

Resource allocation: idealism, realism, pragmatism, openness

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Author's abstract

Lewis and Charny have come under siege for suggesting remote questioning to decide appropriate medical care. While the criticisms are theoretically valid, the idea is so important practically that Lewis and Charny should be supported and their approach investigated as a way of making medical treatment at least more open and possibly more fair.

Lewis and Charny (1) have started a debate that is one of the most important ethical considerations of the moment: that surveys of public opinion – remote questioning – should be a guide to appropriate medical care. It is, as we struggle to implement changes demanded by the reforms of the National Health Service, topical. In its broader applications it is applicable to the whole world (2). Whitaker (3) takes Lewis and Charny to task for not being realistic; Lamb (4) doubts their approach is democratic. Lewis (5) seems to answer these criticisms effectively, while Lamb (6) searches for idealism free from the constraints of prevailing socio-economic considerations.

But where does it get us? The hospital in which I am based decided last Christmas that it could not afford to reopen two surgical wards after the customary break; we were unable to treat patients whom we all agreed should be treated, never mind those over whom we might have disagreed. Meanwhile there were two medical stories on the front page of the Christmas Eve edition of a local evening newspaper. 'Race to save heart baby' (7) was about a six-day-old baby born with a hypoplastic left ventricle and awaiting a suitable donor for transplant, though the paper seemed to ignore the irony that this required a dead baby. 'Comfort and joy as tiny triplets come home at last' (8) made no mention that 'many weeks in the special care baby unit' consumes NHS resources, and that this expenditure is increasing as *in vitro* fertilisation becomes more common (9).

As I have written informally elsewhere (10), there are some squeaky wheels for which oil might not be the

best answer; it might be better if they are stopped from turning. This, surely, is what is at the heart of Lewis and Charny's question, and it cannot be dismissed by saying, as Whitaker does, that lack of funding is not a real consideration, or as Lamb does that Lewis and Charny's question is not democratic. Discussions of democracy could quickly become a semantic argument: surely it is less important exactly how members of society become more involved in decisions of health care than that they do become involved?

The Oregon State legislature's attempt to involve society is having effects in the real world (11,12,13). An index figure is derived from cost, benefit, and public opinion, this last sought by detailed telephone interviewing of a sample of the electorate. It is no more immune from Whitaker's criticism of social distance (see below) or Lamb's of whether it is democracy. It is not perfect. But it sets some sort of guidelines, and these are essential: 'vigorous management of scarce health-care resources is as unavoidable as it is necessary' (14); "Medical need", in the context of constant technological innovation, is inherently elastic and open-ended; as a guide to what is actually good for patients or what doctors are obliged to give them, it is highly unreliable' (15).

Whitaker places much emphasis on the concept of social distance: that a hypothetical decision is different from the personal one demanded when a loved one is actually ill. This is undeniably true, but while Whitaker uses this truism to invalidate Lewis and Charny, the alternative view that I take is that having a loved one in this situation precludes one from being able to make a societally rational decision. Consider hijack victims: the relatives want them back home no matter what but governments must think more circumspectly. The financial cost here may be nothing; it will often be less expensive (and certainly less strain on the victims) to bow to the demands right away. But for hijacks, and less spectacularly but no less importantly for health care, those involved are necessarily limited in their rationality.

Lewis counters Whitaker by distinguishing general health care from that of special priority, using the example of the Cystic Fibrosis Trust. This is fine, but the sum available for health care from charitable sources is also finite, and not always well directed:

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there was a report (16) of 'captains of industry' funding a £2 million plan for a flying squad to carry artificial hearts to seriously ill patients (other captains of industry?).

On one matter Whitaker was correct: we should be researching the principles people use in considering the right of an individual to treatment. I do not believe that, in British medicine as I have experienced it, 'right to treatment' is considered; if the patient appears, then he or she is treated to the best of the doctor's ability within the available resources, which is not the same as saying he or she is treated regardless of likely outcome.

The British public are probably not as well informed about medical matters as the Americans, but that does not stop questions about what is perceived to be important in health care. To some extent one could argue that people should get what they want; if the vote is for artificial hearts for all then who are doctors, ethicists and philosophers to say differently – despite the awkward conundrum of what the result would be of a referendum about capital punishment.

If nothing else, surveys and suggestions similar to Lewis and Charny's and the Oregon experiment will bring discussions of appropriate medical care into the public mind. It cannot be absolutely true, but an overt system is likely to be better than a covert one; unless the rules prove too unpalatable to those unable to accept the certainty of their own mortality.

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