
Priorities and Choices

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Introduction

1. A number of doctors have sought guidance from the General Medical Council (GMC) concerning their responsibilities when they do not have the resources to provide the treatment or the care that their patients need. These dilemmas are not new, nor are they a particular feature of the National Health Service (NHS). Before the advent of the NHS, therapeutic options were often limited to what the patient could afford. The introduction of comprehensive universal healthcare, funded through taxation, as in the case of the NHS, or by social insurance, served to ameliorate these problems. More recently the rapid advances in medical technology, combined with the increased demands of an ageing population, have once more exposed an increasing level of unmet need. This dilemma is not unique to the National Health Service, but exists in all countries, including the most wealthy. In effect, healthcare is now rationed in all countries by restricting the availability of what is provided or when it is available or to whom. This applies both in health services funded through taxation and in the private sector, where care is rationed according to ability to pay, or because insurance policies exclude particular treatments.

The Duties Of Care

2. The three main duties of care of a doctor are to protect life and health, to respect autonomy and to treat justly. These duties can conflict. For example, the duty to respect autonomy means that a competent adult has the right to refuse treatment, even if to do so will result in death. The duty to protect life and health is not absolute; the availability of modern technology to maintain life does not mean that it should always be applied if, for example the overall consequence might be to cause distress in a patient who was dying.

3. To treat justly or to ensure equity in the provision of treatment and care is at the centre of the NHS. It means that no-one should be discriminated against because of their ability to pay, their social position, their health status, their race, religion, sex, lifestyle or their age. Indeed, those whose needs are greatest, for whatever reason, even if their illnesses are to some extent self inflicted, have the same rights as anyone else and if equity is to be respected they may well require a greater share of

the available resources to maintain life or restore health. But treating justly in a way which meets everyone's needs is impossible where resources are limited. This duty of care, therefore, may be in conflict with both the need to protect life and health and to respect autonomy.

4. Resources are usually thought of in financial terms, but there are other resources which are limited, such as the availability of doctors, nurses, other health professionals and carers or the availability of equipment or other resources such as organs for transplantation. Under the NHS, the approach has been to attempt to ensure equal access to all citizens and then to prioritise access according to clinical need whilst determining the scope of public provision by discussion, whether at health authority or at the national level.

The Provision of Services

5. It is for government to decide on the broad resource questions which relate to the National Health Service both in terms of the overall financing of the service, the provision of equipment and the employment of personnel. Recently attempts have been made to eliminate postcode rationing, by establishing a national body (the National Institute for Clinical Excellence (NICE)) to advise on appropriate healthcare provision with regard to new and current technology. Within this national framework health authorities and boards, and in the future, primary care groups, will have important roles in commissioning services, thus deciding on priorities if not choices.

The Role and Responsibility Of Doctors

6. The GMC's guidance entitled Management in Healthcare: The Role of Doctors states:

"Conflicts may arise when doctors are called upon to make decisions about the use of resources and about patient's care, and the needs of an individual patient and the needs of a population of patients cannot both be fully met. Dilemmas of this kind have no simple solution. When taking such decisions, a doctor should take into account the priorities set by government and the NHS and/or their employing or funding body. But they must also be clear about their own role. As clinicians, doctors must make the care of their patients their first concern, bearing in mind the effects of their decisions on the resources and choices available for other patients. As managers, doctors must allocate resources in the way that best serves the interests of a community or population of patients. In both roles doctors should use evidence from research and audit to make the optimum use of the resources available."

7. But it is the individual clinician, striving to help the individual patient which is the very essence of medical practice, who faces the most difficult dilemmas when inadequate resource and unmet need coincide. Clinicians have a responsibility to practise medicine as efficiently and as effectively as possible. Decisions to treat or provide care should as far as possible be based on sound research information, for profligacy in the treatment of one patient may restrict the opportunities for treatment for another. Unfortunately research evidence is rarely clear cut in terms of the certainty of benefit for an individual patient and there will be occasions when the

introduction of expensive treatments will simply not, in the view of a clinician, be justifiable in terms of the suffering entailed or the opportunity costs involved.

8. In determining priorities between individuals for a limited resource, clinicians should have regard for the three duties of care. In many cases this assessment will give priority to the need to protect life and health, so that those whose healthcare needs are greatest or most urgent on clinical assessment will receive priority.

9. These discussions should involve the whole of the healthcare team, where appropriate. This means that specialists in hospitals, general practitioners and other doctors in the community will sometimes need to consult one another and will certainly need to involve other healthcare professionals in the discussions, particularly nurses, who often have knowledge and experience of an individual's needs and wishes that must be taken into account. Wherever possible, a full, frank but sensitive discussion should take place with the individual patient so that the respect for autonomy is fully met. (See GMC Guidance, Seeking Patients' Consent: the ethical considerations). This is not to ignore that there will be some occasions when even the most sensitive discussion will cause unnecessary and unwarranted distress for patients or that some patients, because of illness or disability, will not be able to properly understand the issues that are involved. In such circumstances the views of relatives should be ascertained, whilst recognising that the clinician's responsibility is fundamentally to the patient.

10. The essay on the Science of Medicine in the Hippocratic canon states: "First of all I would define medicine as the complete removal of the distress of the sick, the alleviation of the more violent diseases, and the refusal to undertake to cure cases in which the disease has already won the mastery, knowing that everything is not possible to medicine." (Hippocratic Writings, Lloyd, G.E.R. Chadwick, J and Mann, W.N. Penguin Classics, p.140, Penguin Books London 1983). This still constitutes reasonable guidance, emphasising as it does that the provision of care to alleviate distress in circumstances where more active treatment is not advised, or is not available, remains a fundamental clinical responsibility.

11. Treating justly embraces the concept that discrimination against an individual on the grounds of other disabilities, for instance, the child with learning disabilities or in the case of an elderly patient, on the grounds of disability or age is not acceptable. Nonetheless, the clinical team in determining priorities and the utilisation of the resources made available to them by the NHS, is entitled to take into account the likely success of the treatment proposed. As a simple example, and whilst recognising that few examples are simple, it would be appropriate in assessing priorities for renal transplantation to take into account co-morbidities, such as the existence of cardio- or cerebrovascular disease and the effect they might have on prognosis.

Quantity or Quality?

12. Doctors in the NHS work long hours and are under increasing pressure. Clinical care is more complex, the numbers seeking treatment are rising, the role that doctors can and should play in management is recognised as is the need to maintain

skills through continuing and medical education and professional development, to participate in clinical audit and appraisal, and to qualify for revalidation. All these activities are necessary to maintain quality but nonetheless reduce the time available for clinical practice. The increase in the medical workforce, or more efficient ways of working may not compensate for these increasing demands. Doctors, like all other citizens, have a right to a reasonable quality of life outside their profession, and to participate fully in the life of their families. Within this context the need for flexible working, particularly, but not exclusively by women, must be recognised and met.

13. In the face of all these pressures, many doctors feel an increasing conflict between their ambitions to maintain the quality of the services they provide and the volume of service that must be provided, if patient's needs and demands are to be satisfied. In coping with this conflict the first priority has to be to maintain the quality of the service as judged by risk adjusted monitoring of outcomes (RAMO), process indicators and patient satisfaction surveys (See Enthoven AC, In Pursuit of an Improving National Health Service, The Nuffield Trust, London 1999). Satisfactory quality standards have to be agreed both within the profession and with the National Health Service and met, even if this means restricting the volume of services that can be provided.

14. Having met these standards, it is reasonable to strive for efficiency to increase quantity but not at the expense of lowering these agreed standards of quality. It will be for the NHS and for government to determine what actions need to be taken if in these circumstances the volume of service is inadequate to meet the need, either by increasing resources or determining what services are to be provided and what services are to be excluded from the NHS.

Conclusion

15. It is clear from this brief analysis that the problems posed by the need to determine priorities and choices in the face of limited resources are not easy to solve. The GMC certainly recognises this and would wish to do everything it can along with other representative bodies of the profession and of patients to ensure that society as a whole, and its political representatives, understand these dilemmas. Doctors can only do the best they can with the resources that are made available to them.

16. In determining priorities and choices we would recommend that doctors should pay attention to the three duties of care, and discuss individual problems within the whole clinical team. They should ensure that as far as possible, and to the extent that this is appropriate, both the patients and the relatives are fully consulted and that details of these consultations are fully documented. We would suggest that given the finite nature of the available resource, there is an ethical responsibility on doctors to practise as efficiently and effectively as possible and this is an appropriate area for regular clinical audit.

17. Finally, the GMC recognises that health economic issues (or whether the expense of a medical intervention is justifiable compared to the opportunity costs and the likely outcome), is an unfortunate necessity in the practice of medicine nowadays. But we would wish to make two points in relation to this. The first is to

draw attention to the advice of Professor Archie Cochrane, to practise medicine within the bounds of reasonable probability, rather than on the margins of the possible (Cochrane AL, Effectiveness and Efficiency: Random Reflections on Health Services, Nuffield Provincial Hospitals Trust, 1972) and second, to recognise that even when active treatment is not indicated, the duty to provide care to alleviate distress remains.

Withdrawn - 13 November 2006