "Time" to Share the Care*, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., & POL'Y, Apr. 2009, at 1, 2 (arguing that patient care demands prevent physicians from providing all recommended preventive services as a matter of course, and suggesting that enforcement of the recommendations as requirements would be impractical at best).

90. See, e.g., Alan Stoga, *Overtreated: Is Too Much Medicine the Real Cause of the U.S. Health Care Crisis?*, FLYP (Mar. 7, 2008), <http://www.flypmedia.com/content/are-americans-getting-too-much-medicine> (discussing the dilemma and examples of morbidity due to inappropriate screening and treatment).

91. See, e.g., BEAUFORT B. LONGEST, JR., *HEALTH POLICYMAKING IN THE UNITED STATES* 51, 163 (Health Administration Press 4th ed. 2006) (citing J. S. HACKER, *THE ROAD TO NOWHERE* (1997)) (discussing the long and arduous process of enacting health care legislation in response to changing health care agendas and advances in medical technology).

92. See, e.g., Brandi White, *Making Evidenced-Based Medicine Doable in Everyday Practice*, FAM. PRAC. MGMT., Feb. 2004, at 51, 52-53, 55 (Feb. 2004).

93. Daniel Kessler & Mark McClellan, *Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care*, 84 J. PUB. ECON. 175, 194 (2002).

94. Amy Lynn Sorrel, *Doctors Fear Criminalization of Medical Mistakes*, AM. MED. NEWS (Nov. 27, 2006), <http://www.ama-assn.org/amednews/2006/11/27/prl21127.htm>.

95. See Hillman, *supra* note 87, at 138; Laura B. Wilson et al., *The Status of Preventive Care for the Aged: A Meta-Analysis*, in AGING AND PREVENTION: NEW APPROACHES FOR PREVENTING HEALTH AND MENTAL HEALTH PROBLEMS IN OLDER

and patients require flexibility in determining what care should be provided in what circumstances.⁹⁶ Patient autonomy principles dictate that patients are entitled to consent to or to decline screening or treatment in an informed manner.⁹⁷

CONCLUSION

This article does not propose to answer the questions raised within its borders. Rather it presents the questions of how to determine and provide appropriate medical screening and preventive services for elders, as affected by considerations of elder patient autonomy in medical decision making, flexibility in decision making through the physician-patient relationship, and criminalization of medical practice, as significant issues that need to be addressed, and if possible, resolved as we move forward in designing and redesigning preventive services for this nation's elderly populations.

ADULTS 23, 35 (1983) (stressing that individual characteristics, financial status, and psychosocial factors must be considered by physician and patient in determining which preventive measures to undertake).

96. *See id.*

97. *See, e.g.,* *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) (upholding use of an objective patient-centered standard for informed consent analysis); *see also* *Culbertson v. Mernitz*, 602 N.E.2d 98, 101-2 (Ind. 1992) (instituting use of a material risk standard for informed consent analysis); *see also*, Tsai, *supra* note 68, at 171-76 (stating that physician ethics demand that physicians respect patient autonomy in medical decision-making).