

experiment in transparent and accountable priority setting in health care.

Conclusion

The debate about priority setting in health care in Scandinavian countries has not been changed—as if by a magic wand—by the fact that various official committees have proclaimed that simple solutions are theoretically flawed and practically impossible to implement. Health economists still extol cost utility analysis as the instrument to end the woes of health-care administrators and politicians, claiming that the treatment of the most serious diseases should receive the highest priority.

This is not surprising. Talking about priorities and, by implication, rationing of healthcare resources is difficult. It means accepting that some citizens will not get

treatment that is potentially beneficial to them. But it is, nevertheless, a public debate which every country with a public healthcare system will have to conduct. Otherwise rationing will take place without public input and control.

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Fairness as a problem of love and the heart: a clinician's perspective on priority setting

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From the clinician's perspective cost effectiveness analyses and priority setting exercises are highly abstract compared with the experience of taking care of patients. We encounter the ill person directly, convey the priorities, and deal with the impact on patient and family. For those of us who take direct care of patients, priorities and rationing—at their deepest level—create what is ultimately a problem of love and the heart.

To be truly excellent clinicians we must love our patients, and that makes us want to do as much as possible for each person's health. To be truly responsible citizens, however, we must want to do as much as possible for the population's health within the available resources. This commitment to fairness requires us to embrace priorities and rationing. In the United States we call love for patients fidelity and seeking fairness for the population stewardship. Since priority setting and rationing inevitably deprive identifiable people of potential benefits, the question for practising clinicians is whether they can embrace fidelity and stewardship at the same time in their dealings with patients.

I believe the answer is yes and disagree with Kassirer's recent argument that doctors should not adopt a population based ethic.¹ Embracing both fidelity and stewardship, however, poses at least as much

Summary points

Because they care for the patients who present to them, some clinicians think that their only duty is to those patients (fidelity) and eschew stewardship for society's resources

In the United States this has led to an adversarial approach, splitting fidelity and stewardship

Patients understand the need for priority setting if the case is made simply and honestly

Clinicians and managers must share a common language with the public and be explicit about the limits of care

challenge to the heart as to the mind. Correspondingly, the four step analysis that follows emphasises passion as well as logic (box).

Clinician support for rationing

Political leadership is a key factor in helping the public to understand the need for priorities and rationing. In the United States Dr John Kitzhaber, now the governor of Oregon, was crucial in helping Oregon carry out its justifiably famous priority setting process. But clinicians are at least as important as political leaders in shaping public attitudes. Every clinical appointment, whether with a general practitioner, a specialist, or a district nurse, is an opportunity for patients to learn about priorities and rationing and for clinicians to learn what these policies mean in their patients' lives.

Combining passion and logic

- Priority setting and rationing will not work without the support of clinicians
- Ethical clinicians can (and should) accept fair priority and rationing policies
- Implicit rationing is not a viable strategy for the 21st century
- Societies must deliberate about how to make priorities and rationing work best

When we clinicians support policies about priorities and rationing we can be educators and salespeople. But when we oppose the policies we can undermine them and foment resistance. We may not always be wise in our judgments, but no national approach to priorities and rationing will work without our strong support.

Fair priority and rationing policies

On the clinical front line we ask ourselves: Are these priorities ethical for the patient who is in front of me now? How can I discuss the policy openly and honestly? To be able to practise in a health system that sets priorities and rations we need a professional ethic that can give us guidance for these questions.

The United States provides a useful test case here. It probably has the world's strongest culture based on individual rights. It certainly has the least inclusive healthcare system among developed nations. However, an experience at the health maintenance organisation I have practised with for 23 years taught me that even in a culture as individualistic as that in the United States clinicians and patients can understand and accept priorities and rationing if the rationale is clear and readily understandable.

Six years ago my colleagues in mental health—with the advice of the population we serve—concluded that we needed to offer more outpatient care to our sickest patients. Although we were not given any new money to do this, we were allowed to reorder our service's priorities. We concluded that we could increase services to our sickest patients only by requiring a new payment from the less sick after their eighth outpatient appointment.²

After we made this change my colleagues and I had innumerable conversations with our patients about the new policy. With patients who were eligible for more services we said something like: "The bad news, as we know, is that you have the misfortune of suffering from a severe illness [schizophrenia or a similar severe ailment]. The good news is that we now have more outpatient treatment resources available to us." With our healthier patients, who now had to make a payment after eight outpatient sessions, we had the opposite conversation: "The good news is that even though you have some significant problems you do not have a severe illness like schizophrenia or manic depression. The bad news is that after eight sessions there is now a new fee." No one was happy about paying the new fee. But virtually no one thought that the policy was unfair.

We did not explain the priority system by presenting cost effectiveness analyses or complex ethical arguments. We used simple, commonsense terms that made fundamental human sense. The policy had the same kind of obvious reasonableness as when we interrupt an appointment with one patient to attend to an emergency with another.

To support priorities and rationing, clinicians must be able to see the policy rationale with the same emotional clarity and immediacy with which we see our individual patient's needs. To explain the policy we must be able to put it in simple terms that do not presuppose a university degree in economics or philosophy.

We clinicians can love our patients and the population they are part of only when we can comprehend



VICKI WEHRMANS

the needs of both in emotional as well as clinical and epidemiological terms. Being able to do this depends partly on whether our clinical education and professional ethics include public health as well as individual care values.³ But it depends at least as much on a political process that addresses priorities and rationing in the same caretaking spirit that the best clinicians apply in the care of their patients. This requires a form of political leadership that has been comparatively rare to date.

Implicit rationing is not viable

Although I strongly support openness about priorities and rationing, there are two strong arguments for implementing them implicitly—that is, not discussing them in the clinician-patient relationship.⁴

Firstly, withholding benefits is socially divisive. Being explicit about priorities and rationing requires acknowledging that there are good things that a healthcare system could do for identifiable people that it will not do.⁵ In the United Kingdom explicitness leads to shroud waving. In the United States it leads to lawsuits. Neither is pleasant for policymakers.

Secondly, patients (and clinicians) prefer to see clinicians as giving, not withholding. We clinicians chose our careers to care for patients, not to implement priorities. And sick patients need to see their clinicians as devoted caretakers, not as coldly utilitarian cost effectiveness analysts.

Since the kinds of expectations patients in the United States have about disclosure and active participation in treatment planning almost certainly predict the worldwide trend for the next century, the United States can provide useful lessons about implicit rationing. Fifty years ago the phrase "doctor's orders" was used with great seriousness. What the doctor said, the patient did. Now we use the term only in quotation marks, as a quaint and humorous relic. Patients in the United States expect to be told the medical facts about their conditions and the policy facts about what the healthcare system will and will not do for them.

Personal computers and the internet drive the nails into the coffin of implicit rationing. The internet gives

patients immediate access to worldwide information about healthcare policies and choices. This means that within a short time implicit rationing will be impossible. Explicitness is the inevitable direction for priorities and rationing. Clinicians and political leaders will be wise to shape the process rather than waiting to have it forced on them. I believe that this is the best climate for practice. But even if it is not it is nevertheless the direction all societies will be moving in.

How to make rationing work

Setting healthcare priorities and rationing is an unavoidably messy, conflict ridden, ultimately tragic social process.⁵ Different societies will conduct the process in accord with their own political culture. But whatever approach a society chooses, it is not likely to succeed without some form of deliberation among the concerned stakeholders.⁶

We in the United States have conducted a social experiment in which we tried to shape health care without explicit priorities or deliberative process. Motivated by the reluctance of the medical profession to accept the need for priorities and rationing, and the conviction held by influential physicians that ethical clinicians must advocate any intervention of possible benefit to their patients,⁷ the United States has experimented with what is best described as an adversarial system of priority setting. We have asked our insurance companies—the United States version of district health authorities—to set priorities for us.

Here is how the adversarial form of managed care works. Physicians recommend services for their patients. Insurers decide whether the service will be covered. Physicians act as pure advocates. Insurers make decisions in the light of the available funds. Physicians hold to fidelity. Insurers take care of stewardship.

The United States's experience shows that this adversarial approach results in a high degree of public distrust of the system itself.⁸ How could it be otherwise? Since patients largely trust their clinicians then of course they distrust a system in which their clinicians petition the insurer for coverage and get turned down. Whether or not the insurance decisions and policies can be justified by ethical reasoning and cost effectiveness analyses, splitting fidelity from stewardship and placing them in opposing camps invites patients to see their clinicians as impotent and the system as unfair. A system that splits fidelity from stewardship simply doesn't work.

The American system commits itself to providing medically necessary treatment. We have skirted, however, the fundamental question of how to define medical necessity. Is any intervention that physicians believe will benefit their patients medically necessary? Many doctors define the term this way. Does medically necessary mean worthwhile in the light of the available resources and needs of the population? Many insurers define the term more like this. Except in the state of Oregon, however, the United States has had no open debate on what standards we will use for necessity in medical practice. In the absence of debate, the public, sensing the wide disparity among definitions and realising that unacknowledged rationing decisions are being made, has responded with anger, cynicism, and distrust.

To create the necessary dialogue about priorities and rationing, societies must learn how to do what a

popular book on corporate management calls “replacing the tyranny of the OR with the genius of the AND.”⁹ American clinicians call the managers who concern themselves with budgets and priorities bean counters. A British physician told me that management is the syphilis of the NHS. I am sure that clinicians from other countries can add choice terms in other languages. And I am equally sure that managers have just as many disparaging terms for clinicians.

Until clinicians, managers, and other stakeholders find a common language for deliberating together about priorities and rationing, we cannot expect the public to understand and accept limit setting policies.¹⁰

Conclusions

I believe that our path towards societal resolution of the conflicts between individual and community needs and desires demands more of the heart than the brain. Clinicians are inextricably in the midst of these conflicts. Our distress with priorities and rationing must be understood as crucial data on a social process, not as resistance to be overcome. Patients and society need clinicians to love both the individual and the collective and need to join with them in deliberating about solutions to this painful but ultimately unavoidable conflict of the heart. The key requirements are an expanded healthcare ethic¹¹ and courageous political leadership.

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Corrections

Obituary

In the obituary of Dr Andrew Swan (22 August, p 545) his widow should have been named as Philippa, not Patricia.

Lessons from New York's tuberculosis epidemic

In the editorial by Richard Coker (5 September, p 616) the third sentence of the fifth paragraph should have read: “The success of New York's public health measures was highlighted by the fall in the number of children developing tuberculosis (from 146 cases in 1990 to 45 in 1997) and the fall in the total number of cases of multidrug resistant tuberculosis, such that in 1997 there were only 56 cases of multidrug resistant tuberculosis (from a peak of 441 in 1992).”

Book review

Irvine Loudon and John Horder were editors (not authors) of *General Practice Under the National Health Service* (reviewed 1 August, p 357). The book had a third editor (omitted in the review), Charles Webster.