Medical Law, Ethics, & Bioethics

FOR THE HEALTH PROFESSIONS

6 edition

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The way a book is read—which is to say, the qualities a reader brings to book—can have as much to do with its worth as anything the author puts into it.

Norman Cousins

Preface

It is imperative that the health care professional have knowledge of medical law, ethics, and bioethics so that the client may be treated with understanding, sensitivity, and compassion. No matter what the professional's education and experience, any direct client contact involves ethical and legal responsibility. It also is imperative that this knowledge be used to provide the best possible service for the physician employer. Our goal is to provide the health care professional with an adequate resource for the study of medical law, ethics, and bioethics.

Although the material is applicable to all health care professionals in any setting, our emphasis continues to be on the ambulatory health care setting rather than the hospital or long-term care setting. For example, we do not address such legal and bioethical issues as whether or not to feed an anencephalic newborn in the neonatal center of the hospital because this book's focus is on the ambulatory health care setting. We realize, however, that all bioethical issues may affect ambulatory health care personnel. Continued enthusiastic feedback from instructors, students, and reviewers is gratifying and has resulted in many changes that will make this sixth edition an even more useful resource than the first five editions. We are reminded of the truth, which comes from colleagues in our respective community and technical colleges that no matter how many times a piece is written, it can always be improved.

The continuing evolution of health care, of legal and, especially, bioethical issues necessitate this revision. The material is updated throughout the book to reflect the latest developments and to reflect emerging ethical issues. The newest developments in stem cell research for treating disease and for creating new organs and tissue are included in the Genetic Engineering chapter as the legal and ethical debate 'rages.' The chapter introducing the reader to the cultural perspectives of health care continues to heighten our awareness of the importance of culture in health care. There will be additional cultural pieces when appropriate throughout other chapters as well.

The authors and their editors have made every attempt to ensure currency and pertinence of the material. However, some bioethical issues change almost daily as lawmakers and the public become actively involved and press for legislation. Even as the sixth edition goes into production, the co-authors struggle to be current as federal and state legislations clash. Further, funding issues and morality issues are being addressed in the political arena sometimes bringing to a standstill continued research and advancement in medicine. For ease of reference, pertinent codes of ethics appear in Appendix I. Appendix II offers samples of some of the legal documents clients may use in implementing decisions about health care, life, and death.

Reader response to the vignettes has been remarkable. A thought-provoking vignette appears at the beginning of each chapter. Some of the vignettes are adapted from actual case law, and for these we have provided the relevant citations. Other vignettes recount actual situations of which we are aware. The sixth edition continues to place critical thinking exercises in chapter text. For students' benefit we have included Questions for Review at the end of each chapter for increased learning. All will whet the appetite, stimulate discussion, and highlight the most pressing legal, ethical, and bioethical issues faced by ambulatory care employees.

Learning objectives designed for the educational setting precede each chapter. The Critical Thinking questions are intended to be thought provoking rather than a test of chapter contents. References are provided at the end of each chapter whereas a complete bibliography is found at the end of the text for anyone seeking additional information. Web Resources are introduced to assist the reader in further research on the Internet. "Have A Care!" has been updated and returned to the end of the book at the request of our readers. We hope that you will derive from this book a great sense of pride for your professional position in health care.

Marti Lewis
Carol D. Tamparo

Contents in Brief

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CHAPTER 12

Allocation of Scarce Medical Resources

"Due to budget cuts, light at the end of tunnel will be out."

Bumper sticker on car

KEY TERMS

apgar score System of scoring newborn's physical condition 1 minute and 5 minutes after birth. Heart rate, respiration, muscle tone, response to stimuli, and skin color are measured. Maximum score is 10; those with low scores require immediate attention if they are to survive.

bioethics Morals or ethics connected with biology or medicine.

diagnosis-related groups (DRGs) Categorization of medical services to standardize prospective medical care.

macroallocation System in which distribution decisions are made by large bodies of individuals, usually Congress, health systems agencies, state legislatures, and health insurance companies.

microallocation System in which distribution decisions are made by small groups or individuals, such as hospital staff and physicians.

LEARNING OBJECTIVES

Upon successful completion of this chapter, you will be able to:

1. Define key terms.
2. Explain the phrase *macroallocation of scarce resources.*
3. Describe how decisions are made at the macroallocation level.
4. Explain the phrase *microallocation of scarce resources.*
5. Describe how decisions are made at the microallocation level.
6. Discuss the influence of politics, economics, and ethics on health care.
7. Outline both systems of selection.

Vignette: "Who decides?"

You are employed by a team of transplant surgeons in a major city when a call comes from a hospital that donor organs are available. The wheels move quickly to determine proper matches among the clinic's clients. Your physicians discover that two equally needy clients are waiting for the donor liver. One is an 18-month-old infant whose first liver transplant is being rejected. The other possible recipient is a 7-year-old recently diagnosed with liver failure.

Vignette: Focus on Client

1. A young boy in a rural area of the country dies in a small hospital after an automobile accident. Your physician, on emergency call at the hospital when the ambulance brings in the boy, works feverishly for more than an hour, but the boy dies. Your physician relates to you the next morning the feeling of hopelessness of knowing the boy's life might have been saved if a neurosurgeon and more sophisticated equipment had been accessible to the hospital. Why is it that geographic location may dictate who lives and who dies?
2. The family at 913 Twelfth Street will be saved from financial ruin because Medicare will help defray the costs of their young son's kidney dialysis. The family at 909 Twelfth Street may suffer great financial stress because of increasing medical bills for the treatment of their daughter's juvenile onset diabetes mellitus, which has left her blind and nephrotic. How does our government determine that one medical problem warrants financial assistance and another does not?
3. When a 58-year-old employee, Sam, loses his job because his company is downsizing, he is unable to maintain his health insurance premiums for more than 6 months. He also finds it impossible to find any employment with similar pay and benefits. His wife, receiving care for cancer, is now left without insurance. Sam pays more than $160,000 of his money for his wife's care before her death, just 3 months after the health care coverage was lost. Sam is nearly bankrupt.

Allocation of scarce medical resources and access to medical care are major bioethical concerns in today's society. Allocation refers to the distribution of available health care resources. Access refers to whether people who should have a right to health care are able to receive that care. Winners in this dilemma are healthy and well-insured with good corporate coverage. Losers in this dilemma are often those who are poor, powerless, and persons of color. It is reported that 46 million Americans are living without health insurance. Many more are underinsured.

A large portion of Americans without adequate health care are children. Prenatal care is an unaffordable luxury for the uninsured. Often, adequate care is unavailable even after infants are born. The elderly are increasingly having difficulties obtaining adequate health care. Medicare, with its increasing costs and decreasing coverage, is inadequate. Without a quality Medicare supplement program, the elderly, like the nation's children, will go without. What value do we place on human life in our country when basic health care is not available to those who need it most?

With the ever-changing health care climate and the increased managed care contracts, health professionals in all facets of the industry, ambulatory as well as inpatient care, are required to do more with less. Hospitals and acute care centers have radically altered their delivery system of health care. For example, a surgical nurse with 10 years of experience may be moved to the role of circulating nurse, and a surgical technician with only 9 months of recent training will actually assist the surgeon. The circulating nurse is removed from the actual operation yet is ultimately responsible for the supplies and equipment in the room and documenting any incidents that might occur. Responsibility and accountability issues are shifting toward cost containment. Clients are directly affected, for example, when providers do not take any more Medicare clients and turn away all Medicaid recipients because the providers' costs are not adequately reimbursed.

At the same time, well-insured, and financially successful clients are able to purchase nearly any kind of health care they desire. Expensive nonessential reconstructive surgery, assisted reproduction, and experimental therapies will be made available while the less fortunate are denied access and are given no choice in their health care treatment. The result is there are medical luxuries for a few while others do without.

▲ CRITICAL THINKING EXERCISE

The changes occurring in our nation's health care pose economic, ethical, and political questions:

1. **The economic question is "How can scarce resources be allocated in light of the costs required and still satisfy human needs or desires?"**
2. **The ethical questions are "Is medical care a right or a privilege?" and "How will these scarce resources be justly and fairly distributed?"**
3. **The political questions are "Who will pay for basic health care?" and "Who decides what kind of benefit package everyone should receive?"**

Whenever health care access (providing care for those entitled to it) and allocation (deciding what services should be covered) decisions are made, improving health care should be the primary goal. Health professionals, researchers, and members of nearly all academic disciplines have been formally debating such issues for more years. For discussion, it is easier to define the problem in terms of macroallocation and microallocation of scarce resources.

Macroallocation and Microallocation

Allocation decisions deal with how much shall be expended for medical resources and how these resources are to be distributed (Fig. 12–1).

Macroallocation decisions are made by larger bodies, such as Congress, health systems agencies, state legislatures, health organizations, private foundations, and health insurance companies. For example, Congress determined that Medicare should provide medical care for the client with chronic renal disease. No other chronic disease is specifically named in the Medicare program. Macroallocation decisions also are evident when determinations are made regarding funding of medical research. How much should be allotted for cancer research, for preventive medicine, or for expensive equipment? The health insurance industry largely determines the "reasonable and customary" charges in medical care and therefore what will and will not be covered by health insurance premiums. In addition, Congress has instituted a prospective payment system that reflects macroallocation called **diagnosis-related groups (DRGs),** which categorize clients' conditions and identify them by number. Payment is made on the basis of a predetermined rate or average cost.

Microallocation decisions concerning who shall obtain the resources available are made on an individual basis, usually by local hospital policy and doctors. Decisions at the microallocation level cut deeper into the conscience, because such decisions are personally closer to each of us. Examples requiring these decisions include who is allowed to occupy that one available bed in intensive care? Does the Medicaid client receive the same care as the local VIP? Does a 60-year-old Medicaid client have an equal chance at the kidney transplant as the foreign visitor who has cash to pay for the procedure? Who gets the flu shots when there is not enough vaccine for all those at risk?

The Influence of Politics, Economics, and Ethics on Health Care

States also enter into the political arena of macroallocation. For example, in 1989, Oregon passed the first program for rationing health care in the United States. The Oregon legislature created the Health Services Commission, which, after holding discussions in many public forums, presented a prioritized list of health services they believed warranted diagnosis and treatment. Illnesses below a certain number were not covered either because it was believed the persons would get well on their own or

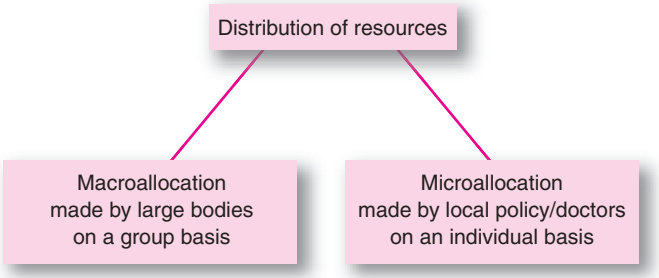

FIGURE 12–1 A brief description of how resources are allocated.

IN THE NEWS

In a business forum on "Health Care Inflation: To Pare Expenses, Ration Services," Robert H. Blank, author of a book on rationing responded to some questions for the *New York Times*. Mr. Blank believes that rationing takes place on three different levels: (1) Macro level where we determine how much we should spend on our nation's health care. (2) Spending priorities. Do we spend the money on preventive and primary care, on curative medicine, or should we emphasize care for the young or the old? (3) Individual priorities. Do we spend it on kidney transplants and if so, how many? Or do we spend it on other procedures? Mr. Blank stated that the United States needs a national commission on rationing to help solve our health care crisis.

treatment would be futile. The Oregon Health Plan extends Medicaid eligibility to all state residents with incomes below the federal poverty level; establishes a high-risk insurance pool for people refused health coverage because of preexisting health conditions; and addresses small businesses by offering them options to provide their employees with the ability to change jobs without losing their health insurance coverage.

In 2006, Massachusetts lawmakers required all its 500,000 uninsured citizens to have some form of health insurance. Every citizen earning $9,500 or less yearly is covered at no cost. Businesses that do not offer health insurance pay a $295 annual fee per employee. Maine passed a law in 2003 to expand health care to its underserved population. Other states with similar actions include Tennessee and Minnesota. Some say such legislation is long overdue; others see such plans as examples of government controlling health care. In any instance, the plans provide for treatable health care coverage, however limited, to all state residents. Only time will address their effectiveness, efficiency, quality, and cost.

▲ CRITICAL THINKING EXERCISE

On a national level in the United States and of worldwide concern is the cost of HIV antiviral drugs. Physicians and pharmaceutical representatives are receiving pressure from persons who have HIV to do something about the antiviral drugs that can cost as much as $20,000 a year. A large portion of the world's AIDS cases are in Africa. How will the nation supply antiviral drugs for its infected individuals?

With advancing medical technology and the increased choices in health care options, we have moved affordable health care outside the reach of many consumers. Employers find it increasingly difficult to include a health care benefits package for employees. Purchasing health care insurance without a group is exorbitant. The American Medical Association (AMA) fought long and hard to prevent government health care reform, fearing the loss of control in decision-making. That control, however, has been compromised by the increasing stipulations of health insurance carriers and managed care contracts. The insurance companies fear they will be responsible for more services than premiums allow. Businesses continue to want to offer good health benefits to attract and to retain employees

IN THE NEWS

On a Holistic Health Topics website, it's stated, "Our society is at war. Although it may not be commonly publicized in this manner, make no mistake, our society, and even the world's population in general, is truly at war against a common enemy. That enemy is modern chronic disease." In the United States, we spend 3.5 times more for the chronically ill and disabled than for other health care recipients. The authors' position is that we should spend more on prevention of illness and disease than on the chronically ill.

but understand that they cannot pass on those increases to their customers and workers indefinitely.

Whether the issue is macroallocation or microallocation, the problem is how best to maximize the health of the population with available resources.

Systems for Decision-Making

How are the criteria established that attempt to answer such questions of allocation? Two prominent systems have arisen. The first system identifies three possible selection processes. The second system identifies five principles for a fair selection process.

An outline of the two systems follows:[1]

System I

1. *Combination criteria system.* Those who satisfy the most criteria ought to receive treatment. Such criteria might include the following:
   a. Capacity to benefit from treatment without complications
   b. Ability to contribute financially or experimentally as a research subject
   c. Age and life expectancy
   d. Past and potential future contributions of the client to society
2. *Random selection system.* This system is more like "first come, first served," or a simple chance selection or drawing of lots.
3. *No-treatment system.* This system is based on the premise that if all cannot be treated, treatment should be given to none.

System II

Decisions should be made on the following bases:

1. To everyone an equal share
2. To everyone according to their individual needs
3. To everyone according to their individual efforts
4. To everyone according to their contributions to society
5. To everyone according to their abilities and merits

A summary of the AMA's Council on Ethical and Judicial Affairs suggests that, when making allocation decisions of scarce resources, physicians should only consider ethically appropriate criteria such as quality of life, benefit and duration of benefit, and urgency of need. Such factors as age, ability to pay, patient contribution to illness, or

IN THE NEWS

A *Wall Street Journal* Online July 2006 poll posed the question whether unhealthy individuals should pay more for their health insurance premiums than healthy individuals. (Unhealthy lifestyles were defined as smoking, obesity, and not exercising.) The response showed that 53% said it was fair to require higher premiums. In addition, those surveyed thought it fair to seek higher co-pay and deductibles from the unhealthy. The same poll, however, indicated that respondents do not favor providing a higher level of care for those who make and pay more for their health care. Can you identify which system for decision-making this news report represents? Discuss the ethical implications this poll raises.

social worth should not be considered. If the allocation decision poses little disparity among patients who will receive treatment, physicians should use the "first come, first served" approach.

How Would You Decide?

To enable you to appreciate more fully the difficulties in making choices related to the allocation of scarce medical resources and to assist you in establishing a criterion for selection, the following cases are given for you to ponder.

Allocation of Resources

Example 1

On the advice of the staff nurse in an assisted living facility, an 82-year-old woman is transported by Medic 1 to the nearest hospital with suspected fractures after a fall in her bathroom.

Two miles from the hospital, Medic 1 is advised that the hospital emergency room is overflowing and is on divert. Medic 1 continues to the second hospital, 10 additional minutes away. The second hospital emergency area is so busy that two patients on hospital beds are placed in the hallway. After x-rays and a long wait for a physician's examination, it is discovered that there are no fractures, only bruises. The doctor sighs, "I'm so glad to send you back to your home. If you needed hospitalization, I'd have to send you to another hospital an hour's drive away. We do not have one empty bed."

Example 2

You have just given birth to a 20-oz infant of 6 months' gestation. The ***Apgar score*** *is –2. The infant cannot suck and has no muscle tone, no gag, and no reflux. There is a need to protect the brain and the nervous center. The attending physician approaches you and the infant's father with the news that the only chance of survival is to transport the infant to a neonatal center in the nearest city, 200 miles away from home.*

What is your response? How might the infant's father respond? What problems do you foresee? What are the legal implications of your decision?

After discussing the situation, consider the following circumstances 6 months later. You made the decision to send the infant to the neonatal center. After 2 weeks, your medical bill was well over $300,000. You have only enough money to add to your medical insurance to cover a normal labor and delivery. It appears that the infant will be unable to come home for several weeks, if ever. The infant has now been diagnosed with the following problems: cerebral palsy; blindness; hydrocephalus, which has been alleviated with a shunt in the brain; and seizures.

What choices are available to you and the infant's father now? Who is responsible for the increasing hospital bill? Is medical care a right or a privilege under these circumstances? Who makes the decisions involved in this case?

Example 3

A managed care client calls the medical clinic requesting a different antihistamine because she "has seen an ad on TV" and knows "this medication is the one for me because it causes fewer side effects." You know the medication costs four times as much as the generic, over-the-counter drug she is currently taking. Who decides?

At this point, it should be obvious that no established criteria provide clear-cut solutions to the aforementioned cases. None would be easy to follow. Factors other than those mentioned in the two systems will also influence decisions. They include personal ethics, personal preferences, religion, geographic location, legal requirements, and the political climate. Many problems and few solutions are evident when considering how and to whom scarce medical resources should be allocated.

IN THE NEWS

England has socialized medicine, and some people think the United States should consider such a system. Others believe that we are too culturally different and choice-oriented to even consider it, stating we can't even agree to national health insurance. What do you think? Would England's socialized system make micro- and macroallocation decisions easier?

Allocation of scarce medical resources is a complex issue of **bioethics,** but it is one the health professional cannot ignore because it presents itself frequently.

Summary

Many times allocation and access to scarce medical resources pose more questions than answers. Influences such as economics, geographic location, availability of health care professionals, politics, and insurance coverage determine both allocation and access to health care. How decisions are made and who decides are critical questions to be asked. As a health care provider, it is important to help clients recognize what services are available to them and to help them determine where or how to access other services if needed.

QUESTIONS FOR REVIEW

1. Define and give examples of microallocation and macroallocation.

2. List two influences when making allocation decisions.

3. Describe one system for making an allocation decision in the ambulatory care setting.

CLASSROOM EXERCISES

1. Consider each of the examples at the beginning of the chapter and answer the following questions:
a. At what level (macroallocation or microallocation) is a decision made?
b. Can one of the selection systems be applied?

2. On what basis do you decide who gets the last open slot of the physician's appointment book? What system of selection is followed?

3. Two clients desperately need the use of one remaining hemodialysis machine. One is aged and a Medicaid client. The other is a young college student who has full health insurance benefits. Which client would you choose to treat? Support your answer.

4. What suggestions do you have to make health care available to all? How would your plan be funded?

REFERENCE

1. Beauchamp, TL, and Walters, L: Contemporary Issues in Bioethics, ed 4. Wadsworth, Belmont, CA, 1994.

WEB RESOURCES

▲ Strategic Technology Institute. "Toward a Fairer Macroallocation of Biomedical Resources by Constraining Microallocation's Market-Driven Excesses" by Blake L. White. www.ncbi.nlm.nih.gov