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Should Health Care be Rationed? The Physician's Viewpoint

by

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The United States currently spends approximately 14% of its gross domestic product for health care, and this is likely to climb to 18% of GDP by the end of the decade.¹ In contrast, the United States spends roughly 6% of GDP both for education and defense. It is clear that the greatest part of our increase in health care costs is best understood as a result not of the failures of medicine, but of its successes. The expanding capabilities of medicine, with the marvelous advances in biomedical technology and pharmacotherapy, together with specialization in the medical profession, have certainly contributed greatly to the current situation. The unbridled appetite for health care on the part of the public and our continuing expansion of the definition of "health" also contribute to this escalation.

This increase in costs is certainly alarming. A recent Harris poll indicates that 94% of the respondents thought health care needed "fundamental reform or to be completely rebuilt."² Since the introduction of President Clinton's Health Care Reform Act, this is now an official matter of concern for the Congress and the nation. Certainly the next two years will see the attempt to solve this problem as one of the major political activities of the American people.

The concern for public expenditures for health care implies a rhetorical question: where will it all end? We recognize that even government budgets are not without limits. We know that what goes into health care will have to be diverted from other areas of public concern. Health insurance premiums turn out to be an increasingly heavy burden on individual incomes. Can we afford to continue as if the sky is the limit? A second rhetorical question can be asked: does pouring more money into the health care system indeed buy a commensurate increase in actual health, prolongation of life, and relief of pain and suffering? If the answer to this second question is "no," it is certainly time to consider the limits of medicine as well as the limits of the welfare state.

In considering limits, the specter of rationing raises its head. Daniel Callahan has argued persuasively that universal health care is neither feasible nor plausible

without health care rationing.³ Rationing is a word that packs many meanings. To some, rationing means cost containment. To others, rationing means that some individuals are uninsured. To still others rationing is understood as an inordinate waiting period for medical service. When a precise definition of rationing is not utilized by all, ethical discourse concerning its value and disvalue is very difficult.

Dr. William Schwartz of Tufts Medical School has written extensively on rationing. He defines it as "not all care expected to be beneficial is provided to all patients."⁴ Such a definition would imply that the withdrawal of Nancy Cruzan's feeding tube as sanctioned by her legitimate surrogate, her father, would be a form of rationing. Such is clearly not the case.

The definition of rationing which I wish to use in considering the ethics of same is "the intentional withholding of needed diagnostic services or effective medical therapy by the patient's individual physician on the perception by the physician of scarce resources."⁵ This is the definition which we at the Center for Clinical Bioethics at Georgetown University use in considering the ethical issues involved in rationing. This, of course, precludes a discussion on the ethics of the action of a community, e.g., Oregon, or, indeed, of the greater community, the nation, through the ordered political processes to produce cost containment by limiting the amount of money to purchase health care services and of deciding just what health care services will be purchased and for whom. This problem of setting limits for health care in the macroeconomic world is considered under the rubric of the allocation of resources. Society in general resists such limits. Such setting of limits creates different problems and requires a different ethical consideration, primarily one concerning distributive justice. This is quite different from the ethical considerations required when the individual patient's physician makes a determination to withhold needed and effective diagnostic and/or therapeutic modalities based on that individual physician's perception of scarce resources.⁶

As Ten Haave has pointed out, the resource allocation debate is set about a distinction which is made between the limits *of* care and the limits *in* care.⁷ These terms refer respectively to limiting the health care system, which is regarded as a responsibility of government, and to limiting the care of individual patients or patient categories, which is considered to be the responsibility of health care professionals. Morrein, in considering the Oregon health plan, well understands this.⁸ He argues for a clear separation between the duty of a doctor to decide what a patient needs and the duty of the supplier of resources to decide what can be paid for. The key issue appears to be the analysis of the relationship between the common good and the good of individuals. What matters ethically seems to be not only the minimum of health care that should be due to all, but also the upper limit of optimal care we should attempt to achieve. Within our present system unlimited claims are generated. On this fragile basis, the health care policy of equal access and financial solidarity produces an almost uncontrollable system, which we now all recognize, and with which we struggle for solution. The body politic currently has set external limits as a policy favored to control these spiralling costs, i.e., a la carte discounting, rate setting, formula driven utilization controls, technology utilization assessment, micromanagement of providers for

wasted expenditures and excessive administrative costs, etc. These are measures and regulations initiated by governmental authorities and carried out at the institutional level. It has been repeatedly argued that this external approach will remain unsuccessful and morally inadequate as long as there is no evolution from external to internal limits.

The argument is made well by Ten Haave and others that we must learn autonomously whether or not to restrict our claims to health care and whether to withdraw or not from a system of scarcity. The withdrawal is in large part maintained by an obsession with longevity, i.e., in the sense of "surviving others," living longer than and thus outliving others as a consequence of an inability to integrate and accept death and suffering as an integral component of life. Gaylin put it very well.⁹ "People will pay anything to defend against the possibility of death, all the more so when money involved doesn't come directly out of their own pockets."

The concept of autonomy is very often linked with the concept of solidarity. Self-determination may be considered to imply, in a Kantian interpretation of autonomy, an ability to restrain our claims for the benefits of others. Self-determination should involve responsibility on the individual's part, indeed, for the self-realization of the other members of the community.

In any system, if the physician decides that he or she will be the arbiter of rationing, I believe we have fallen upon very hard times, indeed. We can ask the question: "Why is it unethical for the individual physician to be the determiner of rationing in the sense that I have defined it above?"

First of all, the physician's role as expressed in the Hippocratic Oath is to act benevolently, i.e., in the best interests of his or her patient. This means, of course, that the physician will do all in his or her power to bring cure or comfort to the sick individual. This means that the physician will bring effective diagnostic methods and treatment to the patient as needed. The physician will not utilize ineffective, futile, or burdensome treatment, but treatment that is beneficial and effective. Effective treatment is defined as treatment which cures the disease or corrects and brings more toward normal the functional incapacitation that the disease or condition imposes. Beneficial treatment may not be effective, but brings about an enhancement of the individual patient's life values. The concept of beneficence, however, does not mean acquiescing to the patient's every whim under the rubric of respecting autonomy. Patient requests can be far-fetched and invalid claims against the physician. Giving antibiotics to a patient suffering from a viral upper respiratory tract infection is an example of such. It is incorrect medical practice. It is not a form of rationing to withhold this ineffective treatment, and it is inappropriate for the physician to acquiesce to the patient's request for this treatment under any condition. Such withholding is not rationing.

The physician, in representing the best interests of the patient, however, and acting upon these is obliged to give to the patient necessary and effective treatment, insofar as the physician can judge its effectiveness, no matter how scarce the resources! If the individual physician withholds due to the perception of preserving scarce resources, he is acting unethically, in my opinion, for he or she is not acting in the best interests of the patient.

In withholding necessary treatment the physician is basically making an ethical judgement on the value of that particular individual's life. An illustration of this is well-documented in an anecdotal report. One of the members of our Center for Clinical Bioethics was speaking to the medical staff of a local hospital and presented this scenario to the staff:

A mildly demented 80-year old minority woman was brought to the emergency room of the hospital vomiting blood and passing blood through her rectum.

The staff members were given three scenarios and asked how they would handle the case: 1) admit the patient to the hospital for a diagnostic work-up to determine the cause of the bleeding and, if correctable, to correct it; 2) to admit to the hospital but give comfort care only; or 3) to refrain from admitting to the hospital. One quarter of the physicians argued that because of the expected poor quality of life, "dementia and age," and because of scarce resources, e.g., limited supply of blood, overused radiographic facilities, the limited number of beds in Intensive Care, and other cost factors related to hospital operations, that they would not admit. Such rationing of services based on consideration by one individual of the "low quality of life" of another individual debases all forms of human life and particularly puts the more vulnerable — the poor, the elderly, the demented, and minorities — at greater risk. Nat Hentoff, in an op-ed article in the *Washington Post*, of Tuesday, August 18, 1992, writing about the famous Oregon Plan, which made "quality of life" a factor in rationing, made a very profound statement.¹⁰ He talked about the increasing number of physicians and politicians around the country convinced that money is wasted on people with a low "quality of life." He suggested that all such physicians should take a moment to think on the advice of the eighteenth century German physician, Dr. Cristophe Hufeland, who was Professor of Medicine in Halle and a great humanist. In letters to both Goethe and Herder on medicine, he said, "If the physician presumes to take into consideration in his work whether life has value or not, the consequences are boundless and the physician becomes the most dangerous man in the state."

The phenomenon of illness makes an unequal partnership between the physician and the patient, a partnership which is based upon mutual trust and respect. The patient is vulnerable. The patient is weak, frightened, and often hostile or angry. The patient suffers a loss of freedom. There is an inequality in power and knowledge between the physician and patient. Illness causes an assault upon self-image. The patient is exploitable. It is on the basis of trust that the patient turns to the physician with superior knowledge and power, and in trust relies fully on the physician's good offices to do the right thing. If the physician determines a program of rationing, the physician has broken this trust with the patient. The physician, in acting as a referee for society to protect scarce resources, is violating a most fundamental ethical principle in the practice of medicine, namely beneficence in the best interests of the patient.

In addition, it is hard to see that a decision in the microeconomic sphere, i.e., withholding a single treatment, diagnostic procedure, or therapeutic modality, will indeed permit a better distribution of scarce resources. No physician,

withholding an effective treatment from an individual out of the perception of scarce resources, can be assured that the resources which he freed and allegedly is protecting will be distributed in a way that will fulfill the canons of distributive justice.

Dr. Marcia Angell, the capable deputy editor of the *New England Journal of Medicine*, has written about physicians as double agents.¹¹ By this she refers to the dual role of the physicians working in some settings such as in an HMO or another managed care enterprise. In such organizations the physician is called upon to be an agent both for the patient and, at the same time, an agent for society. As an agent for society the physician is called upon, in a sense, to ration resources at the level of patient care. This refers to the so-called "restrictive gatekeeper" role that a physician is asked to play in a health maintenance organization.¹² The gatekeeper role sets up a conflict of interest for the physician between medical practice and the economic aspects of the physician's work. Requirements of the organization for a certain number of patients to be serviced in a given time by the physician may preclude expenditure of adequate time with each patient to render the needed medical care. The requirement to hold down costs for the organization by not utilizing needed laboratory and therapeutic modalities, under the guise of scarcity, precludes the physician's acting in the best interests of the patient because his or her economic well-being may be contingent upon the withholding of needed services. Withholding from one patient in a single cohort of patients in an HMO violates distributive justice, which requires that all like individuals in a given category must be treated the same, regardless of all their differences. In other words, it rations by making a judgement on a person rather than on technology.

In sum, rationing, when practiced by the physician at the bedside, limits the caregiver's ability to act in the best interests of the particular patient. It destroys the trust relationship between patient and physician. It promotes, fosters and legitimates discrimination and bias. It makes the patient a means rather than an end, in that the patient is used and manipulated for the purpose of saving certain finite material goods for the sake of other patients whose lives are considered to be of more worth. It forces the physician to act in a way which violates distributive justice.

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