STRONG MEDICINE

The Ethical Rationing of Health Care

PAUL T. MENZEL

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Preface

Early in 1988, the Oregon legislature affirmed an administrative decision that the state's Medicaid program should no longer cover heart, liver, bone marrow, and pancreas transplants. Averaging more than $150,000 per procedure for a projected thirty recipients a year, these expensive remedies were deemed unaffordable, at least compared to the prenatal care for more than 1,500 women that could be funded in place of the transplants.

One of the people waiting for a liver transplant who consequently never got one was a thirty-six-year-old single mother. Her fourteen-year-old son attended the Oregon hearings. He heard the lofty ideals cited in favor of the prenatal program and the denials that anyone here was "playing God"—they were only doing what had to be done for the public good. To the son, however, the senators must have seemed like God.

Interestingly, the president of the state senate who led the fight against providing the expensive high-tech procedures was a practicing physician. "If we pay for transplants now," he said, "we will put a very small Bandaid on a very large iceberg" of people without care. His opponents called him "Doctor Death." One bitterly rejected his "abstract discussion" about saving more lives another way. The state administrator who initially proposed cutting transplant funding, though, was hardly abstract or insensitive. On her desk she kept a picture of an adorable seven-year-old boy, one of the potential recipients who died after the legislature's decision.2

This is only one of many possible cases in which rationing health care presents moral difficulties. The essential sort of dilemma raised by all rationing cases is classic: how do we treat with dignity and genuine respect the individual who gets tragically shortchanged by a policy that seems best overall? If it is economic efficiency that leads us to choose that policy, then the conflict lies
between the demands of efficiency and commitment to the individual patient. Both sides of that conflict pull hard on our moral sensitivities, so we may just want to compromise between them. Yet we want a true reconciliation, not an unstable cease-fire or some question-begging “victory” for either side.

Such a fundamental reconciliation, I will argue, is possible—not always but certainly sometimes. Cost containment does not have to be just a cliché mouthed by budget-constrained administrators, heartless legislators, or narrow-minded economists. Under the proper conditions it can represent respect for the hard trade-off preferences of patients as persons. If individual patients beforehand would have consented to certain policies of denying marginal procedures, those policies would appeal to far more than some economist’s or manager’s fascination with aggregate “efficiency.” They would appeal to respect for patients as persons who make these hard choices themselves.

How far can this line of thought carry us in decisions about scarce resources in medicine? It is largely this question that has led me to write this book of connected essays. Sometimes my conclusions endorse economic efficiency; at other times they do not. An implicit theme throughout is that we should neither blindly follow nor blindly reject considerations of economic efficiency. To avoid those two narrow channels we very much need an ethical framework for making rationing decisions. If we use our heads and think hard about what rules we really want to govern our lives, I argue that we will selectively restrict what we do to promote and preserve life and health. That, of course, will be strong medicine to swallow, but, backed up by individuals’ consent, there is nothing morally crude, cheap, or callous about it.

Chapter 1 examines several ways of looking at the health-care provider’s basic moral conflict between commitment to individual patients and the socially efficient use of resources. Individuals’ prior consent to less than maximum health security for their futures, I argue, allows the best resolution of this conflict. Chapter 2 attends to the philosophically fundamental issue beneath that argument: whether it is morally legitimate to cite persons’ presumed consent to risk to justify policies that later happen to work to their disadvantage. Chapter 3 focuses on the particular problem of putting a monetary price on life, and then Chapter 4 takes up a fascinating question about how to compute the cost of saving lives. If we extend smokers’ lives, for example, by persuading them to quit, do we have to include as a cost of our action their later “normal” expenses from living longer, such as pension support and health-care expenditures? Chapter 5 critically applies prior consent reflections to an existing model for measuring quality of life and making more efficient rationing decisions—“quality-adjusted life years.” Chapter 6 focuses on one of the most disconcerting and difficult contexts for rationing policy: imperiled newborns. And Chapter 7 proposes a way of thinking about what would be an equitably efficient level of care for the poor. Chapter 8 takes up several nasty problems exacerbated by competitive forces in the current American health economy, and Chapter 9 defends a conceptual strategy for responding to the serious threat to effective cost containment posed by malpractice suits. Chapter 10 draws together consent considerations with other ethical distinctions to argue for expanding our supply of transplantable organs with a procedure usually thought to dilute the role of consent: “routinely” taking people’s cadaver organs unless they object beforehand. Finally, Chapter 11 defends a qualified version of the threatening notion of a duty to die cheaply.

Throughout I presume that we confront a situation of scarce economical resources for health care. Some will charge that such a presumption already reflects mistaken social priorities. Daniel Callahan rightly rejects “guns versus canes” objection to health-care rationing which he sums up as follows: “if we can afford to spend more than $300 billion on national defense each year, another $25 billion on tobacco products, and $500,000 for one Super Bowl commercial, why should we entertain ... any serious discussion” of cutting back on expenditures for beneficial medical care?23

Like Callahan, I would reject this objection. His reasons are entirely adequate. (1) “The fact that worse economic villains can be found” does not justify burying our heads in the sand about how we use our valuable health-care resources. (2) “One of the prices of democracy is that people are allowed to have other needs and interests than those of health and health-care delivery,” no matter how much we may disagree with the way they get prioritized. (3) The tolerance of taxpayers is limited, so while a reduction in medical expenditures admittedly does not guarantee that the savings will be spent wisely, “an escalation of spending ... almost ensures that money will not be adequately available for other needs, including those of children.”24

Rationing exists already in the actions of insurance companies, legislatures, hospitals, physicians, and individual premium payers. The demands of efficiency are here to stay, from market competition to government regulation. We need to get on with the public business of determining how we should handle all of this ethically.

Tacoma, Wash.
March 1989

P.T.M.

NOTES
1. In the United States, health care for welfare recipients.
3. Callahan (1987), p. 126. Callahan’s context is specifically the restriction of expenditures on the elderly; mine is broader.
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