



The unseen face of resource rationalization in medical practice

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Abstract

The rationalization of care, leading to lacking medical goods, represents a broad moral geography that encompasses important, often unarticulated social values, as well as dilemmas regarding the nature and purpose of medical care as a social good. The COVID-19 pandemic has highlighted a shortage of intensive care units, prompting health officials to develop or revise protocols for admitting patients to intensive care units. Christian bioethicists argue that the way we choose to allocate medical resources reveals our fundamental beliefs about the obligations we have to the most vulnerable, especially the sick and dying.

Keywords: medical practice, rationalization, bioethics

Introduction

Looking at things objectively, even from the perspective of faith, we have to admit that in the last decades, medicine has made amazing progress. However, this effort faces the barrier of increasingly high prices. Medical services are more and more subject to the laws of the market economy, and patients have inevitably become their commodity. What would Hippocrates or Jesus, the son of Sirach, have to say about such notions: “*the marketing of health services*”, “*the health market*”, “*the waiting list*” ...etc.

On the other hand, the difficulties in financing the health systems have stimulated their rationalization efforts, a fact that brings about a series of inconveniences, such as limiting access to care, therefore to improving and/or maintaining the patient’s well-being. When resources are reduced, health service planners will determine what will be rationalized. Disadvantaged categories such as the poor, the elderly, women and children may fall victim to these inequities of the market economy.

From a moral point of view, rationalization imposes the restriction on the person’s right to choose, ultimately limiting the freedom of expression and

movement of society as a whole. From another perspective, the staggering increase in prices in the health system reduces the available money of society, which could be used for housing, education, transport, etc.

I believe that our medical ethics must start from the principle that people have the same value and it concerns all those needing care, and they must be approached primarily as individual persons, whose life is a good that fully deserves to be saved. Did the strategies of the health services in Romania take into account the way of spiritual manifestation of the Romanian people? Is the weight of implementing the reform of health services in Romania not due to this fact?

The rationale of the protocols of dialysis and renal transplantation

Even before organ transplantation, one of the most discussed medical care rationalization exercises took place at the beginning of the 60s of the last century, in the context of the inclusion of patients in renal dialysis programs. In other words, the committees established at the hospital level were tasked with deciding which of the patients with chronic renal failure were to undergo renal dialysis. The

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bioethics literature, analyzing the way things were done at the “*Swedish Hospital in Seattle*” in the USA, found that in the first stage the hospital committee rejected children and patients over 45 years old. In a deliberative process, known as “*the bourgeoisie sparing the bourgeoisie*”, selection criteria such as income, marital status, number of dependents, emotional stability, educational background, religious profile, etc. were subsequently imposed [1]. This tendency of the committee to select patients on the basis of comparative evaluations, cultural and social values has drawn much criticism from bioethicists, who have pointed out that such practices totally wrecks the doctor-patient relationship by violating the Hippocratic Oath [1].

Over time, it was established that hemodialysis and peritoneal dialysis cannot exceed 12-13% of the efficiency of renal purification, hence the conclusion that, under the conditions of using these methods for a long period of time, the patient still remains a clinical and biochemical uremic, the renal transplantation becoming the only complete therapeutic modality that ensures morphological and functional substitution, capable of restoring the endocrine and purifying parameters of the body in decompensated chronic renal failure.

Concerns regarding kidney transplantation have existed since the beginning of the 20th century, but the first favorable results were obtained in the 1960s, when the use of immunosuppressive medication began to prevent and treat rejection reactions. In the following decades, the introduction of immunological tests (HLA typing, cross-match, etc.), as well as the discovery and use of new immunosuppressive drugs, led to the expansion of transplantation activity and to obtaining superior results.

In Romania, the primacy in carrying out kidney transplants is held by the Fundeni Clinical Institute, where, on Feb. 13. 1980, Prof. Eugeniu Proca together with Dr. Anghel Popescu and the team of resuscitators, carried out this intervention in pioneering conditions. It was a big step in Romanian urology that substantially changed the approach and perspective of the patient with chronic renal failure. In the financial conditions of the political system at that time, this intervention, although it represented a “*dissent*”, was followed by other transplants, their number reaching 45 until 1997. The second stage of the evolution of kidney transplantation in Romania began after year 1990 by Prof. Dr. Mihai Lucan, at the Urology Clinic of the Cluj-Napoca County Hospital (1992) and Prof. Dr. Ioanel Sinescu at the Fundeni Clinical Institute (1997) [2].

The realization of the kidney transplant depends to a large extent on the transplanted kidney and the method of obtaining and preparing it. Given that the kidney is a paired organ, functionally oversized, transplantation can be performed not only from cadaver donors, but also from living donors. The classical axiom: “*There is no transplantation without organ donation*” is more present and more pressing, from day to day.

In Romania, currently over 80% of kidney transplants are performed with kidneys harvested from living donors. Undoubtedly, this only illustrates the difficulties of the national network in making the diagnosis of brain death more frequently, maintaining the donor in optimal conditions, obtaining family consent and finally harvesting more organs (including kidneys) from this category of donors. Renal transplantation is the treatment of choice for patients with end-stage chronic renal failure who have no major contraindications.

The protocols issued by the American Society of Transplant Physicians consider the following situations as absolute contraindications for transplantation: life expectancy <1 year; recent or untreatable neoplasms; untreatable acute or chronic infections; HIV or AIDS infection; psychosocial problems: uncontrolled major mental illnesses, drug addiction, non-compliance, etc.; mismatch in the ABO system and positive cross-match between the donor's lymphocytes and the recipient's serum [2].

One of the most important problems in the kidney transplant clinic is the most accurate assessment of the donor and recipient. The better the clinical, anatomical and immunological parameters are adapted, in order to provide a closer “*match*”, the better the results of this “*miracle*” therapy, addressed to formidable ailments, will be.

As the number of potential recipients by far exceeds that of donors, unfortunately, in recent years more and more emphasis has been placed on the notions of donor and marginal recipient for renal transplantation. The ideal kidney donor for renal transplantation must meet immunological criteria (blood group, HLA typing, negative cross-match) and non-immunological criteria (voluntary donor, mentally normal, 1st degree relative to the recipient, aged between 18 and 65 years old; kidney and urinary tract anatomy within normal limits; normal anatomical arrangement of renal arteries and veins; the donor's nephrectomy must not affect her/his state of health; the donor must not be a carrier of infectious agents - hepatitis B, hepatitis C, cytomegalovirus or HIV). By considering these ideal criteria as rules for selecting a kidney donor, it is obvious that the number of those who can fulfil these conditions is reduced. In order to broaden the indication of a potential donor, in renal transplantation, the notions of “*relative and absolute contraindications*” of kidney donation were taken into consideration. About the absolute ones, the discussion does not make sense, but the relative contraindications overlap very well with the notion of a marginal donor [2].

Today, transplant surgery has overcome technical difficulties. Its success depends exclusively on immune reactivity, which triggers a rejection response. Bioethical issues remain to be discussed.

The organ to be transplanted belongs to a living person, whose heart is still beating, but at the same time dead, electroencephalogram being flat, however miracles

do exist and the patient still has a chance, at least in theory, to survive. On another hospital bed, someone lives with the hope that Providence will relent, offering them the replacement organ, without which their days are numbered. Perhaps, with cynicism, they even paid in advance for the organ they need so much.

In another corner of the world, a well-known person such as the governor of an American state, suffering from a serious cardio-pulmonary disease, quickly entered the top of the transplant waiting list, which was carried out in 24 hours. Upon hearing the news, bioethicists began to wonder. Was it influence peddling, and the governor, as a connoisseur of the law, knew exactly which resort to touch to get the expected result? And such scenarios can continue. This is why moral reflection must be characterized by accuracy and caution. In reality, the ethics of transplantation derives from the confrontation of two values, one individual, *bodily integrity*, and one social, *human solidarity*.

Rationalization dilemmas in the COVID-19 pandemic

At the beginning of the COVID-19 pandemic, many experts predicted a widespread shortage in the availability of places to receive patients in Intensive Care Units, more precisely restricted access to ventilators for patients with acute respiratory failure. In April 2020, the World Health Organization reported that one in six patients with COVID-19 had significant breathing difficulties and were dependent on ventilator support [3]. The discussion is older and arose several years ago in the US in connection with the controversy over extraordinary therapies, which divided the medical world. There was the question of no longer needing to care for dying patients in the intensive care units, the only ones prepared at that time for this kind of assistance. Moreover, the partisans of this idea considered hydration, artificial nutrition and oxygen therapy as therapeutic interventions of an extraordinary nature and, consequently, granting them to certain categories of patients did not fall under the obligations of the ICU departments [4]. The care given to patients with a reserved prognosis has been questioned from the point of view of secular ethics, due to the high costs, and of noetic ethics, due to the vulnerability shown by this group, but also their inability to make decisions in ignorance of cause.

However, the major objectives of an intensive care unit (ICU) are to preserve and improve the quality of life, as well as to restore the patient to an independent status of social reintegration, and in specific situations, to remove pain, suffering and ensure the transition to eternity in dignity. Also, a coherent, rational and non-discriminatory selection of those admitted is required. The actual process by which the selection of patients with a “*reasonable profile*” and a satisfactory recovery perspective and who have an undoubted indication for intensive support is not fully known; at the national level, a coherent system

unanimously accepted for admission has not been established yet.

Although numerous guidelines have been developed for the reception of patients in intensive care services, their implementation remains difficult and represents a “*challenge*” for doctors, since the special literature does not specify very clearly which patients are not subject to admission, leaving this at the discretion of the doctors. This conduct sometimes leads to wrong decisions, errors, resulting in malpractice interpretations. In addition, when medical personnel do not act as they believe is ethically correct, moral distress occurs with long-term negative impact on the quality of the medical act and the health system in general.

There is a lack of understanding (poor definition) regarding the selection criteria of those who will be admitted and those who will not be admitted to intensive care services. Often, at presentation, it is almost impossible to select those who will have a favorable evolution and those who will not survive [5].

Limited access to intensive care units due to resource rationing during the COVID-19 pandemic has led many institutions and health officials to develop or revise protocols for ventilator rationing.

Ventilator allocation guidelines published by the New York State Task Force on Life and the Law (NYSTLL) in 2015 (in anticipation of an influenza pandemic) based the allocation decisions on the “*best medical evidence*”. The stated goal of these guidelines was to save as many lives as possible by prioritizing patients most likely to survive the acute medical episode on ventilator therapy [6]. The triage team used SOFA (Sequential Organ Failure Assessment) scores, which measure “*the number and severity of organ dysfunction in six systems: respiratory, coagulation, liver function, cardiovascular, renal excretion, and neurological status*”, to identify patients with low probability of survival, even using the means of intensive therapy [7]. Although appreciated for their pragmatic nature, the NYSTLL guidelines suffer criticism for exclusions due to comorbid conditions that may disqualify a patient for ventilation therapy, such as cardiac arrest or severe burns. Furthermore, the guidelines call for the removal of patients who do not show sufficient progress on ventilator support as assessed by SOFA scores at 48-120 hour intervals. Such judgments may lead to the removal from ventilatory support of a patient who is recovering at a slower rate than desired in favor of a patient assessed with a better prognosis. These attitudes were also valid in the first days of the COVID-19 pandemic, when the clinical course of the disease was not yet well understood. Although at first sight the SOFA score is unbiased, it must be understood that it was created by human beings who have histories, values and beliefs subject to social, cultural and economic influences, all influenced by comparative judgments [8].

Comments have subsequently emerged arguing that the equitable allocation of resources in medical practice requires an ethical framework with values that can be adapted according to the resources and the relevant context [9]. This utilitarian approach is based on four fundamental values that must be taken into account when proposing to rationalize health care under conditions of scarcity: maximizing benefits with limited resources, treating patients equally, promoting and rewarding instrumental value, and providing priority to the most affected. However, with regard to equality of opportunity, this can be achieved by various forms of random selection such as first come, first served, or a random draw between similarly situated patients. As for “*instrumental*” value, this could take the form of gratitude for past contributions or prioritizing people who can in turn save more lives.

Based on these principles, in the conditions of the COVID-19 pandemic, the specialists stated six recommendations for rationalization [10]:

1. When resources are limited, the priority will be to save the most lives, as well as to improve the life expectancy of people after treatment
2. Frontline healthcare professionals should be prioritized in the allocation of essential resources for the diagnosis and treatment of COVID-19 (tests, protective equipment, intensive care units, ventilatory support and therapy);
3. In the case of patients with a similar prognosis, limited medical treatment will be allocated based on random selection;
4. The phrase “*to save the most lives*”, will take into account the context and the type of intervention in question. For example, when allocating vaccines or other preventive measures, it is appropriate to prioritize frontline health workers, followed by older patients and then younger patients. From a utilitarian point of view, things are reversed, with the priority going to younger patients. Furthermore, it may become ethical to disconnect one patient from the ventilator, even without consent, in favor of another when a greater overall benefit results;
5. Those who voluntarily participate in trials of vaccines or innovative treatments are entitled to a certain priority for COVID-19 interventions.

In the event of an absolute shortage in the medical system, the allocation of medical goods and services will be directed with priority to the management of the COVID-19 pandemic.

Although the ethical framework offered above and the guidelines published so far are not perfect, they are efforts to articulate the rational principles of fair allocation, free from arbitrary or prejudicial judgments. Today, we are increasingly aware that the sometimes tragic choices during the COVID-19 pandemic are largely due to the unacknowledged moral geography around intensive care

units, in the entangled network of social, political and economic choices.

The Christian understanding of rationalizing resources

As hospitals around the world have developed standards of care in the COVID-19 pandemic crisis, some patients have been de-prioritized or deemed ineligible for treatment. Although resource allocation decisions are described as being based on “objective medical evidence”, Christian bioethicists argue that this is not entirely true, due to the significant amount of unreliable information that has been accepted as evidence. In addition, often unrecognized social value judgments were used [9].

Even where there is no question of rationalization, merely a limitation of resources, there are routine practices and recommendations inconsistent with Christian morality. For example, the decision to recommend prenatal genetic diagnosis or prenatal testing only for certain conditions reflects views about the lives of people with certain disabilities, as well as judgments about what kind of lives are worth living and what are not [11].

In the Christian tradition health care has long been seen as a strong extension of the healing ministry of Jesus, whose miracles recorded in the Gospels relate to physical or emotional healing. Indeed, the healing touch of Jesus is one of the most common and profound signs in the Gospels that human history is a history of salvation, or that Jesus came to redeem all creation and break the bonds of disease and suffering. In this view, the Church believes that not only people who suffer should be cared for, but that all people have the right to medical care by virtue of being human. To recognize the fundamental and universal equality and dignity of all people is to recognize both their equal potential and their common vulnerability to the threat of disease, disability and death. The biblical mandate to care for the poor and vulnerable is often stated as a “*preferential option for the poor*”. This second core value implies both a special attention to addressing the health care needs of the least well-off or marginalized in a community and an obligation to assess the economic, political and social conditions that can ensure the protection of the fundamental rights of all persons [9].

I would give an example, first of all, of people over the age of 65 who represented the group with increased vulnerability to the infection with COVID-19, which most often resulted in death. Bioethicists believe this is due to a complex set of social issues, political and economic choices made and reaffirmed over time.

The Church calls on health decision-makers to practice responsible stewardship of resources, meaning the promotion of equitable access to personal health care as well as public health care. As an observation, resources should be used to guarantee health systems that respond to the needs of communities and not only the interests

of individuals. Regarding the conditions of scarcity, the Church recommends that distributive justice be guided especially by the needs of the most vulnerable: children, the elderly, women, etc.

Even among Christian bioethicists there is a different approach to the rationalization of medical care. If some prioritize “*saving the most lives and maximizing the improvement in life expectancy after treatment*”, another view promotes a qualified egalitarianism, assuming that people should be treated as equally as possible with increased attention to the most vulnerable [9].

The COVID-19 pandemic is considered by the Church “*the moment to see the poor*”. It is a call to face an existing reality and to reorder humanity’s global priorities in terms of resource distribution and access, especially to science and technology, without which the gap between rich and poor nations widens over time [12].

Conclusions

Difficulties in financing medical systems have stimulated efforts to rationalize health care. With the introduction of new but restricted availability technologies, committees have been established to draw up protocols that include selection criteria for those who will benefit from the innovative technologies and who will be left to die. For example, making decisions about dialysis or organ transplantation, and in the case of the COVID-19 pandemic, establishing access to intensive care units. But the rationalization of medical care, in any form, imposes restrictions on the person’s right to choose, thus a limitation of the freedom of society as a whole. If the care given to the sick with a reserved prognosis has been questioned from the point of view of secular ethics, due to the high costs, and of noetic ethics due to the vulnerability shown by this group, Christianity has always considered that the effort to comfort and heal disease is the duty of the Christian to fight every form of evil in this world.

While the COVID-19 pandemic has made people aware of the ways in which we are all vulnerable by virtue of our coexistence, I am confident that we will eventually overcome the threat, provided we convince those on the wrong side of the networks of distribution about the true value of human life.

References

1. Ramsey P. The Patient as Person: Explorations in Medical Ethics. 2nd ed. New Haven: Yale University Press; 2002.
2. Sinescu I, Manu MA, Hârza M, Șerbănescu B. Kidney Transplant. Rev. Română de Urologie. 2008;3:1-15 [Romanian]. Available from: http://revista-urologia.ro/transplantul-renal/1_transplantul-renal/
3. Gelles K, Petras G. How ventilators work and why COVID-19 patients need them to survive coronavirus. USA Today; Apr 10, 2020. Available from: <https://www.usatoday.com/in-depth/news/2020/04/10/coronavirus-ventilator-how-works-why-covid-19-patients-need/2942996001/>
4. Kaufman SR. Ordinary Medicine: Extraordinary Treatments, Longer Lives, and Where to Draw the Line. Duke University Press, Durham, USA, 2015.
5. McIntosh N. Intensive care monitoring: past, present and future. Clin Med (Lond). 2002;2:349-355.
6. New York State Task Force on Life and the Law and New York State Department of Health. Nov 15, 2015. Ventilator Allocation Guidelines. Available from: https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf
7. Jones AE, Trzeciak S, Kline JA. The Sequential Organ Failure Assessment score for predicting outcome in patients with severe sepsis and evidence of hypoperfusion at the time of emergency department presentation. Crit Care Med. 2009;37:1649–1654.
8. Yadav E. New York state ventilator allocation guidelines: Legal and ethical dilemmas in the materialization of policy. Juxtaposition. Jun 30, 2020. Available from: <https://www.juxtamagazine.org/editorial/new-york-state-ventilator-allocation-guidelines>
9. Ryan MA. Tragic Choices, Revisited: COVID-19 and the Hidden Ethics of Rationing. Christ Bioeth. 2022;28:58–75.
10. Emanuel EJ, Persad G, Upshur R, Thome R, Parker M, Glickman A, et al. Fair Allocation of Scarce Medical Resources in the Time of COVID-19. N Engl J Med. 2020;382:2049–2055.
11. Iltis AS. Prenatal screening and prenatal diagnosis: contemporary practices in light of the past. J Med Ethics. 2016;42:334–339.
12. von Braun J, Zamagni S, Sorondo MS. The moment to see the poor. Science. 2020;368:214.