Letters to the editor

The tragedy of medical ethics

The difficulty with current day medical practice is that it allows—indeed, makes morally obligatory—practices and behaviors that increase health care spending without regard to other public priorities, which get crowded out by the incessant demands of health care. To the extent medicine drives resource use it does not give adequate moral guidance to the larger distributional decisions faced by government and other third-party payers. Ironically, to the extent that medical ethics drive marginal spending, they actually lower both the quality of life and well-being of the community.

Key tenants of medicine drive marginal spending for some while ignoring others and their associated, much needed social goods. However well meaning, medical decision-makers assume that we can afford—and should pay—what they demand. They focus on a particular patient to the near exclusion of others. They do not take into consideration how health care needs are to be weighed and balanced against other national civic needs. They neither guide nor allow a sense of proportion among total community needs.

"Justice" is one of the four principles of medical ethics, but it is not operational. We can't even agree on what it is supposed to mean. Perhaps, if we could give it meaning we would not have a system that over-delivers to some, while ignoring so many others. When dealing with individuals "beneficence, nonmaleficence and autonomy" are always on guard, and "justice" is seldom heard from. How do we place on the scale of justice our deteriorating roads and bridges while we give health care almost twice what other developed nations see fit to allocate?

The moral life of the community includes, but cannot be defined by, medical ethics. Medical ethics may be useful in dealing with individual patients, but not for the broader allocation issues all nations face. Karen Ann Quinlan was kept alive in a persistent vegetative state in a community where women gave birth without prenatal care, kids went without vaccinations, and large numbers of people had unmet medical needs. E. Haavi Morreim, PhD, professor, Department of Human Value and Ethics, College of Medicine, University of Tennessee, says it so well:

> We cannot fairly insist that physicians owe to patient resources [what] they neither own nor control…we should neither expect nor permit the medical profession unilaterally to choose the values that will set the amounts and purposes for which other people must spend their money.[1]

A doctor may not have to "ration" medicine, but public policy always rations for it must decide among the total needs of its jurisdiction. Governors ration taxpayers' money in a process called budgeting. Public policy deals with broad goals that maximize the broad public interest. Public policy can never maximize individual goals in a system, for there is too often a conflict between the individual good and the good of the group. We do not build police, fire, roads, or any other governmental system around individuals.

Some thoughtful scholars claim our current practice and ethics actually decrease the overall health of the nation. Robert Evans, author of *Strained Mercy: The Economics of Canadian Health Care*, warns:

> A society that would spend so much on health care that it cannot, or will not, spend adequately on other health enhancing activities may be actually reducing the health of its population through increased health spending.[2]

We cannot hope to solve the problems facing health care until we first get our ethical theories straight. This will require us to rethink the nature and assumptions of important parts of the health care culture and associated ethics. Setting ethical standards and practices in a world of common resources must be thought of as an empiric process. Ethical beliefs are theories or suggestions about how human beings can live in a just society. They are human constructs not written in stone. They cannot be morally obligatory. They must be tested by trial and error, tempered with reality, and evaluated by what they cause to happen in the total social world.

Ethical beliefs are successful when they promote moral behavior that fosters the integrity and moral well-being of the total society. Any ethical practice which decreases the overall well-being of the community, or doesn't recognize its specific relationship to the total public good, disqualifies itself as a guide for public policy. If it decreases the moral life of the community, it repudiates what ethics is all about.

Good public policy is not the domain of abstract thought developed unrelated to available resources. It is not purely hypothetical or theoretical like physics, geometry, or mathematics. Ethical principles of the public budget cannot be independent of fiscal realities. They cannot assume that a priori criteria—reason, conscience, and the great moral traditions—justify unconditional moral behavior. It is not theological, but a painful process of practical trade-offs with winners and losers.

Public policy has no obligation to fund social policy that conforms to medical ethics or maximizes every service that is, or may be, "beneficial" to every patient. On the contrary. Public policy must look at the total battlefield of social need and justice. There should be no unexamined demands on the public purse, no mega-priorities, no blank checks.

Present ethical principles both reward and require behavior that maximizes medical care spending at the expense of all other social goods. They look at the moral health and well-being of the community with only one eye. They too often ignore the law of diminishing returns. If every American would get all the "beneficial" health care demanded by the current medical culture and practice, we would have an unethical society where medical care trumps most other important social goods. Medical ethics provide no mechanism to weigh and balance health needs with other social needs. No matter how elegantly reasoned, they cannot control the practical allocation of pooled funds.

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References

1. Morreim, EH. Medicine Meets Resource Limits: Restructuring the Legal Standards of Care. University of Pittsburgh Law Review. 1997;59: 1.

2. Evans, RG. Strained Mercy: The Economics of Canadian Health Care. Toronto (Ontario, Canada): Butterworth-Heinemann; 1985.

Advice to Old Patients

As an 84-year-old retired cardiologist who has enjoyed a relatively healthy life I was not prepared for critical care in an intensive care unit. A major cardiac arrhythmia complicated by acute renal failure was the culprit. During the event I required vasopressors and a respirator. During this episode I had a dream I will never forget.

I was in a coronary care unit. There were no windows. In the dream, though, I was in the Sunday school room in my childhood Episcopal church. Outside was the family graveyard where my father, grandparents, and great-grandparents are buried. It was dark inside the school room, but I could see my son sitting in front, on the left side, and my wife in a similar position on the right. They both spoke encouraging words to me, "Hang in there, this is not the end." There was a window to my left in the room. I looked out the window. Everything was dark.

Random thoughts ran through my mind. Lines from a John Mellencamp song, "Oh, yeah, life goes on, long after the thrill of living is gone."

My family's voices were fading. I was aware of the weakness of their hopeful words, yet there was a strange absence of sadness. For some reason, I had imagined dying would be more special. I was feeling weaker and more desperate. My persistent thought was that I did not want to die.

I kept looking out the window, searching for light. A building next door was dark, but as I kept looking at it I saw a steel pipe, and light reflecting off the pipe. Behind the light was an orange colored windsock tossing in the wind. At that moment there suddenly was light all around me. I felt I would survive.

After I regained consciousness I was transferred to a progressive care unit where I had a bed next to a window, through which I saw the orange windsock. It was in front of a heliport. The hospital helicopter, Life Flight, was preparing to take off. Life Flight. It was an appropriate name.

I cannot explain the mystery of the window, or that I dreamed it before I saw it. I was close to dying, and sought life. I moved from darkness to light. I remembered the strange absence of sadness as I grew weaker, the temptation to close my eyes and sleep.

Now, as I remember each moment, I hasten to record it as best I can. It was such an extraordinary experience I do not want it to be forgotten. Albeit an obvious message to patients in a critical state, it pleads one should never give up seeking the light no matter how vast the darkness, which brings to mind Dylan Thomas' plea to his dying father:

> Do not go gentle into that good night,
> Old age should burn and rave at close of day;
> Rage, rage against the dying of the light.

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