MEDICAL HUMANITIES PROGRAM MICHIGAN STATE UNIVERSITY FALL 1985

*** MEDICAL HUMANITIES PROGRAM WELCOMES VISITING PROFESSOR ***

Dr. Leonard Fleck, Ph.D. is actively involved as the first visiting professor to the MSU Medical Humanities Program. Dr. Fleck comes to us from Indiana University at South Bend, where he has been since 1976.

Dr. Fleck's predilections include an understanding of the problems of philosophy as not simply intellectual exercises for academics but rather that they arise from conflicts in social practice. He sees these conflicts as cognitive and normative in character as well as political, and the validity of philosophers' proposals is found in the adequacy of the policy solutions proposed and tested in social practice. Dr. Fleck is currently involved in teaching three courses focused on ethical issues to MSU students in the Colleges of Human, Osteopathic and Veterinary Medicine, participating in the ongoing MHP programs, continuing work on his book Pricing Human Life: Moral and Public Policy Dilemmas, and presenting papers at several local and state conferences. Dr. Fleck authored the lead article for this issue of Medical Humanities Report (below).

*** JUSTICE, RATIONING HEALTH CARE RESOURCES, AND HMO'S ***

Will strict rationing of health care resources in America be necessary in the very near future?[1-10] In this essay I examine two focal claims of the debate on rationing: First, rationing is avoidable; it is neither politically nor economically necessary. And second, the moral claim that rationing ought to be avoided.

For many, HMOs represent an institutional affirmation of these two claims. It is well documented that HMOs are effective vehicles for health care cost containment,[11] achieved by identifying and drastically reducing unnecessary medical care, without compromising quality. In this way physicians both remain true to their patient-centered ethic and escape the need for rationing.

To be sure, HMOs cannot provide to their subscribers access to every conceivable medical advance, cost what it may. Certain very expensive, rarely required medical technologies may be excluded. These exclusions are properly described as the outcome of prudent purchase decisions rather than some morally problematic form of rationing. Finally, if, with Enthoven,[12] we expand our vision beyond a single HMO and conceive a health care system dominated by competing HMOs, then that competition will yield even greater savings, which can then be used to expand the range of available health services and provide the poor with greater access to the health care system, thereby improving the welfare of all. The logic, politics, and economics of such a system seem clear and compelling. In addition, it seems to evoke moral admiration. But is that admiration really deserved?

I reject both the claims advanced earlier. There are some serious moral issues connected with HMOs. Specifically, I shall maintain that **HMOs typically represent a form of implicit or invisible rationing.** Such rationing is subtle, hidden from public scrutiny, and hence, tends to be more subversive, morally speaking, of both the physician's commitment to the welfare of his patient and society's commitment to principles of justice. Rationing itself is not inherently immoral. Rather, the issue focuses on **whether specific rationing practices are just.** That issue cannot be

meaningfully addressed, as long as rationing is carried out invisibly. Invisible rationing allows all parties (physicians, patients, and policymakers) to deny the reality of rationing, and thereby avoid painful, prolonged, public discussions of these very difficult moral issues. The result of this moral blindness is that real injustices go unremedied.

The rationing of health care resources is an inescapable feature of our health care system.[4,5,7,13] What "rationing" means here is denying access for potentially beneficial health care to some patients. The primary reason why rationing is inescapable is that resources are always scarce relative to wants and needs, and hence, choices need to be made. Rationing can be effected in many ways, including both market mechanisms and government policy mechanisms. Most people associate rationing with coercive government restrictions on resources, but this is an excessively narrow conception of rationing that hides important economic and moral realities from our view. The most common and pervasive forms of rationing in health care are carried out by physicians themselves when they determine which patients will have access to their time and services.[14] It seems unreasonable to believe that each and every patient has a potentially unlimited claim on the services of his/her physician. I concede that some wasteful and unnecessary care is now provided, but deny that eliminating all such care will obviate the need for rationing. The potential benefits our health care system can provide for patients far exceed the available resources.

Opponents of the "rationing is necessary" thesis maintain that legitimate health care cost containment goals can be achieved simply by eliminating wasteful and unnecessary care.[6,8,9] This is what HMOs are supposed to be doing. But Donabedian has called our attention to an important assumption in this claim, namely, that there is a perfectly objective, technical, **medical** way in which we can identify unnecessary (non-benefical) care.[15] But if it is the patient's welfare that is of primary concern in the health care enterprise, then it seems reasonable to consider **what patients judge as being beneficial** for themselves. Otherwise it is excessively paternalistic.

Further, physicians may effectively ration resources, but in ways that may be blatantly unjust, under the guise that they are simply making a medical judgment not to make available to their patients "unnecessary" medical care. But they are really making a **medical-moral judgment disguised as a pure medical judgment.**

In Britain, essentially moral rationing decisions get disguised as medical judgments in their renal dialysis program. [16,2] Briefly, Britain provides dialysis only to about 35% who have that need. Usually patients over age 65 are denied dialysis, as are patients with a complicating medical condition who are over age 55. But physicians do not tell patients they are being denied dialysis for either of these reasons. Instead, patients are told that their medical condition does not warrant dialysis, and nothing more can be done. Note: the British government has not identified any criteria that physicians must use in rationing dialysis, which would allow physicians to shift the blame for denial to government policy. Instead, the government simply establishes a budget. Physicians then collectively determine how those resources might best be used. What emerges are informal understandings among physicians regarding the efficiency, fairness, and relative social worth criteria that will govern whom they admit to dialysis. In short, there are many **moral values** that get incorporated into these decisions, but they are publicly presented to patients as purely **medical judgments.**

The moral circumstances of dialysis programs in Britain and American HMO's are similar in that both must live within fixed budgets, and this encourages both to engage in **invisible rationing practices,** which I contend are **prima facie unjust.** For example, under HMO cost saving guidelines, first-time uncomplicated heart attack patients may be dismissed from the hospital sooner than non-HMO patients. The justification is that the extended hospitalization provides an excessive margin of safety which benefits only a small percentage of patients who have a second heart attack. An HMO patient under those circumstances would have been discharged earlier, and might die as a result of that second heart attack because instant emergency care would not be available.

Non-HMO patients purchase at a very high cost that margin of safety. In effect, HMOs ask their clients to give up that margin because they collectively judge that it is not a prudent use of resources. However, HMOs do not usually explain to their

clients that this is part of the package that they are buying into, and **in that respect HMOs represent an invisible rationing mechanism.**

My last point is perfectly illustrated by a recent ad in The Detroit Free Press by Michigan HMO Plans. (EDITORS NOTE: See case study in this issue) The ad shows a young mother and baby; the baby required 15 weeks of hospitalization at a cost of over $94,000, and Michigan HMO Plans "paid every penny". The clear inference is that the reader may expect unlimited health care in the HMO. Certainly no reader would come away from **this** ad thinking they would be buying into a system that rationed health care.

To return to our HMO heart attack victim, he is a victim of bad luck, not of the HMO, because no one will have been guilty of practicing "bad medicine." If this individual joined the HMO knowing that he was purchasing less in the way of risk reduction because this was carefully and explicitly explained to him by the HMO, then there would be no moral problem with his extra complications. But it would be quite otherwise if the individual joined the HMO without this knowledge.

In both the British system and HMO's, cost saving practices encourage invisible rationing, which is to say they provide powerful incentives for undertreatment, which may result in serious, but hidden, injustices. For example, will HMO physicians acquiesce too readily to the wishes of terminally ill patients to discontinue aggressive therapy, perhaps claiming that they are just respecting their patient's autonomy?

Then there are cases, like the 1975 Texas burn victim Donald Cowart who vehemently refused treatment for several weeks and insisted that he be allowed to die. Therapists worked intensively with him, and eventually he acquiesced to medical treatment. He is alive today, but handicapped in several major respects. Our question is whether HMO therapists would be motivated to work so intensively to change Donald's mind, especially if a $500,000 hospital bill was anticipated, plus the costs of ongoing treatment and rehabilitation?

At present HMOs cover less than 10% of the health care consumer population. Mostly they are well educated middle class consumers who can fend for themselves. But the poor, the elderly, the chronically ill, the potentially seriously ill who can be identified ahead of time, all those who have the greatest health care needs and for whom, in the recent past, we sought to assure some kind of equality of access to the health care system, would be effectively kept out of these health care payment programs, especially as health care competition intensifies. Such a state of affairs would be terribly unjust. What we would have then is a vicious, but invisible, form of rationing, as Luft has shown.[17]

This essay should not be construed as a moral indictment of HMOs. Rather, it is a moral indictment of invisible rationing mechanisms, which will become increasingly widespread and morally problematic as pressures for health care cost containment increase. Invisible rationing did not come about accidentally. From a political and organizational perspective the virtue of invisible rationing is that it reduces group conflict by placing outside the domain of public conversation the painful moral and economic choices we must make. But it exacts a terrible price so far as moral integrity is concerned, especially with respect to justice and honesty, at both the individual and societal levels. In a democratic society justice requires that our rationing decisions be visible, explicit, howsoever painful that might be. This requires the initiation of a very broad **public conversation** regarding the relative fairness of a variety of rationing alternatives. If there is a plea implicit in this essay, it is that health professionals take a leadership role in stimulating and sustaining that public conversation. **Leonard M. Fleck, Ph.D.**(EDITOR'S NOTE: For references, please write to the author % MHP, C-201 E. Fee Hall, MSU.)

*** Work Nearly Completed On Undergraduate Pre-Medical Thematic Curriculum ***

Dr. Peter Vinten-Johansen (MHP, History) is bringing to a close his past year's work on the development of a pre-medical thematic curriculum for MSU undergraduates. The project is to develop an alternative to the traditional, one-dimensional "hard science" preparation by many undergraduate medical school applicants. A special report on his work will be featured in the **Winter 1986** issue of **Medical Humanities Report.**

*** CASE STUDY: Health Care Advertising and Truth-telling ***

Here is reproduced a newspaper advertisement which ran in the Detroit area newspapers on several recent occasions. While we do not wish to debate the ethics of the advertisement of health care generally, nor to question the quality of care delivered by HMO programs (reports indicate they deliver high quality care), we do wish to present two perspectives on the obligations of truth-telling in such advertisements. Specifically, is the message presented an accurate reflection of the nature of HMO health care business, or are important facts intentionally omitted from such advertisement, leaving the reader with an incorrect understanding of the health care coverage? In the essays below two physicians provide differing responses to this question.

Health Maintenance Organizations find themselves in an increasingly competitive market not only with each other but with standard insurance plans. The price advantage they enjoyed throughout the last ten years is disappearing. Sustaining or expanding their market share will necessitate dispelling negative images in the minds of the consumers who will consider a change in coverage this year. It is no longer an industry secret that HMO's have been successful largely due to their ability to control access to high tech medicine. Fears that these controls may result in "needed" services not being provided due to concerns for cost have caused many consumers to pass on HMO options.

This advertisement seeks to remind us that health care can become very expensive very suddenly. For the young families that are prime targets for HMO marketing, there is an almost universal fear of adverse pregnancy outcome. A healthy, happy mother and child reassure us that this HMO can provide us with a healthy baby through truly miraculous technology while protecting us from the catastrophic effects of trying to pay for this care. When the benefits are clear this HMO will spare no expense to assist us. The concern remains, however, for all of us, that as our health care system becomes more cost-conscious, we'll be forced to overtly decide that saving a life is too expensive. **James Hudson, M.D., Director of Clinical Services, Dept. of Family Practice, MSU.**

We solicited a commentary from the medical director of the HMO responsible for the above advertisement but received no reply. Had the director responded, I suspect he/she would have raised several of the issues noted by Dr. Hudson. For instance, letters to the editor have appeared in Detroit newspapers over the past year suggesting that patients seeking **private, fee-for-service physicians** will get decisions aimed first and foremost at **benefitting the patient**; patients enrolling in an **HMO** will get decisions aimed first and foremost at **controlling costs.** In this climate, the HMO may well have decided that it was necessary to counter the erroneous impression that HMO's **never** serve the interest of the acutely ill patient and **never** commit major resources to saving lives. Assuming that advertising in organized medical groups is not in itself ethically inappropriate (a point needing a debate of its own), and that the facts are not misrepressented, this seems a justifiable route to take.

Ultimately, however, I would charge that this approach is both ethically questionable and self-defeating. **An HMO physician faces an unavoidable conflict of interest.** She can serve the patient according to the patient's best interests and wishes; **or** she can conserve the limited financial resources of the HMO. In many cases of routine medical problems, she can do both fairly easily; but the cases that are most upsetting to physician and patient alike are those in which she cannot do both at once. **The only ethically sound resolution of such a conflict is full disclosure.** The patient

must know explicitly when a medical recommendation is being made solely for the patient's benefit and when cost-containment factors are also being considered. I think it fair to assume that most patients enrolling in HMO's do not read all the fine print in the contract. It takes an extended education process to alert patients to how the HMO works and to instill in them an awareness of what questions to ask when they wonder the basis on which the doctor is recommending care.

By creating an impression that HMO's desire only to spend money to save babies, and by leaving out any mention of cost effectiveness or cost restrictions, this ad retards this necessary education process. It increases the chance that patients will enroll in the HMO with the wrong expectations and then will feel unfairly treated later when they become aware that cost factors are entering into their physicians' decisions. **Howard Brody, M.D., Ph.D., Dept. of Family Practice/Medical Humanities Program.**

*** HONORS COLLEGE/ARTS & LETTERS ***

Announcing a course in: **"Perspectives in Philosophy: Medicine and Illness" (AL 391 H-3 credits).** Instructor will be Howard Brody, M. D., Ph.D., Assoc. Professor of Family Practice, Philosophy and Medical Humanities Program and other members of the Medical Humanities Program. No prerequisite. Students with an interest in medical and health care issues, or interested in philosophy and its application to practical problems are invited to participate. For information phone 355-7550.

COURSE CONTENT: This seminar will address philosophical issues in medicine and health care, looking both at a philosophical understanding of the nature of illness and an ethical analysis of the relationship between physician and patient. The first five weeks will be devoted to an analysis of the concept of an illness showing how scientific facts and human values both play a role in understanding what illness is. The practical implications of precise definition for medical practice will also be addressed. The second five weeks will be devoted to an analysis of the doctor-patient relationship, with a focus on patient participation in medical decisions. The philosophical ideal of providing patient participation through informed consent will be contrasted with the practical and historical difficulties in medicine of achieving this sort of relationship between physician and patient.

*** MEDICAL HUMANITIES GOES TO ENGLAND ***

A special overseas study program in ethics and history sponsored by the Medical Humanities Program at MSU will be conducted from July 6 to August 8 in **London, England.** The core of the program is two seminars which present an ethical analysis of the relationship between physician and patient (Philosophy 340, Moral Problems in Medicine) and a comparative, historical analysis of health care in British and American contexts (History 409, History of Medicine). Because of the unique interdisciplinary content of these two courses, MSU students who have already received credit for these courses on campus may take either or both courses again by enrolling in Philosophy 490 and History 495 or 898. Independent study credits and other history courses are also available through this program.

Student costs cover private room, two meals per day, tuition for 8 credits, overseas administration fees, class activity fee, at least one theatre production and all field experiences. For 25 students the cost per student will be $1766; above 25, the fee will decrease proportionally. Class sizes are limited and admission will be granted on a first come basis. The program costs do not include lunch, daily transportation in London, round trip transportation to England or spending money.

For more information contact the instructors, Howard Brody, M.D., Ph.D. and/or Peter Vinten-Johansen, Ph.D., Medical Humanities Program, MSU, C-201 East Fee Hall, East Lansing, MI 48824, (517)355-7550.

*** LITERATURE REVIEW ***

Review of "AIDS: The Emerging Ethical Dilemmas", Hastings Center Report Special Supplement, August 1985.

The Hastings Center Report Special Supplement on AIDS consists of an introduction by Arnold Relman and seven individual articles: AIDS: The Challenge to Science and Medicine (Krim); Screening Blood: Public Health and Medical Uncertainty (Levine and Bayer); The Epidemiological Investigation of AIDS (Mayer); Clinical Care and Research in AIDS (Volberding and Abrams); AIDS and the Threat to Public Health (Silverman and Silverman); AIDS: Public Policy and Biomedical Research (Panen); and Public Education on AIDS: Not only the Media's Responsibility (Check).

As these titles suggest, a broad range of issues are discussed within the supplement, and each individual article provides an informative discussion of the particular issues it addressess. Taken as a whole, the articles help define the ethical problems posed by the AIDS epidemic both by carefully articulating the ethical issues and, just as important, by distinguishing empirical questions that have relatively secure answers from those that do not.

Against the public hysteria about AIDS, Krim contends that "in order to be infected, [the AIDS virus] must be virtually injected into the blood stream and then encounter the cells on which it can multiply" (p.4). She goes on to note that there are no known cases of transmission through casual contact, including among family members living in close contact with AIDS patients and among health care professionals who treat such patients. This latter point is confirmed by Volberding and Adams, who have considerable first-hand experience treating AIDS patients (and who suggest, incidentally, that health care professionals have a duty to treat the sick even where this does involve personal risk). The authors agree in general that AIDS can be contracted only through sexual contact, shared syringes, or transfusions of contaminated blood, and conclude that public education, epidemiological studies, and screening donated blood (rather than extreme measures such as quarantine) are the most ethically defensible and effective means of combating AIDS.

Each of these solutions raises its own problems, however, which receive special attention from Levine and Bayer, Silverman and Silverman, and Mayer. Using public monies to instruct individuals, especially gays, on "safe sex" prompts significant protests from certain quarters, as does providing drug users with free syringes. Careful, methodologically defensible epidemiological studies threaten the confidentiality and thus the welfare of research subjects due to the current and predicted responses of employers and insurers. Finally, screening the blood supply by use of the "ELISA" test must trade-off reducing contamination by minimizing false negatives on the one hand with protecting the welfare of uninfected individuals by minimizing false positives on the other hand, and significant uncertainties about the ELISA test that go beyond the false positive rate versus false negative rate trade-off (notably, whether an asymptomatic individual may be in the early stages of infection such that no antibodies to the AIDS virus exist for the ELISA test to detect) further cloud the issue of blood screening.

In summary, the collection of articles that comprise the special Hastings Center Report supplement undermines an empirical basis for the reactionary, finger-pointing, punitive response towards victims of the AIDS epidemic that characterizes what the editors of The New Republic (October 14, 1985) dub "Acute Fear Regarding AIDS", or AFRAIDS. The collection identifies those areas where genuine uncertainty exists and where hard and controversial choices have to be made. One may hope that the collection will help raise the level of discussion about the AIDS epidemic. **Ken Howe, Ph.D.**

*** NOTABLE NOTES ***

The **Medical Humanities Program** at MSU has received a special grant from the **Nutritional Division of Mead-Johnson** to produce and distribute a **monthly newsletter** to the physicians and hospital nurses in the tri-county area on **ethical issues in medical care,** highlighting recent articles and judicial decisions in the literature. The publication is entitled **BIOETHICS UPDATE** and currently is sent to over 1,100 health care professionals.

Bruce Miller's (Philosophy) essay **"Autonomy and Proxy Consent"** was published in V. Melnick and N. Dubler (eds) Alzheimer's Dementia: Dilemmas in Clinical Research Human Press, 1985.

Howard Brody's (MHP) essay **"Placebo Effect: An Examination of Grunbaum's Definitions"** appeared as a chapter in Placebo: Theory, Research and Mechanisms, L. White, B. Turski, G. Schwarz, (eds) Builford Press, 1985.

Tom Tomlinson (MHP) is special guest editor of Theoretical Medicine focusing on **"The Physician's Influence on Patient Decision-Making: Persuasion, Manipulation or Coercion?** The issue is expected to be published in Spring 1986.

Tom Tomlinson's proposal to the MSU school of Nursing curriculum faculty resulted in their adding a **new course requirement to the nursing school curriculum: Philosophy 340: Moral Problems in Medicine.** The other course, Philosophy 344: Nursing Ethics will continue to be strongly recommended and carries a Phil 340 prerequisite. This is a result of the work done with the MHP NEH grant of 1981-1984. The requirement takes effect in 1988.

Tom Tomlinson coauthored with three members of the COM Department of Family Medicine at MSU a paper on **"Teaching Medical Students the Effects of Values and Stereotyping on the Doctor/Patient Relationship"** forthcoming in fall 1985 in the Social Sciences and Medicine journal.

Ken Howe presented a paper **"Summary of the Evaluation of the Ethics in the Core Curriculum Project"** at the 24th Annual Conference of Research in Medical Education, on October 30, 1985, in Washington, D.C. The paper on which the presentation was based was co-authored with Tom Tomlinson, Ph.D. and Martha Jones, M.A. and was published in the conference proceedings.

Martin Benjamin (Philosophy) has been extraordinarily busy of late, compiling the following: with **Joy Curtis** an article **"Virtue and the Practice of Nursing"** in Virtue and Medicine, a volume in the Philosophy & Medicine series published by D. Reidel, E. Shelp (editor); an essay **"I'm the Teacher"** in Teaching Philosophy; Awarded Michigan Council for the Humanities grant with Professor Richard Peterson **"The Role of Humanities in Higher Education"**, bringing Professor Richard Bernstein (Haverford, PA) to MSU for a special lecture on Nov. 13; presented a talk to the Michigan Senior Advocates Council on the **"Philosophical Foundations of the Right to Refuse Medical Care"**; presented two public lectures in September at Miami University, **"Social Policy and Compromise on Abortion"** and **"Compromise and Moral Integrity"**; with **Joy Curtis** has published an essay on nursing ethics in the Health and Medical Annual (1986) of the Encyclopedia Britannica and completed the second edition of Ethics in Nursing due out in Spring, 1986; with **Bill Weil**, M. D. is editing a new book on Ethical Issues in Perinatal Medicine to be published by Blackwell Scientific, Massachusetts.

***** CALENDAR *****

Nov. 6-8 Martin Benjamin participated in a conference on **"Moral Theory and Moral Judgment."** at Rice University, Houston, Texas.

Nov. 14 Howard Brody, Tom Tomlinson, Ken Howe, Len Fleck, Dan Bronstein, Dave Rovner and Sumer Verma. **"Medical Ethics: the Physician as Gatekeeper"**, MSMS Meeting, Dearborn Hyatt Regency.

Nov. 15-16 Tom Tomlinson, Bruce Miller, Ken Howe, "Making Babies-Can We Do It Better? Reproductive Alternatives." A symposium for the professions and the public. **"An Emerging Code of Ethics"**, Ken Howe. **"The Role of the Mental Health Professional"**, Tom Tomlinson. **"Ethical Issues for the Legal Professional"**, Bruce Miller. Wayne State School of Medicine, Detroit.

Nov. 18 Martin Benjamin, **"Ethical Issues in Medical Social Work."** Sparrow Hospital, Lansing, lecture-workshop. Sponsored by Dept. of Social Work at Sparrow Hospital.

Nov. 25 Howard Brody, **"Ethical Issues in Palliative Care,"** Ingham County Chapter American Cancer Society, Kellogg Center, MSU.

Nov. 25 Tom Tomlinson, **"Moral Issues in Designating a Patient NO CODE,"** Hurley Hospital, Flint, Michigan.

Dec. 2-3 Howard Brody. Two faculty seminars on teaching medical ethics, College of Osteopathic Medicine, Ohio University, Athens, Ohio.

Feb. 4 Howard Brody. **"Ethical Issues in Public Health"**, Michigan Department of Public Health Conference, Lansing.

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