

Ethical Differences Between Socialized and HMO Systems

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Abstract

A visiting scholar from the School of Philosophy of Leeds University, England, was invited to participate in a seminar at the Section of Bioethics of Drexel University School of Medicine, which discussed (a) ethical differences between socialized and HMO systems, (b) physician-assisted suicide, (c) reproductive technology, (d) triage and rationing, and (e) organ donation and sale.

Key Words: Medical ethics, HMO, socialized medicine, physician-assisted suicide, reproductive technology, triage, rationing, organ donation, ethics.

Differences Between HMO and Socialized Systems

DR. SAVITZ: PHYSICIANS ARE regularly involved in making decisions that affect the lives of their patients. In effect, doctors are called upon to apply ethical considerations with regard to the various illnesses encountered in their practice of medicine. The terms "ethics" and "morals"

are often used interchangeably, but morality is a set of personal standards arising from family background, religious training and social rules, whereas ethics is a philosophical discipline concerned with what we ought to do, based upon reason and objectivity.

It bothers me a great deal to see how much technology is taking over medicine and how little dialogue is actually taking place regarding ethical considerations of particular cases. My son just finished his internship at a Harvard-affiliated hospital in Boston, and after 12-hour shifts the following ritual would take place. The incoming staff would meet the outgoing staff; no word would be exchanged; they would all hold up their palm-corders, which would electronically talk to each other and give reports; and that would be the end of any daily en-

The Seminar in Medical Ethics was sponsored by the Bioethics Section of the Department of Humanities and Community Medicine of Drexel University, Philadelphia, PA, on September 28, 2001.

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The material in this discussion has been edited and condensed. Accepted for publication March 2004.

counter these groups might have. I worry about that kind of ritual, and I think that medicine is losing a great deal. If there is no time to transmit the information gleaned from patients and family, then there will certainly never be any time for ethical considerations among fellow physicians.

Much of this behavior has emerged because of our present health care system in the United States. In order to reduce the rapidly rising cost of medical treatment, sound business practices have been applied to the bills presented by hospitals, doctors and other health care professionals. The government had already set fees for service for Medicare, the elderly, Medicaid, the care of the indigent, Worker's Compensation, the care of injured workers, and no-fault (the care for those injured in a moving vehicular accident). Fees for service were now to be universally determined by insurance companies for the average American who required a medical checkup or actual medical or surgical treatment. Business practices that lowered premiums included contracting their physicians and hospitals to limit intake for care, reducing the fees submitted for care to 50–80% of previously prevailing rates, confining policy holders to health care professionals in the facilities within each plan, restraining efforts to discuss optional or better treatments from outside the plan, and using managers with no medical background whatsoever to make decisions.

Very quickly the problem with health maintenance organizations (HMO) became obvious. The patients could not choose their own family physicians or hospitals unless they had contracted with their plan. Referral to specialists and radiologic testing was under the control of doctors who were constrained by contracts that contained provisions to withhold payment if guidelines were not obeyed. Individuals in distress with colic, chest pain, and rotating back pain who came to the emergency room without notifying their HMO became responsible for the costs generated by the emergency care physician who ordered the required tests and did not obey cost constraints (unless the patients were admitted to an intensive care unit or underwent emergency surgery). Mothers were sent home 24 hours after uncomplicated vaginal delivery. Agism or discrimination by the age of the patient was tacitly in effect. The enormous profits generated by such sound business practices were not used to reduce premiums, but rather to fatten the paychecks of the managers and to increase the returns to shareholders of the HMOs.

In contrast, the Canadian health care system is often touted as a method of providing comprehensive medical care without private funding. Yet few Americans would tolerate its rationing of quality care or of kidney dialysis machines, its waiting lists for surgery, its lack of choice in assigned physicians. Even fewer know that when the annual governmental budget runs out of money, by November, most Canadian doctors go on vacations to warmer climates, and all elective health care ceases until January, when new governmental funds become available. In effect, dissatisfied Canadians, affluent Canadians, and sometimes Canadians with emergent conditions will actually cross the border and come to the United States. These facts, of course, are not mentioned by anyone who favors the Canadian system. But neither the American system nor the Canadian system is anything like the National Health Service in England. Dr. Rivlin, who is with us today, lives in the United Kingdom, has actually been treated by the National Health Service, and will give us an overview of the National Health System in England.

Dr. Rivlin: Recently, there has been a seismic change in medicine in the U.K.—it has nothing to do with any new drug or treatment, but rather with the shift from paternalism and “doctor knows best” to the power of the patient. Or to simplify, patient autonomy has taken its place. The increasing availability of information via the Internet coupled with a tendency toward greater individual rights means that patients will inevitably want to have a far greater input into the way they are treated, in both the medical and ethical sense. Respect for autonomy requires that patients be given sufficient information to make an informed choice about treatment. Failure to get informed consent from a patient would leave a doctor open to charges of assault and battery.

In English law, there are three things that must be in place for legally valid informed consent or refusal of medical treatment: the patient must be competent to consent or refuse, the consent or refusal must be based upon adequate information, and the consent or refusal must be given voluntarily. And there is a major difference between United States and English law [with respect to how much information is adequate]. In the U.S., the test is what would a reasonable patient expect in a given situation, whereas in England the test is what a reasonable doctor would provide in a given situation. The

seminal case in English law is that of Bolam, decided in 1957 (1). The lawsuit concerned a patient receiving electroconvulsive treatment which caused his limbs to flex violently. The defendant doctor took no precautionary measures, and his patient suffered serious damage to his thighs and hips when the treatment propelled him from his hospital bed onto the floor. In his summation, the judge instructed the jury that “a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art” (2). One of the problems for doctors is to know how much information they should give regarding risk of a procedure, for consent to be deemed informed. If a doctor tells a patient of all possible risks, however remote, the patient might worry to such an extent that recovery is hindered. In a famous case, a Mrs. Sidaway complained to the courts that she would not have had an operation had she known of the remote risk of severe disablement (3). The judge, relying on the Bolam case, said that a doctor’s obligation was only to give her information that a responsible member of the medical profession would think it proper to give.

Only recently has the National Health Service admitted that rationing is needed. In England, health care funds are allocated on a “macro” basis (governmental or regional) and a “micro” basis (controlled by general practitioners). In the past, the government allocated a budget in trust and allowed health authorities to allocate the funds within the localities for which they were responsible, and that is still the case for most of the funds. Recently, however, the government set up the National Institute for Clinical Excellence (NICE) to take a more active role in the decision-making process for individual drugs and treatments. The idea was to make cost effective procedures available nationally. However, the government does not always make extra funds available to pay for what the NICE recommends. The trust and health authorities in the hospitals have respectfully declined to live within their budgets, but they are not allowed to overspend. The result is that the government has a reserve lifeboat on a sinking ship providing passengers with additional means of being saved. In other words, if the NICE says that interferon should be given to every patient with multiple sclerosis, the government does not provide extra money, so the money for interferon has to come from somewhere else in the National Health Service

(NHS). Another way in which health care funds are distributed is by general practitioners. The NHS employs them, but as independent contractors. A doctor has an obligation to provide primary medical care to his or her patients. However, general practitioners will argue that they simply cannot adequately treat or care for all their patients, because there are not enough funds available. Of course, patients will be seen by their doctors, but there is no guarantee that they will receive the best treatment that is available or that they will not have to wait a significant length of time to be treated. It should also be noted here that doctors can remove any patient from his or her list without giving reasons to the patient for doing so.

In France, there is no such thing as waiting for treatment—they have twice the number of doctors and hospital beds per capita. The main reason for this disparity is that the French are prepared to pay much higher taxes and more money out of their own pockets. The truism that you get what you pay for applies to health care. Why are we so unwilling in the U.K. to spend more on such an important service? First, in my opinion, we are essentially a selfish nation and do not like the idea of paying more taxes, even if it will benefit us ultimately. Whenever a political party has gone into an election saying they would increase taxes for the benefit of health and education, that party has lost. Politics is based on a short-term outlet. Politicians want to get elected. Second, for years the public was told both by the government and the medical profession that the U.K. has the best health service in the world. The public believed this report and, as a result, saw no reason to pay more taxes to increase funding for the NHS. Third, about 6.2 million (about 8% of the population) buy private medical insurance and are able to “jump the queue.” These people, often from the higher socioeconomic group, are the very ones who complain about the NHS if they have no alternative.

What can be done to improve the National Health Service? Substantially more money will have to be spent. These funds could come either from increased taxation or by moving funds from other areas of government. More patients might travel to France and Germany for treatment, where there is an oversupply of facilities, especially in view of the recent ruling from the European Court of Justice (4). The NHS does provide a limited safety net for the general population. Most people who need treatment for life-threatening conditions will eventually get it—though not always the treatment they need or

when they need it. I am informed that there are more than 40 million people in the United States who do not have health insurance. In England, they would certainly get treatment eventually. All patients would get to see a general practitioner even if they had to wait a few days for an appointment, or be attended to in an emergency department after waiting 8–9 hours to be treated. Improving the socioeconomic status of poor people may come down to a choice between more health care facilities and improving the education, diet, and health habits, such as smoking and drinking, of the general population.

The care of the infirm and elderly in the U.K. is sorely lacking in governmental funding, but is shored up a great deal by private charitable donations for hospices and nursing homes. The government has decreed that agism should be banished from the NHS. It should be obvious that elderly people are not a group of identical people, but are individuals, some of whom will gain greatly from treatment and some of whom will not. Agist policies suggests that one section of society can be dispensed with, something that runs counter to centuries of medical teaching and has profound and disturbing implications both for the doctor-patient relationship and for the practice of medicine as a whole.

Physician-Assisted Suicide

Dr Savitz: The U.S. Supreme Court left it up to each state to pass legislation allowing physician-assisted suicide by saying that in such cases the patient's rights outweigh the state's interest. Some states have proposed acts to legalize physician-assisted suicide, but so far only Oregon has passed such a law. The requirements are very rigid, as you might imagine, and appropriately so. The patient has to be 18 years of age or older and have legal capacity. No one who is unconscious or retarded, or who cannot otherwise express his or her own wishes may make such a request. The person must be a resident of Oregon. The diagnosis must be a terminal, incurable, and irreversible illness that will lead to death within 6 months. The consulting physician has to concur with that diagnosis, and two additional physicians must agree to the option. The patient has to be advised of palliative care options, especially pain control. One cannot just move to Oregon on a Thursday and get physician-assisted suicide on Friday.

Dr. Fleetwood: Jack Kevorkian, a pathologist, is probably the best-known physician who has

been a strong supporter and vocal advocate of what he calls physician-assisted suicide. But actually, the kind of thing that Kevorkian is doing and the reason he is in prison today is not physician-assisted suicide at all. His initial attempts were at what he termed euthanasia—providing for a quick death for people who did qualify for physician-assisted suicide under the definitions that most people knew. The American Medical Association (AMA) definition of physician-assisted suicide is a doctor facilitating a patient's death by providing the necessary means and/or information to enable the patient to perform a life-ending act. That means was a prescription or even in some cases information on how a patient might kill himself or herself. The patient performed the life-ending act by swallowing the pill or pushing the button that started the lethal intravenous injection. Initially, Kevorkian followed these guidelines. He is in prison because he went one step beyond that and actually pushed a button to start a drug that killed the patient. It is important to think about this distinction, because we are talking about suicide and not murder by your newly found friendly physician.

The term "life-sustaining treatment" is often confused in the literature. Any therapy that serves to prolong life without reversing the underlying medical condition—a ventilator, nutrition or hydration provided by tubes, or any number of things—could qualify as life-sustaining treatment. Withdrawing life-sustaining treatment is considered legally and ethically permissible in the U.S. as long as the patient has decision-making capacity. In fact, the law says that physicians have to respect competent patients' wishes to refuse life-sustaining treatment.

Our case study focuses on three patients. A patient in the U.S. with terminal lung cancer and bone metastases has exhausted all treatment options and suffers from intractable pain despite hospice treatment. He has decisional capacity and has requested a prescription from his physician to use in committing suicide. Another patient, a resident of England, also has lung cancer with bone metastases. He also has exhausted all treatment options and suffers intractable pain despite hospice treatment. He has decisional capacity and has requested a prescription from his doctors to commit suicide. The third patient, living in Oregon, suffers from terminal lung cancer and bone metastases, has exhausted all treatment options, and suffers from intractable pain despite hospice treatment. She has decisional capacity and has requested a

prescription from her physician, for assisted suicide. According to anonymous independent studies, the U.S. patient, where physician-assisted suicide is against the law, may find a physician willing to prescribe drugs in non-lethal doses while knowing that the patient intends to commit suicide by taking an overdose. The patient in England will have a hard time going to a physician, making clear what his intentions are and getting the physician to write the prescription. As for the third patient, she qualifies to go to a physician who is willing, and receive a prescription that she can then use for physician-assisted suicide.

There is a history here that is largely overlooked, changes in how people approach euthanasia and physician-assisted suicide. When you look back at ancient Greece and Rome, you see that euthanasia was really widely accepted initially. Physicians gave their patients poison when they were suffering and dying. They thought that relieving suffering was an important part of their job. However, some physicians became part of the Hippocratic School and swore never to give anyone a drug that would cause death. The Christian view was that one's life was held in trust from God, that one's body was a vessel inhabited for a period of time, that killing oneself was immoral and assisted suicide even more immoral. From the 12th through the 15th centuries, there was consistent opposition to euthanasia among physicians throughout Europe. With the advent of anesthesia in the 1800s, people really started thinking about using ether to mitigate the agony of death and not just the pain of surgery. By the 1870s, Samuel Williams suggested the use of chloroform and other drugs to hasten death. In 1885, in the *Journal of the American Medical Association*, Williams' proposal was characterized as an attempt to "make the physician down the road be an executioner." Suddenly you can see that there was a debate whether ether and other drugs should be used to ease people's passage before death.

One argument against physician-assisted suicide is that it would be difficult to limit—sort of a slippery slope. If you accept physician-assisted suicide by patients who voluntarily agree and are willing and able to take the lethal drug themselves, what happens with patients who are not so able, are retarded or have limited ability to understand what is going on? Once you accept physician-assisted suicide, you will inevitably slide down the slippery slope of accepting other patients.

Another argument, one which is actually more persuasive, is that palliative care may receive less consideration if physician-assisted suicide is a legal alternative. The funding for palliative care and teaching it in medical school will get shorter shrift than it already does. Yet another argument is that legalization would undermine the patient-physician relationship and the trust necessary to sustain it, throughout the medical profession and society, and endanger the value our society places on life, especially on the lives of the disabled, incompetent, and terminally ill.

Dr. Rivlin: In the United Kingdom, euthanasia and physician-assisted suicide are illegal. Doctors who have given patients a lethal dose with the intention of ending the patient's life have been charged with murder, although suicide is not illegal. Also, just like in the U.S., the option of withdrawing life support is acceptable. Life-sustaining treatment can be withdrawn from a patient who does not want to be on a ventilator, without committing physician-assisted suicide.

The British Medical Association supports the distinction between relieving suffering and literally killing somebody.

A flurry of articles recently looked at terminal sedation, that is, sedating a terminally ill patient to unconsciousness and withdrawing nutrition and hydration, so that he or she eventually dies without ever waking up from the sedation. Removal of nutrition and hydration which are not beneficial to the patient is permitted. Is terminal sedation physician-assisted suicide? The patient is not performing a life-ending act. Should terminal sedation become a viable option when pain is truly serious and intractable?

Anthony Bland was a young man of 18 who was crushed in a soccer match. He ended up in a persistent vegetative state. His parents and doctors went to court and asked for permission to withdraw the feeding tube, with the certain knowledge that this act would cause his death. It went through all three British court systems and ended up in the House of Lords, which is equivalent to the U.S. Supreme Court. The House of Lords decided to permit the cessation of his artificial feeding; however, the Lords emphasized that it would be illegal to kill Bland by lethal injection or by commission. Artificial feeding is medical treatment. Medical treatment should be given only if it is in the patient's best interest. Once there is no hope of recovery, it cannot be in the best interest of the patient to receive treatment. There is no obligation for the

doctor to give treatment that is futile. Nevertheless, there was another major hurdle for the doctors to overcome. As noted, killing by commission is illegal. Could it not be argued that withdrawing the nasogastric tube was an act and therefore illegal? The five judges approached this matter in various ways. In general, they decided that it was impossible to distinguish between not starting nasogastric feeding, which would of course be an omission, or withdrawing the feeding tube once it was in place.

The issue of euthanasia is coming to the courts soon in England. The case concerns Mrs. Diane Pretty, who suffers from end-stage renal disease and wants to die at home at the time of her choosing, with her husband's help. She has gone to court to challenge the refusal of the Director of Public Prosecutions to rule out prosecution of her husband if he assists her in killing herself. Mrs. Pretty argues that the government has subjected her to degrading treatment in forcing her to live. The judge has allowed this case to go forward to judicial review. If Mrs. Pretty succeeds in her claim, then the courts will be sanctioning euthanasia by commission. I would be very surprised if the courts granted her wish. What they are likely to do is leave it for Parliament to decide, if Parliament wants to change the law. This case is going to be the most important one concerning euthanasia that we have seen in England in the last decade¹. One last comment from me, as someone who thinks the slippery slope argument is very persuasive—few cases (29 cases in each of the last 3 years) have succeeded in obtaining permission for physician-assisted suicide in Oregon.

Reproductive Technology

Dr. Savitz: It is very interesting for me to have lived through all of the changes in genetic technology that have taken place. We have all become used to the fact that it is possible to have test tube babies, Petrie dish conception, and surrogates (women who carry the fetus to term but neither are the biological mother nor have an interest in adopting the child). The most fas-

inating case is that of the Buzonga family, a relatively wealthy couple. After a suitable work-up and a number of tries, it was found that neither the husband nor the wife could be a biological parent. (He had problems with low sperm count and she with endometriosis.) In effect, they purchased sperm and found an egg donor. They further went to the trouble of finding a surrogate, named Pamela. All went well. The fetus was conceived and implanted, and the gestation was going on when the couple divorced. At that point, they decided that neither one of them wanted the child after it was born. The courts ruled, for the first time in history, that this child truly had no legal parent. How it all resolved isn't surprising, namely, a fund was finally set up by the wealthy parents to support the child even though neither one of them wanted to adopt him. Tinkering with Mother Nature can result in problems, and you are going to hear further on this subject from Dr. Connie Perry.

Dr. Perry: The case of the Buzongas and other cases of reproductive technology are really my areas of expertise and primary interest. However, since we are comparing the United Kingdom and the United States, I thought I would focus on cloning and stem cell technology, because of the major differences of opinion. In January of this year, the British Parliament passed legislation to extend authorization of research on human embryos. Previously, human embryo research in the U.K. was limited to research questions involving reproduction, fertility, and embryology. This act includes allowing the use of cloning technology to create embryos for research purposes and to enable any such knowledge to be applied to developing treatment for serious disease. In all such cases, researchers proposing to use embryos must prove to the Human Fertilization and Embryologists Authority (HFEA) that the use of embryos is necessary for research purposes. Unlike the U.S., there are extensive protections for the patients in the U.K. For example, there are statutory limits on the storage of embryos. A number of steps are taken to ensure voluntary consent and even posthumous use. Prior to submission to the HFEA, proposals need to be approved by multiple centers or a local research ethics committee, not unlike our Institutional Review Board.

The difference between United Kingdom committees and ours is that the U.K. committee is required to be more independent from research institutions. No more than one-third of

¹Since the seminar was held, the House of Lords ruled that Mrs. Pretty's husband could not be granted immunity from prosecution if he helped his wife to die [2001 2 WLR 1598]. Mrs. Pretty subsequently appealed to the European Court of Human Rights but that court endorsed the House of Lords' decision [Pretty v. The United Kingdom, No. 2346/02, European Court of Human Rights, 4/29/02.]

the committee members can be from or have a financial interest in the institution in question. Furthermore, the chair of the committee must be entirely independent. In the U.S., peer review occurs only for proposals that require grants for funding, and the fertility industry is largely unregulated. On July 31, 2001, the U.S. House of Representatives passed the Human Cloning Prohibition Act, prohibiting the creation and use of human clones for any purpose. President Bush announced his decision to allow federal funding for limited embryo stem cell research with existing embryonic stem cell lines.

In my opinion, the resistance to the use of cloning to create embryos for research is based largely on a "gut level" reaction rather than on careful analysis. Cloning creates the fear of engineering of humans and of playing God. The "playing God" concern invokes the question of naturalness and argues against most medical practices. A person in respiratory arrest will naturally follow the course toward cardiac arrest unless there is a divine or human intervention. To avoid playing God, one could argue that one should leave these situations to the divine. In the U.S., belief in the freedom of religion implies that to impose a law based solely on one's religious interpretation would violate the rights of others and those with other beliefs. But is the argument against creating embryos through cloning based only on that religious stand against unnaturalness? There is also the fear of engineering humans or creating cloned people; therefore, the law is meant to prevent any cloned embryos from becoming sentient beings. The risk of pain and suffering is not an issue. The true problem is advancement of technology that would allow the creation of a whole person merely for the use of others. However, this argument can be used against many technologies. Research on medications can create knowledge that can harm as well as help individuals. In learning how to save a life, one also learns how to end a life. The difficulty with the argument that benefits of embryonic stem cell research outweigh the risk is the fact that the real benefits are unknown and unknowable without actually using the technology of human research. There are a number of conditions for which stem cell research shows great promise. The point of this talk is that we need to examine whether embryos have moral status before they become sentient beings. If such embryos cannot be used as a mere means to an end, then we cannot destroy them even for the innocent purpose of curing serious disease and injury. To restrict an individual's or a couple's

voluntary choice to donate leftover embryos for research, the government wants to impose a specific moral principle. Given that these embryos are not going to develop into members of the public, the public should have no say in their disposal since it is perfectly legal and even desirable for these couples to destroy the embryos that are no longer candidates for gestation nor desired for implantation, nor being donated to other infertile individuals.

Triage and Rationing

Dr. Savitz: The idea for triage should be accredited to Napoleon's chief surgeon, Baron Dominique Jean Marie. A system of ambulances transported injured soldiers to field hospitals on the basis of wound severity rather than military rank, which had previously been the sole basis for transporting the wounded. Soldiers who were in need of and could be saved by surgery were now given priority. Next, military personal requiring first aid were treated. Lastly, those expected to die of their wounds were made comfortable, if possible. If anyone thinks that this doesn't have meaning, September 11 made it very clear that triage is still an essential element of health care. The concept of triage also comes into play when you have a single patient who presents with brain, chest, abdominal, and/or orthopedic injuries and thus requires more than one specialist. If those specialists are treating one patient, then obviously they cannot be distributed among many patients who require specialized, but individualized treatment. It is interesting to note that in the dictionary the verb "ration" has two definitions. One "is to use sparingly" and the other is "to distribute equitably." Those of you who have studied rationing know that you have to get both definitions to work.

A final note: It has been my privilege to have lectured in a number of countries and I especially remember a visit to the Kantonspital Zurich, the main hospital in Zurich, Switzerland. There was a veranda, and every day, whether it snowed or it was sunny, every patient was bundled up in blankets and brought outside. The veranda overlooked a park. The Swiss specifically built parks around their hospitals, where children would play, and as long as patients were alive they were exposed to life.

Dr. Rivlin: Rationing in England takes place in a number of ways. The first way is by waiting lists. In England, there can be long waits for treatment of even serious conditions. If the gen-

eral practitioner sends the patient for a hip replacement, it could take three years for a patient to be scheduled. In addition, the patient might have to wait 12 months to get an appointment with a consultant. Overall, it could take 3–4 years to get a hip replacement. Patients have to wait not only for non-life-threatening conditions; many patients with chronic obstructive pulmonary disease do not get to see a consultant quickly enough and die as a result. The second method of rationing is by the doctor not informing patients that there are drugs and treatments that would help them. The third method is by cost saving that occurs when the patients do not receive the necessary drugs or treatment because they are too costly. It was reported in the *Financial Times* only last month that the National Institute For Clinical Excellence has decided to reject the widespread use of interferon because it is too expensive (5). Even though the clinical effectiveness is proven, the cost effectiveness is not. According to the Multiple Sclerosis Society, only 2–3% of multiple sclerosis sufferers in England receive treatment with interferon, compared to 12–15% in many other European countries (6). Another way of saving money is by not replacing out-of-date equipment. Many of the X-ray machines in England are very old, and there is such a shortage of MRI scanners that getting an appointment, even as a private patient, can take 3 weeks or longer.

I want to refer briefly to something that could put the government in a very difficult situation regarding the rationing of health care, namely the new Human Rights Act from the European Parliament. Article 11 of the Human Rights Act provides for everyone's right to life to be protected by law. This absolute right makes no exception on grounds of lack of funds. When a patient has been refused a drug for reasons of cost, steps may be taken to challenge the decision as incompatible with Article 11, since withholding the drug treatment could lead to an earlier death. No patient has yet made such a challenge.

Organ Donation and Sales

Dr. Savitz: There is a new market which is growing fast in today's global economy—the market in human organs to be used for transplants. For the last 30 years, organ transplants have become more and more commonplace. As the demand for organs increases, so does the need to find more donors. All of us are aware

that some cadaveric organs can be used. You should also be aware that the American Medical Association is presently backing a plan by which people could donate their organs upon their death, but money would be paid to their family or anyone else that they designate. In the meantime, it has come to the press's attention that in China the organs of condemned prisoners are removed before they are executed and the organs are then sold on the open market. In India, poor people sell their organs in order to purchase items they could never afford otherwise, from tractors to dowries for their daughters. In Brazil, it is not uncommon for the wealthy to buy organs from members of Indian tribes and then claim they had received them from poor relatives.

Dr. Caputo: In China, even political prisoners may be executed; and they are shot in the head to prevent the loss of any organs. Surgical harvesting may unceremoniously take place in the field—an act that is quite horrible. I think this subject has given us a perfect sequel to talking about rationing, because in the U.S. we are convinced that if we throw enough resources at a problem, we can fix it. When there is something wrong with an organization, no matter how much money we are pouring into it, somehow more money is found to fix it.

You can buy a liver, but there are just so many livers in the marketplace. What is the problem with organ sales? The problem is that there are a lot of people waiting, and increasingly more people waiting over time. Why? We are getting better at transplantation. We have anti-rejection drugs that are getting more and more effective. We are able to get organs into people who are older and less medically stable. The other side of the coin is how many organs are being put on the table, so to speak—not enough to meet the demand. What strategies are being planned? From one person, you may get a liver, a heart, two kidneys, and a pancreas; but supply and demand studies indicate that some patients are dying while waiting. The number of cadaver and living donors continues to go up and up, but the resources remain limited.

Philosophers may ask, "How can we treat this situation?" The prevailing concept is something called distributive justice. How can we be fair? We talk about rationing, we talk about allocation, and we have numerous would-be recipients. You say, "Let's do the most good or cause the least harm that we can for the greatest number of people, all at once. Let's treat every-

body truly equally with our blinders on.” If you were to talk about totalitarianism, you might say that the only fairness is saving no one; but if you give priority to saving everybody, then maybe you should employ the principle of medical neediness. Should you give priority to those who are medically needy, to those who are most helpless, or to those who are first-come? Egalitarianism, utilitarianism, totalitarianism—are philosophers going to come up with the answer?

What about organ sales or other financial incentives? In Great Britain, organ sales are absolutely illegal. In the United States, it is not allowed, but people are starting to think about its legalization. In Pennsylvania for example, there was a proposal to pay \$300,000 to the family of the organ donors for funeral expenses. A lot of civil libertarians argue that “it’s my body and if I want to give up one of my kidneys, it’s my right.” On the other hand, what will happen if we start making an organ market legal? People may ask why they should give up a kidney freely if they can get \$5,000–15,000 for it. In other countries, such as Belgium and Switzerland, there is a presumed consent mechanism: it is understood that organs will be donated unless the deceased has left instructions to the contrary.

How are most decisions about transplantation made in the United States? In general, most of the decisions are based on a specific patient who is about to die, the likelihood of success, how good the match is, the relative sizes of donor and recipient, and geographic proximity. First, the physician puts the patient on a national registry list. If the surgeon who makes his or her own medical assessment decides that the patient will never adjust to the anti-rejection drugs, he or she won’t put the patient on the list. Other factors include addiction. A smoker who cannot stop smoking before the heart transplant will not be placed very high on the list.

Dr. Rivlin: A couple of interesting cases have

come out of England recently regarding transplantation. In Sheffield, a white patient donated his kidney on the condition that it should only be given to another white person. His bequest was accepted, but there was an outcry in the press, and the government said that under no circumstances could that ever happen again. The general practitioner said that he would accept the donation so that he wouldn’t have to tell the mother that her 15-year-old son could not get a kidney because of some vague philosophical principle. The second matter concerns a group of people who are willing to accept organs, but not give them. Some Orthodox Jewish people maintain that they have to be buried whole, but an organ donation is acceptable to save the life of one of its members. The question to think about is that if somebody is not willing to donate organs, should they be allowed to be eligible to receive organs? I am not offering answers, just making an ethical point.

Dr. Savitz: I want to thank you all for attending our seminar, and I hope you won’t mind if I finish with one of my favorite modern parables, which concerns the young mouse who came upon an old lion crying in the jungle. “What’s wrong?” said the mouse. “I can’t walk,” replied the lion, “because I have a thorn in my paw. Could you pull it out for me?” “Nonsense,” said the mouse, “Stop acting like a baby. Everybody has a little pain, it builds character. I am sure that the thorn will fall out by itself eventually. In the meantime, stop walking around on it. The hurt will stop after a while and you will be just fine.” So the old lion limped off into the jungle and the young mouse started his own HMO.

References

1. *Bolam v Friern Hospital Management Committee* [1957] 2 All ER.
2. *McNair J* [1957] 2 All ER 118 at 122.
3. *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1984] 1 All ER.
4. Human Rights Act 1998, Article 2 (1).