

## **The 12th Gordon Arthur Ransome Oration: Practising Medicine with Limited Resources — “The Doctor’s Dilemma”**

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I am indeed honoured to have been asked to deliver the Arthur Ransome Lecture to your prestigious Academy and I am most grateful to you for giving me the opportunity. The problem of trying to find sufficient resources to match the demand for medical care is not a new one and it is certainly not one which is limited to any particular country. It is universal and affects both affluent and deprived countries.

Now, although I sub-titled this talk “the Doctor’s Dilemma” and although doctors are brought face to face with the issues of trying to provide care with limited resources on a day to day basis, it is not a problem which the doctors alone can resolve. Furthermore, it is increasingly clear that governments and other bodies are taking a much closer interest in the way doctors practise and we, in the medical profession, are having to come to terms with the knowledge that we are no longer the sole arbiters of how health care is provided.

Our dilemmas therefore are at least two-fold. Not only do we have to examine how we might provide care with limited resources; we must also try to define our roles in providing care for society as a whole as well as for our individual patients.

You may ask why, if we have never been able to provide sufficient resources for all the care that every patient needs, are there such universal interests in this problem and why are we focusing so hard on it now? Why, for example, are President and Mrs Clinton staking a great deal of their credibility on health service reforms in the United States? Why is the medical profession at loggerheads with the government over the health service reforms in New Zealand? Why are many governments around the world so interested in the experiment in a health service market which the British Government has inflicted on the public in the United Kingdom? The outcome of this experiment seems to be eagerly awaited in many countries where they are struggling with ideas about how to match resources to demand.

The change in culture which doctors are having to face in the new environment of cost containment is more keenly felt in the United Kingdom than in those countries where private practice play a bigger role and doctors are more involved in the financial aspects of care. For a long time, doctors in the United Kingdom have had the luxury of not having to consider whether the individual patient could afford the care they were receiving but now have to consider whether the state can afford it.

The reason, of course, why there is such universal interest in the problem is that the costs of care are spiralling, seemingly out of control; and extrapolations from the rise in most countries raise fears that there is some sort of “bottomless pit” in which in a few years’ time, health care will consume the whole of our gross domestic product (GDP).

Well, why are costs rising so rapidly?

Firstly, we are seeing an unprecedented rate of advance in medical science and technology so that today’s treatments will be historic footnotes in a few years’ time. The last fifty years has seen a transformation of practice. Pharmacological developments are such that we are likely to have more and more effective treatments for many of the major diseases such as mental illness, cancers, coronary artery disease and so on. And I do not believe that these are over optimistic expectations.

New technology, modern imaging techniques and scanning procedures mean that it is now possible to investigate patients who, in the past, might have been judged too feeble or fragile. And surgery has advanced at a great pace with transplantation, spare part surgery, key-hole surgery and the like, so that more and more can be done for our patients.

Secondly, patients and the public as a whole have increasing expectations and are making greater and greater demands. Patients are increasingly knowledgeable about what treatments might be available and, furthermore, they are increasingly of the view that all treatments should work! When treatment is ineffective or a side effect of treatment

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occurs then, somehow, that is someone's fault. There is much greater recourse to litigation and doctors increasingly may practise so-called defensive medicine. (We know, for example, that the rate at which babies are being born by caesarean section is rising. In the United Kingdom it is something of the order of 12% and, in the United States of America, nearer 20% or 25%. These rates are rising, it is suggested, due to the fear by obstetricians of being sued if there is even the slightest doubt that a normal baby may not be delivered by the normal route.)

And the third factor, is that the population in most countries around the world is ageing and the proportion of the population over the age of sixty-five and of eighty-five is rising. Of course, the price of everyone living longer is that we all gather more diseases. There is little doubt that the greatest demands for health care come from the elderly.

And so here we have a combination of problems which mean that more treatments can be provided for more and more people who expect more and more to be done for them; all driving up the costs of care.

It has been calculated that costs of health care are rising at about twice the rate of inflation and, of the various factors which contribute, it has been calculated that 10% of the rise is due to the ageing population, 40% is due to general inflation and a further 20% is due to that inflation which is due to the extra rise in costs of medical technology and drugs, the costs of which rise at a greater rate than normal inflation. So that's 10% + 40% + 20% — that's 70% which is outside anyone's control and that leaves 30% which is due to the increase in the volume and intensity of care that can be provided and is demanded. It is this 30% which is the centre of the battlefield where cost containment is aimed.

Well, of course, all of this background does influence the way doctors behave and, incidentally, we will have to take this into account in our programmes of postgraduate education and training. Increasingly, we will have to cope with these pressures and there are several important implications which are a little foreign to the culture of medical practice. These are the concepts of the cost effectiveness of care and the setting of priorities for health care. Of course, they are not entirely foreign concepts. We have always tried to set priorities and to look for effectiveness but the search for increased efficiency makes these very much more prominent in our thinking. Priority setting and justification of the cost effectiveness of the care we provide are becoming much more overt activities.

And all these pose ethical dilemmas which have to be faced because each poses a threat to the doctor/patient relationship.

Let me try to explain what I mean. The relationship between doctors and patients is shifting and we are moving fairly quickly away from the doctor as a "father figure" and paternalistic behaviour is much less acceptable than it was a few years ago. Then, most doctors and patients were happy with the idea that the doctor was acting in the patient's best interests — what Osler called a "singular beneficence". It was, no doubt, heavily tinged with a benign paternalism but in the last two or three decades, this type of behaviour has become increasingly untenable as patients have begun to exert their autonomy and have expressed the need to understand more about their management. And, patients want to know more about how a diagnosis has been made, what the chances are that the diagnosis is right or wrong, what the options are for treatment and what the likely side effects will be and what the prognosis will be. And they want to know more about the doctor's record in treating their condition.

Increasingly, doctors have to explain and justify themselves and that is only to the good. After all, the relationship between doctor and patient should be a partnership. The patient needs to be as fully informed as he or she requires and the doctor has a duty to ensure that the patient understands the pros and cons of their treatment. That is all part of the doctor's beneficence!

So the doctor/patient relationship is shifting but it remains firmly based on the patient's trust that the doctor will do his or her best for his or her patient. In any event, this trusting relationship is put at potential risk if the doctor is now placed in the position of having to be the agent of rationing of scarce resources for the state. For example, an individual patient has every right to expect that his or her own individual doctor will do his best for them. If the patient begins to suspect that the doctor may be weighing up his treatment against the treatment of others, for the common good of society, then that trust is changed to suspicion and the doctor/patient relationship is threatened.

Here, it is important that we draw the distinction between setting priorities for health care and rationing. The setting of priorities is the process in which the medical profession can and should be actively involved. After all, we are in the best position to inform the public and government about which aspects of health care are likely to be worth pursuing and which are less likely to be valuable. The relative merits of different types of treatment can best be teased out by the doctors. Helping the public reach informed decisions about priorities is a valuable role that doctors can play but, when it comes to decisions about either the total resources available to a health care system or what resources should be used for each aspect of health care, then those are decisions which have to be taken away from the bedside and outside the consulting room.

Doctors, although they should be involved in helping reach decisions about priorities, cannot be placed in the

position of being the final arbiters of rationing.

How we resolve this conflict of doing our best for our individual patients as well as doing our best for society as a whole will be critical. As individual doctors there is no doubt in my mind that we must continue to treat individual patients to the best of our ability but we cannot ignore the wider context since it is clear that treating one patient may mean depriving another where resources are limited.

But what about cost effectiveness? I think here there is no conflict at all about striving to ensure that treatments that we provide are effective in achieving what we want of them. Of course, we all do try to use treatments which have been through the rigour of clinical trials but the medical profession is sometimes criticised for hanging on to treatments long after they have been shown to be ineffective; or failing to take up treatments when they have been proven to be effective. Now you may or may not believe that this criticism is justified but we do need to be sure that our own house is in order. We need to pay rather more attention to measuring the outcomes of our therapeutic endeavours and, in training our future physicians, we must try to ensure that they are aware of the need for critical appraisal and measurement of outcomes of care in terms of what patients want, namely, in terms of improved function such as ability to work or carry out social activity, relief of symptoms and improving the quality of life.

It is in all of these areas where the medical profession has to take a lead. In the United Kingdom, we are increasingly having to consider costs and feel that there is a danger that standards and quality may be lost in our search for ever increasing efficiency and it is in just this process of ensuring that standards, and concern for them, remain high on the agenda that makes it imperative for the medical profession and for the Colleges in particular to take a keen interest in the way health services are provided.

If we think about how it may be possible for society to provide sufficient resources to match demand, there appear to be three types of possible solutions. One, you could put more money into the system. Secondly, you could only provide a certain proportion of care; that is, for certain conditions or certain types of patients, that is you could ration care by placing limitations on what is provided. Thirdly, you could increase and improve the efficiency with which you use existing resources, that is, provide more for less. Or, finally, you could use some combination of all three.

Let us look at each of these and try to see what impact they have on the way we as doctors treat patients.

Firstly, putting more money into the system. This very much depends on the position you start at. That approach has been used in the United States of America where the cost of care has risen inexorably and now consumes about  $14\frac{1}{2}\%$  of GDP and it is clear you cannot, as a nation, do that without placing some constraints on the system. It has to be said, however, that not everyone agrees with the "bottomless pit" idea. William Baumol, the respected American Economist, has reasoned that affluent societies at least can well afford to provide a high level of health care and points to the Galbrathian discrepancy between private affluence and public squalor if we do not accept this. But it is unclear from international health care comparisons what the right amount of money really is. In the United Kingdom we put in 6.2% of GDP and, if you look at a wide range of countries and examine the relationship between the proportion of GDP placed into health care and the total GDP available to that country, then there does seem to be a reasonable linear relationship between the two. But, strangely, there appears to be no relationship between the proportion of GDP put into health services and those markers of success of health care such as neonatal mortality rate and longevity rates. These may, of course, not be the best markers of success of the system but, nevertheless, these crude indicators suggest that it doesn't seem to matter in modern society whether you put 6% or 7% or 14% of GDP into health care. In affluent countries morbidity and mortality rates are not very dissimilar over a wide range of countries although there are marked discrepancies between social groups within those countries. So, arguing for more resources is a tricky exercise and, in any event, those governments which are responsible for the majority of the funding for their health care systems will be largely unwilling to consider more funding unless the other two possibilities are exhausted.

If we, as doctors, are to argue for more resources, then we will have to be absolutely clear that we can demonstrate that those resources will be used for demonstrably effective treatments. We have a job to do there in measuring the effectiveness of what we do and demonstrating these not only to government but to the public at large.

This brings us to the second mechanism which involves the setting of priorities and rationing of care so that only those aspects which have a higher priority are funded. As you are no doubt aware, one way in which this has been attempted has been in Oregon in the United States, where they have tried to rank diseases by their importance to the public; that is, they have produced a list of disorders which they have ranked in order of preference according to what the public itself agreed was of importance to them. They have then left it to the State to decide how much money they would put into the system and to draw a line at the end of the list when the money has come to an end; so that those conditions, or patients, at the bottom of the list were not funded for their care.

There have, of course, been problems. If you are a patient with a disease at the bottom of the list you may think differently about the list than someone with a disease above the line! But, whatever its faults it is, nevertheless, an attempt to set priorities for health care and utilises the public-at-large in its construction. Around the world, there is much interest in the results of this experiment which have not yet been played out in full.

In the United Kingdom, there is already evidence of priorities being made by default. For example, dental care is slowly but surely being withdrawn from the National Health Service and some aspects of ophthalmic care are being withdrawn.

The ways in which we as doctors interact with the priority setting exercise will be important and I have alluded to this earlier. But it is important that attempts are made to set national priorities; for example, by broad category of types of patient, (for example, the elderly or the very young) or by broad category of disease. And these should, where possible, have received the widest possible support. There is a danger in any system which utilises market forces that different priorities will be set by different marketeers and a considerable element of inequity in the system can be introduced. That is why it is important for some overall national priorities to be set up for guidance.

But before any overt rationing becomes acceptable, we really do have to be absolutely clear that we are using the resources that we already do have cost effectively and by that I do not mean just cheaply but also effectively and efficiently and to a high standard. And this is where I return to the need for the medical profession to lead in showing that the care we provide is demonstrably effective. The problem of course, here, is that many of the treatments that we offer are difficult to categorise and the results are not always easy to measure. That does not mean that we should not try however. Indeed, the very difficulty of making such measurements means that we should try harder.

Well, all these dilemmas have to be faced in affluent countries; they are even more vital in deprived Third World countries. They are not unused there to having to make choices, setting priorities and ensuring that only effective therapies are utilised. In a number of countries, much has been done by paying attention to important priorities and reaching a reasonable consensus, on the basis of professional advice, as to what can be achieved from meagre resources. The principles here are exactly the same as those in affluent parts of the world; only the scale is different.

So let me just try to summarise the dilemmas we face and consider how we might face them individually as doctors and, nationally, for the greater good of society.

The first is how to resolve the gap between resources available and the demand for health care. This widening gap has, inevitably, focused attention on the costs of everything we do and it is inevitably focusing our minds on the need to ensure that what treatments we do provide are effective and efficient. There is less and less room for the use of ineffective treatments given on the whim of the moment. And, in all of this, we must lead and not be led in developing methods for measuring the effectiveness of the care we provide. That is our role, not anyone else's.

The second dilemma is sorting out the distinction between the setting of priorities and rationing. We can help as a medical profession in determining priorities but when it comes to rationing that has to be determined by others away from the bedside and it is a matter for those who provide the funding to make those decisions and be responsible for them to the public.

And, finally, I believe we have an important job to do in making a strong case for the extra resources that we do need for our patients. Those arguments have to be made on the basis of good, hard, factual evidence. I believe we have the ability, and the determination to do that but, if we are to be credible, we must be able to produce hard data.

There is much work to do on all of these fronts but it is very easy for the medical profession to carry on in the same way and either ignore some of these difficulties and work in isolation from society as a whole, or rely on others in the government and elsewhere to make all these important decisions. I do not believe our patients would thank us if we did this and there is, to my mind, no choice in the matter. We can contribute, we should contribute; indeed, we must lead on this.