Editorial

Where is the value in care?

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Submitted Aug 02, 2017. Accepted for publication Aug 04, 2017.
doi: 10.21037/apm.2017.08.07
View this article at: http://dx.doi.org/10.21037/apm.2017.08.07

In recent decades, medical science has headed in the direction of a remotely possible, albeit disillusioned utopia. However, to maintain a sustainable medical care system, we must reconsider notions of limitless progress in medicine. A controversial question in medicine is whether physicians are morally obligated to address cost. Philosophically, physicians regard themselves as advocates for each patient and attempt to do everything possible to benefit the patient (1). In this piece, I will argue that the role of a physician extends beyond just finding benefit for individual patients. It should also encompass helping patients understand value. However, part of the challenge lies in addressing our society's resistance towards priority setting in health.

We as a society have long operated our healthcare system as if it were "free", without the appreciation that our system costs more than we can afford. If all physicians provided their patients with the most beneficial treatments available, then the cost of health care would be unacceptably high (2). The philosophical question that arises is should physicians be expected to allocate resources between the patient in front of them and other hypothetical patients elsewhere who could gain more benefit if the resources were "rationed" (2). If so, it may appear ethically suspicious—as if physicians are making decisions less in favor for their individual patients and more so for collective consumer benefit. Physicians trained to do the best for individual patients may cringe at this social agency role since patients would appear to lose the undivided advocacy to which they are accustomed.

How do we go about addressing these issues? The only way out of this conundrum, as suggested by Peter J. Neumann, "*is for citizens and physicians to accept the concept and consequences of resource limits, just as they accept speed limits, zoning laws, and other self-imposed constraints in the interest of the greater good*" (3). Just as in other domains of public policy where individual and collective interests' conflict, some form of mutual solution is required. Reaching a collective solution may mean placing explicit constraints on resources available to physicians or implementing more cost-aggressive clinical practice guidelines—and relinquishing the stigma associated with considering the cost of a treatment.

Per the American College of Physicians (ACP) Ethics Manual, such guideline driven parsimonious care, as practiced now, is not the same as rationing: "*the goal of medical parsimony is to provide the care necessary for the patient's good—not to reduce resource use—although it may have the welcome side effect of preserving resources. It is this difference in intent and action that helps provide a foundation for the ethical distinction between parsimonious medicine and rationing*". The problem, however, is that this idealized notion of medical parsimony may not be so parsimonious after all, with "(minimal sufficient) care for the patient's good" frequently amounting to extravagant, even futile care.

The ACP manual asserts that while physicians have a duty to use all health-related resources in a technically appropriate and efficient manner, resource allocation decisions are "*most appropriately made at the policy level rather than entirely in the context of an individual patient-physician encounter*". Simply put, individual physicians should not have to carry the onus of discouraging single patients from costly interventions for the sole purpose of conserving societal goods (4). Instead, physicians should engage in collective actions that make societal resource allocation decisions—not merely case-by-case at the bedside. In a landmark professionalism charter, the American Board of Internal Medicine (ABIM), ACP, European Federation of Internal Medicine included a commitment to a just distribution of finite resources, emphasizing the importance of individual

physicians applying the ethical principle of justice while also meeting the needs of individual patients. The Choosing Wisely campaign is another example of a large-scale effort to identify opportunities to reduce use of low-value care in the United States (5).

While these efforts are part of a work in progress—they are not enough. They fall short of the aforementioned commitment to distributive justice. Globally, the inequalities in life expectancy between the poorest and richest countries and the individuals within those countries are vast. In the U.S., spending 18% of the national gross domestic product (about twice the average in developed nations) and still leaving a rising 16% of the population out of the system is clear evidence that the system needs a fundamental re-prioritization of values and access to health-care services (6). Unfortunately, parsimonious care may not be enough. With the costs of modern health care rising and the menu of possible interventions exploding, doctors should be required to judiciously provide these services.

The American ethical debate has long shrewdly shifted from rationing to the avoidance of waste. However, rationing is inevitable because resources are finite. To say that America does not ration health care appears deceptive: we do so implicitly and perhaps ruthlessly—by income and ability to pay, and quality of insurance. To this effect, then, is (explicit) rationing truly morally corrupt, particularly when practiced with the two-folded intent to both provide care necessary and to reduce resource use? It is certain that if we avoid explicit rationing, we will resort to implicit and perhaps unfair methods.

Regardless of whether it is rigorous priority setting, rationing, or parsimonious care—these health care decisions and guidelines have ethical implications and we must consider which values we intend to advance as a society. Questions to consider include should we spend more money on preventive measures or cures, on treatments to benefit the young or the elderly. What is the most important "outcome"? Understanding how a resource allocation aligns with our society's priorities can help direct whether it will be welcome.

At its core, gatekeeping seems unacceptable, morally corrupt: creating almost a "moral stress test" by compelling physicians to compromise the wellbeing of the patient in the office in the name of patients elsewhere. This appears to undermine the trust between doctor and patient. However, the overall consequence of neglecting to adopt explicit limits to consumption of resources by well-meaning physicians is unsustainable. Resource scarcity and unequal distribution of improvements in healthcare are simply undeniable. Addressing these limits is a tough task, but physicians have a duty to address cost and value, because it should constitute a larger ethos of distributive justice. What we must strive for is a morally tenable system that would attempt to limit costs through transparency and honesty—beyond half-hearted, romanticized notions of parsimonious care.

Cite this article as: Sajja A. Where is the value in care? Ann Palliat Med 2017;6(Suppl 2):S122-S123. doi: 10.21037/apm.2017.08.07

Acknowledgements

None.

Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

Disclaimer: The views in this article do not necessarily reflect that of my institution.

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