

### Readings

Howard Hiatt, "Protecting the Medical Commons: Who is Responsible," *New England Journal of Medicine*, Vol 293, No 5 (July 31, 1975): 235-241

Howard Hiatt, MC Weinstein, "Will Disease Prevention Spare the Medical Commons?" *Ciba Found Symp.*, Vol 110 (1985): 218-35.

Laurie Zoloth-Dorfman, Susan B Rubin, "The Patient as Commodity: Managed Care and the Question of Ethics," *Journal of Clinical Ethics*, Winter 6, No 4(1995): 339-357.

### Class Business

Short Paper 1 handout.

### Blackboard

Percent of GDP spent on healthcare, 1998:

US-42; Canada-75; Australia-70%; Sweden-90%; Japan-75%; Italy 79% (down from 84% in 1980); UK-84%; US spends the most but leaves out undocumented workers, immigrants; many children of immigrants are citizens but have no care

Managed care enrollments in US: 1985-7%; 1995-75%

### Student presentation:

#### "Protecting the Medical Commons: Who is Responsible?"

Background: Hiatt, BIDMC, HMS, health disparities studied through education, training

Introduction: Medical commons – uses a metaphor of sheep grazing, overgrazing on available resources; freedom in commons brings ruin to all. Are we destined to problems and what kind of precautions that we can take?

Question: Page 1. The principle that doctors should do everything possible for the individual patient—a luxury for all patients. Gawande—doing everything they can to avoid cutting off her leg vs. most patients lucky to even be alive. Was it right of them to use those resources and time for the patients?

- Quality of life of patient vs the individual doctor worried about distribution of resources
- Luxury of a hierarchy of how many patients, etc., as decided by managed care
- Concierge/Retainer/Boutique medicine—flat fee to the patients and a new way of paying for health care, the doctor is responsible for providing or limiting care. An overall hierarchy to distributing care. How does that differ from fee for service? Flat amount per year vs fee for service; a whole other tier of care

- How resources differ for the rich vs poor? Extreme hierarchy of access increasingly refined
  - Discussion on social security
- *Is health care privilege or a right? Should health insurance be linked to work?*
- What individuals need, what society needs—
- Monetary value of life; cost-effective ratios – save for second article
- How can you make sure that medical practices are effective? And clinical stage. Posits more clinical testing and trials before entering medicine. But will cost more for it to reach the market, and is that good for patients?
- Regulation over drugs—realm of medical liability, litigation, doing no harm principle still exists. Human subjects for experimentation, research, drug testing, and the ethics around that
  - Vioxx, current issues of drug testing. To decrease time to get to the market, provide optional issues. 10 years to get to market, but still there are these drugs like Vioxx, Celebrex.
  - FDA—don't hold companies responsible for all it does. Don't have to report p value of failed trials; cost of research; cost of liability; overall earning
  - **[ “Fast Track”—how much that really helps the patient. Phase 1—determine maximum tolerance dose before going to Phase 2. Companies sometimes slip through the crack and have their own p value; insider information ]→ may be problematic for drug companies....**
  - What is a “safe” drug? What is the metric that people are using to determine if it is worth putting on the market? → safe for third or second reading
- Case: Dental school work with material science has decreased; dentist's promoted fluoride treatment in water and reduced over tooth problems; most problems of teeth have been solved
  - Non-medical ways of solving medical issues; are we making doctors hurting their own practices? If we solve all health ills, then the doctors won't have any more business? What kind of incentives can we provide to doctors ... to what extent should doctors intervene in the realm of politics, the social realm, the health conditions that are attributed to geography, social ills, poverty? Public health, what discipline, who should address these issues?
  - The medical profession may not necessarily be able to see those connections between social v medical ills.
  - Specializing medicine; treating out of the ordinary cases
  - Would the demand for doctors overall go down?
  - Only 40% of municipal water treatment had fluoride. There's always going to be resistance; we resistance a lot of things.
  - *The issue of medicalization of life, medicine's purview. Is he a proponent of medicalization? How do you define that cut-off point? Paul Farmer goes after World Bank and IMF policies as a physician/activist? Is it*

*enough to provide good care to your patients? Everyone's stakes involved (BigPharma), what's ethical.*

- The medical realm not large enough to take over the realm of religion, family—is that what is hurting it?

### **“Will Disease Prevention Spare the Medical Commons?”**

- “Cost effectiveness” principles—disease, disease categories,
- Cost of quality life saved; Ratios are appealing to deal with, certain cut offs; is this really what we want to do?
- Not all cultures value autonomy; can you assign cost per life for those cultures? Per person, per family, per whose comments on what is the quality of life?
  - Patients as customers; not being as people as lives; can't just make it a number; maybe to generally
  - Engineers—maybe not absolute cut-off at numbers; quantitative value for comparison; this methodology is not perfect but certain more definite and concrete direction (assuming quantitative is direction)
  - Cut offs are arbitrary too. Numbers are arbitrary.
  - *How do the use of statistics not work or be thrown off and how they are understood may not work cross-culturally or within a culture and it's difficult to apply a number to someone's experience. How medicine has shifted to market-based medicine, competitive care, and unit of analysis. Progression to show how practices are shaping object of analysis and how the realm of medicine is really redefining—the health care admin too—how shaping a notion of personhood, v 1927 article about to what extent should he disclose a prognosis? Personalistic feel vs 1995 (not even present day). Our sensibilities shift; Fee for service v HMOs; the realm of care and illness and its experience is very much shaped by institutions, social and otherwise that are intervening in this level.*
- Larger role in medicine than they do now; that doctors in people hold them more accountable; that therapeutic should be effective; preventive must also save money. Recognize that non-medical ways to solve health; costly programs can be reduced (vitamins, etc.). Should prevention programs be important and how should resources be divided?
  - Prevention programs—dependent on programs if it will save money and also be effective. Heart disease – type 2 diabetes – ramifications of preventive care need to be thoroughly research with more longitudinal effects. Will it call another systems problem later on?
  - But if later on prevention may be more cost-effective than paying for therapeutic? Certainly.
  - *What's the balance between needs of individual v society?*
  - *To what extent should we be focused on individual behavior v more institutional issues of inequalities, structural environment? Public health has always focused too much on the individual.*

- *Is it more expensive to provide education in the long run? That will change behavior on the broad scale? (how would you test effectiveness of preventive programs)*

**“The Patient as Commodity: Managed Care and the Question of Ethics,”**

- It’s tempting to see as managed care as a new phenomenon; but evolved stepwise medicine—two kinds—paid on delivery—pay after service. Problems arise now that these are for-profit, rather than non-profit. Financial incentives for doing more tests, more procedures v. financial incentives to reduce number of tests; money embedded in the medical practices. Would it be possible to have no incentives?
  - Gawande at the medical conference.
  - No incentive takes away chance for improvement
  - Would standardization of procedures, treatment? A communistic type system as argued in the system.
  - Medical decisions are not so easy
  - This is how business works; capitalist society
  - *How medicine and medical practice is situated in culture, history, politics, economics; the model that we are discussing—the competitive medicine—is a western model; competing for your dollar, the manager’s choice; there is this underlying notion that competition is good, that there should be choice for the rational actor, but the ideal of choice is not actually the case. What’s the type of society that we are espousing? Choice, rational actor, first world western system*
- Example of doctor who had problem with tumor—doctor has patient with a tumor and wanted to check to make sure that it was benign; HMO wanted both biopsy and pathology tests; on advice of others, documented conversation with medical review board; at the end of the year, they have a reimbursement to give back to the doctor and withheld it. This disturbing example—how can you hold HMOs responsible? We want doctors to act in this way?
  - Sue the doctor or HMO for this algorithm (McMedicine)
  - Are we really receiving all the information and that it can be regulated in the domain of medicine? HMOs have more say in what type of care we get than we have previously said. Managed care is not necessarily “evil” per se, but it’s a domain of power that is difficult to extract.
  - HMO—Doctors—Patients love triangle; penalized for exercising autonomy; dictate what they can and cannot do; but by exercising patients; is this what I am signing up for?
  - Who is sued when error occurs?
  - *Doctors as the gatekeeper; gag rules; MDs not even allowed to tell them about possible treatment options.*
    - *Time spent with patients*
    - *Doctor autonomy—patient autonomy imposed by HMO*
    - *Different forms of legislature*
- Should healthcare companies provide explanation why patients cannot be given?

- Question of choice; How many people can choose their HMO? Are they limiting treatment options? Issues of disclosure
- Nursing hospitals—who has direct care of patients?
- How employees benefited from how happy the medical team?
- If customer satisfaction based care – moving from NP (general) to unskilled workers who may have been
- Hernia factory—in Toronto; specialization; a machine-like doctor with low error; unskilled workers—substandard care. Technical schools—medical assistant;
- Choices reflect inequalities; all resources were more allocated to those who had the difference
- Main idea from the paper: problem of informed consent; if your managed care is not giving all the info about your treatment, you're not likely to know about other treatments? True informed consent? MCOs. Is it ever possible?
  - Patients not aware of what doctors can and cannot provide. *The mystery and constraints of doctors unrevealed perpetuate notions of power of the doctor and the HMO.*
  - A rational decision given the constraints
  - Is healthcare a privilege or a right? In society it is a privilege; but in some places it is a right. But should healthcare be a right?
  - A lot of patients covered means more equal levels of care for everyone; patients have less autonomy; not necessarily perceived as good.
  - Universal health care—in China; the privileged vs the poor who can't afford treatment; commit crimes; get healthcare in prison