

Selection of patients

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Author's abstract

The author joins the discussion on selection of patients in the face of life-saving resources initiated in the Journal by Parsons and Lock, Mooney and the editorial in the December 1980 issue. In this article several selection systems are discussed. The author is in favour of a 'criteria-system'. The criteria for such a system are elaborated. On the basis of a sequence of values a sequence of criteria is proposed. Attention is also given to the procedural aspects.

Introduction

Scarcity of medical facilities is of a structural nature. There always exists a tension between demands (or needs) and facilities available. Selection of patients is unavoidable, being more or less painful according to the health care-budget. When resources are increasingly restricted because of economic developments, the problem of bridging the gap between demands and facilities becomes more and more difficult. Selection especially causes problems in the case of very expensive, advanced methods of treatment such as kidney dialysis and transplantation, heart surgery and chronic artificial respiration. No clear distinction can be made between conventional and advanced treatments, but nevertheless in the practice of medicine the problems connected with selecting patients for these latter treatments can be (literally) breath-taking. The question arises which norms and procedures should be used in this selection. In answering this question health law and health ethics are involved.

In this article I shall concentrate on the advanced and expensive methods of treatment. But it must be recognised that there is a strong connection between the selection of patients for advanced treatments and health care in general. As the selection-problem arises from lack of resources, the scale of the problem depends on the use of resources available for health care. Selection of patients for advanced medical treatment is affected by an efficient use of the health care-budget and the avoidance of waste, the effectiveness of the health care-delivery-system and management, the prevention of unnecessary diagnostic and therapeutic procedures and of unnecessary stays in hospitals, the avoidance of unnecessary demands of the public upon the health care-facilities etc. Another important point is

that the use of advanced methods must be weighed carefully against less-expensive methods to prevent an unargued expansion of these advanced procedures. One cannot avoid the impression that because of hobbyism, prestige and other personal reasons this weighing is not always done. Also the limits of medicine are to be discussed in this connection. Facilities and manpower are sometimes tied up by the continuation of advanced treatments which have become medically pointless.

A very important problem regarding patient selection is the setting of priorities on the macro-level and within the health care-system itself. Fixing macro- and meso-priorities has a direct effect on the micro-level. The influence of such priorities is not elaborated in this article but is accepted as a datum.

Selection systems

Various systems for selection at the micro-level can be distinguished:

a) THE CHRONOLOGICAL SYSTEM

At first sight this system appears to be objective, but looking more closely it is evident that chronological order can be influenced by many factors, for instance relations between doctors, the speed with which doctors refer patients to hospitals, the distance to the hospital, transport facilities etc. Moreover, it is very difficult to determine what the chronological order actually is. Another argument against the chronological system is that the patient's medical condition is not taken into account. From the point of view of health law this is unsatisfactory, because injustice can arise not only from treating the equal unequally, but also from treating the unequal equally.

b) THE LOTTERY-SYSTEM

This system has similar disadvantages to the chronological system. Who is included in the lottery at what time? Blind systems cause a lot of injustice.

c) THE WAITING LIST-SYSTEM

In this system patients are selected on the basis of medical criteria, while the gravity of the case is taken into account to a certain degree. The waiting list-system has some aspects of the chronological system. Less severe patients are on the list and they

will be treated, but one's place in the sequence is partially influenced by the medical condition of other patients. As far as the gravity of the cases is considered the waiting list-system is more satisfactory than the two systems mentioned above, but it has the disadvantage that at a given moment the waiting list can have expanded to such an extent that having one's name on the list has little effect on the chances of treatment in the foreseeable future. Waiting lists only postpone the tension between demand and supply.

d) THE CRITERIA-SYSTEM

In the criteria system values and norms guide the selection of patients. The decisions are recognised to be human ones. Man has to take responsibility for the selection of human beings, which of course conflicts with the principle that no one has the right to decide whether another shall live or die. Nevertheless in medical practice a choice has to be made and in fulfilling this task justice has to be done. In a criteria-system it is recognised, that the selection of patients is unavoidable and that the 'solution' must result from human judgment on the basis of values and norms. For this reason the criteria-system is to be preferred. In other words, selection of patients is being assessed in terms of health law and health ethics.

Criteria

The next two steps in elaborating a criteria-system are to decide on the criteria and to value these criteria against each other. Which criteria can be part of a criteria-system?

a) MEDICAL CRITERIA

In advanced medical treatment medical criteria depend upon the state of medical science and of professional skills. They can be judged by colleagues with relevant knowledge and experience. Medical criteria include for instance: indications and contra-indications for a treatment, physical condition, tissue-compatibility (in transplants), the gravity and acuteness of the disease, the influence of additional illness on the treatment, the chances of recovery, the medical risks etc. A medical criterion can also be the geographical relation between the patient's home and the treatment centre, if distance and transport problems make treatment of out-patients impossible or hazardous. Medical criteria have to be connected with the specific treatment in question. Additional illness as such is no reason to reject the patient; the illness only becomes a medical criterion for selection if it influences this specific treatment. The reason for this is that the selection concerns the treatment for that specific illness and not other illnesses. Otherwise the selection could easily come to a judgment not of the usefulness of the medical treatment, but of the patient, a human being. So for instance psychiatric illness becomes a medical

criterion for selection only when it contains a contra-indication for the treatment (though psychiatric disturbance can hamper cooperation, see (c) below). In the same way medical success has to be assessed according to the professional standard and the competence of doctors. The question is: can the patient be treated successfully for his renal failure through dialysis? The question is not: is this patient worth the dialysis, which medically can be successfully administered to him? Medical criteria, if assessed properly – *eg* without inclusion of social values –, can be relatively objective, even when the consequences of a medical treatment are not exactly predictable and this treatment is partially determined by subjective factors on the part of the patient.

b) AGE

Age as such is not acceptable as a criterion for selection because rights of human beings are not dependent upon age. Another objection against age is that it discriminates imprecisely. An age limit of 70 for instance would exclude a healthy 72-year-old and include a 65-year-old in a bad medical condition. Age-considerations may however be in fact medical criteria (*eg* when it is stated that a kidney-transplant in a baby is medically pointless) and in that case they should be listed as medical criteria.

c) PERSONAL CRITERIA DIRECTLY RELEVANT TO THE TREATMENT

Not acceptable are general personal judgments (*eg* the presence of a phobia or homosexuality). But personal criteria can be important for the treatment, for instance the psychological capacity to meet the demands of the treatment, the motivation to cooperate, the willingness to comply with instructions. An implied value-judgment in these personal criteria is that preference is given to the cooperative patient over the non-cooperative one. Personal criteria must be professionally assessed. The doctor's appreciation of for instance the capacity of the patient to cooperate can depend on subjective feelings of the doctor.

d) SOCIAL BEHAVIOUR

Although social behaviour is difficult to distinguish from personal criteria, nevertheless social behaviour can be viewed independently. Chronic alcoholism, drug addiction, a bohemian way of life, create major problems when used as criteria for selection. Their evaluation is strongly connected to subjective convictions and moral judgments, which differ in society. Is a lifestyle unacceptable to a doctor a reason for exclusion of a patient? And if social behaviour were accepted as a criterion would it then not be a matter of justice to give the patient with 'bad behaviour' a chance to 'improve his life'? Has the prison population less right to such treatment than the rest of society? Selection on the basis of social behaviour would lead to the imposition of

predetermined ways of conduct, because everybody would know that certain sorts of behaviour could exclude him from treatment. Bourgeois conduct would be encouraged and the creative non-conformists and unrecognised geniuses would have less chance, despite possibly making important contributions to the progress of society – even if this were often recognised only posthumously. Except where social behaviour is a medical criterion – *eg* where drinking alcohol is incompatible with the treatment – social behaviour is not acceptable as a criterion.

e) DAILY LIVING CONDITIONS DIRECTLY RELEVANT TO THE TREATMENT

In this and the following criteria the patient is considered not only as an individual person, from which point of view the previous criteria were viewed, but also his position in society is under discussion. A first category concerns the daily living conditions of the patient as far as they are relevant to the treatment: for instance his home circumstances and support; his ability to follow instructions when at home; his family and work environment including the degree of emotional support which he can expect, etc. To an extent these criteria can be assessed objectively.

f) THE PATIENT'S IMPORTANCE FOR HIS IMMEDIATE RELATIONS

In this category interhuman connections are at stake. Should a mother with children have priority over someone with no children, should a bachelor have a lower priority in selection than a married person? In this criterion there is no causal relation with the treatment. The same is true for the following criterion.

g) THE PATIENT'S SIGNIFICANCE FOR SOCIETY

Essentially this criterion regards the social value of a patient. The difference with the previous category is that in (f) the patient's direct relationships are involved. The assessment of somebody's value for society in general is a much more difficult problem. Assessment of social values is subjective and cannot objectively be established. Again it must be said that the contribution to society of a person often only can be judged after his death and that by using this criterion bourgeois-norms are likely to become preponderant. And how should the 'value' of a secretary, a bus-driver, an artist, a scientist or a manager be weighed against each other? Won't there be a risk that economic criteria will prevail? And that the unemployed will have less chance than workers? Will not political factors become involved and political opponents run the risk of low priority? And what about possible discrimination against foreigners? Furthermore, it must be remembered that social values are strongly influenced by the most powerful in society, who can grant themselves

privilege. Apart from a few exceptions which can be imagined, social value is a hazardous criterion, that cannot be assessed objectively. From the viewpoint of law the principle of equality is endangered by accepting social value as a criterion for selection.

Values

In which order the criteria for selection are to be applied depends upon the weighting of the values which are at stake. This order of values must be explicitly established, so that it is clear on which grounds the decision-making process will be executed. This is required by the nature of human decisions regarding others and by justice. In the previous analysis age and social behaviour are rejected as criteria for selection of patients, while grave objections are made against the use of the patient's significance for the society as a basis for selection. Which order of values could be used to decide on the priority and sequence of the criteria? I propose the following values in the mentioned order of importance:

- 1) A scale starting from the individual and then tracing his social relations according to their intensity. On the basis of this scale the greatest emphasis should be placed on criteria relating to the individual and next on social criteria, the relative importance of these decreasing in inverse proportion to the intensity of the social relationships involved. This leads to the following sequence: criteria originating in the individual; criteria based on his immediate relationships; and third – if accepted – criteria based on social value.
- 2) Within this framework a second scale is to be derived from the direct relations between these criteria and the treatment in question. As a consequence medical criteria originating in the individual get the highest priority, personal criteria directly relevant to the treatment are next in importance and daily living conditions directly relevant to the treatment the third category to be applied. Although medical criteria are rated as less important than the individual, in practice they coincide.
- 3) A scale according to the degree to which the criteria are amenable to objectivity, which *sub alia* represents legal security. The resulting sequence of criteria for selection of patients is:
 - a) medical criteria
 - b) personal criteria directly relevant to the treatment
 - c) daily living conditions directly relevant to the treatment
 - d) the patient's importance for his immediate relations.

From the nature of the proposed system it follows that patients should be selected according to the criteria in the sequence suggested. At each stage of the selection process the subsequent criterion is only to be used if patients and resources remain. For

instance, if after the medical selection of severe cases treatment facilities are still available, and the remaining patients are medically in a comparable situation, the next criterion for selection will relate to those personal criteria which are relevant to the treatment, and so on. Thus the medical decisions should be exhausted before other criteria are investigated. It is a matter of life and death that the data to assess the subsequent criteria are professionally, conscientiously and accurately established. Competent expertise from the relevant scientific disciplines is needed.

In the above mentioned sequence of criteria value to society is not included, on the grounds that this criterion is very hazardous. Perhaps in those cases where the previous criteria do not close the gap between supply and demand the suggestion of Rescher (1) can be followed to choose at random from the remaining group of patients.

The proposed selection-system does not entail a comparison of all patients. In the first place, a patient who has already been accepted for treatment has a legal right to (continuation of) that treatment. He cannot be replaced by a new patient with higher priority. Second, not all patients apply at a given moment and thus the proposed system contains a chronological element. The selection can only include the known patients, while the new ones are considered for selection immediately.

In applying the suggested system a satisfactory solution cannot, however, be reached. Such a solution is impossible. But what such a selection-system can do is minimise injustice. Doubtless the comment will be made, that the criteria should not be used consecutively but simultaneously. Should not a young mother deserve priority over a disabled pensioner? However understandable this comment might be, it should be kept in mind, that the principles of equality of opportunity and equal human rights are at stake.

Procedural aspects

The working of a system is not only ensured by material criteria, but also by appropriate rules of procedure (2). These procedures are the more important when material criteria are not exact and can help promote equality of opportunity. I will not elaborate the procedural problems and only discuss a few aspects.

First, the maintenance of an intensive communication with the patient during the selection-process is very important. This will prevent the patient being confronted with a rejection while totally in the dark about the decision-making process. Keeping the patient informed may also lead occasionally to a choice to stand down *eg* by the above mentioned pensioner in favour of the mother of young children.

Another important procedural aspect is that the selection-process be not allowed to achieve a

bureaucratic character, which will only dehumanise the selection of patients.

A further question is, who should make the decisions on the basis of the criteria. A problem which arises in this context is that doctors can assess the medical selection but are not competent to judge the non-medical criteria. Therefore multidisciplinary commissions are often suggested. But such commissions cannot be expected to offer a solution because they lack personal relations with the patient; they cannot, when lay-people are included, be tested on professional norms, and they are not able to judge more objectively than a medical body. Furthermore there are problems with professional secrecy and the right of the patient to the protection of his privacy. A better procedure would be to leave the selection in the hands of the doctors concerned, on condition that the non-medical judgments are assessed in consultation with the relevant professional experts. This solution has the advantage that the selection is done by those whose responsibility it is to carry out the decisions (3). Furthermore it can be expected that a doctor will be better able to treat a patient other than the one he has recommended, if he has had a part in the decision-making.

In my opinion a procedural requirement should be that patients accepted and rejected are registered, along with the arguments employed. Periodic reports based on this registration – leaving out the names of the patients – should be made, so the application of the criteria and the procedure can be reviewed by hospital and health authorities.

Conclusion

An entirely satisfactory solution for the selection of patients in the event of a scarcity of medical facilities cannot be reached. Therefore it is of utmost importance to establish a selection-system on the basis of a scale of values and a procedure, that guarantees the fair application of the criteria in this system. The problem has to be discussed in public. It concerns not only the doctors working in advanced medical care, but everybody in and outside the health care system. This is because efficient use of the available resources influences the selection-problem and because human beings and human values are at stake.

References

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