Response

Priorities in health care: reply to Lewis and Charny

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Author's abstract

This paper is a reply to proposals to base priority health-care decisions on public opinion surveys. Whilst it is recognised that current practice is less than satisfactory, it is argued here that basing health-care priorities on societal attitudes in this way is not a solution and does not provide a satisfactory basis for bringing democracy to the health service.

Lewis and Charny address one of the fundamental issues concerning options for the allocation of health resources. Medical technology is expanding and improving in an atmosphere of increasing reluctance to finance escalating health costs. It is therefore inevitable that acute ethical problems will arise, and it is important that responsibility for decision-making over health priorities is justly distributed.

In any discussion of health priorities two distinct but related objectives need to be addressed. These can be described as general and specific objectives. The former reflects a need to determine priorities as a matter of necessity: no matter how great is the health budget – even if it surpasses defence expenditure – there will always be an imperative to make priority decisions. Not everyone can or should have everything at the same time, and health professionals have, by virtue of their expertise, an obligation to prioritise. The specific objective, however, is to assign priorities *within* the framework of current allocation of resources. In Britain this is determined by the Government and the electorate who, in varying degrees, share in responsibility for decisions concerning health. If cut-backs in health-care lead to choices between life and death the ethical responsibility is spread wider than the physician who has to implement such decisions. Although physicians and others concerned with the allocation of resources have an obligation to determine priorities in the general sense, they should be wary of attempts to make them shoulder all responsibility for priorities in the specific sense.

Key words

It is difficult to maintain a clear distinction between these two priority objectives and it is not clear whether Lewis and Charny adequately address the issue. They rightly regard selection as inescapable and recognise that physicians should not carry full responsibility for decisions which are primarily societal, but the overall discussion assumes the adequacy of a utilitarian framework for such decision-making which is suggestive of prioritising in the more specific sense.

Recognising the need to distribute responsibility for priority decisions Lewis and Charny present the Cardiff Health Survey as a prototype of how societal attitudes towards the value of life can be transmitted into therapeutic decision-making. In this particular case the survey was designed to elicit priorities in relation to age, where the choice was between two people 'alike in all respects other than their ages'. Among other things the survey revealed a 'strong body of opinion that there are cases where an older living individual should be saved in preference to an otherwise identical younger living individual'. On the basis of the survey Lewis and Charny go on to recommend a series of similar surveys which could include 'sex, social class, marital status, etc'. These could be used as a system of maps whereby 'decision-making in the health service could begin to reflect the values of the members of society as a whole...to bring true democracy into the health service'.

Taking the accuracy of the Cardiff Health Survey for granted, along with the relevance of its questions, interpretation of responses and sophistication of the respondents, there still remain several disturbing questions. To what extent should societal attitudes determine medical priorities? Can the value of life be adequately determined by the sounding of public attitudes? Can appropriate mechanisms be devised for society freely to articulate its priorities? If so, to what extent would these mechanisms reflect the *true* objectives of society? These questions have to be addressed before dealing with the question whether Lewis and Charny have outlined the best mechanism for eliciting societal attitudes.

According to Lewis and Charny the interviewees displayed a level of sophistication when answering questions relating to prioritising in terms of age. Maybe the same level of sophistication can be found

with regard to sex, social class, and marital status, which are also cited as being relevant to a 'multidimensional' attempt to bring democracy to the health service. But why limit these categories? Why not elicit choices between 'two people alike in all respects, other than...membership of trade unions/sexual preferences/ethnic background/Irish Republican beliefs, or any other political or religious affiliations? (That strong attitudes do exist in relation to these factors can be seen in the distribution of kidney donor cards which read 'In the event of my death I do not want to donate any organs to a Tory'. Such cards appeared a couple of years ago in some left-wing bookshops as a form of political protest.) If the objective is true democracy then strong arguments are required to separate these categories from age, social class, and marital status.

There are also problems in basing health priorities on societal attitudes which are bound up with the wider problem of how the parameters of attitude formation are determined. Current discussions concerning therapy options for AIDS victims have been irresponsibly presented in the popular media in the context of an ill-informed and bigoted mixture of pseudo-medical speculation, moralising and Biblical prophecy, against a background of hysterical homophobia. How much weight should be attached to attitudes formed in this atmosphere?

There is also the problem that social distance affects priorities. One might indicate a preference for older patients over infants in the context of an interview, but when relatives or near ones are, or have been, affected, then priorities might be revised.

The problem of bringing true democracy to the health service is inseparable from bringing true democracy to society in general. Its precondition is informed discussion, rational argument and avoidance of prejudice – which is not derived from opinion samples.

Lewis and Charny rightly point out that the present system of allocating priorities involves a 'haphazard aggregation of maverick decisions' where society is inadequately represented. And they are correct to stress that doctors should not bear the full burden of priority decisions. But it is not clear that attitudes solicited from 'society at large' can provide the answer. No matter how accurate public opinion sampling may be, it is neither a more democratic nor a more efficient way of spreading responsibility than a system of random choice.

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