Triage of Scarce Resources: Discussion

MODERATOR: DONALD GRIBETZ, M.D. DISCUSSANTS: Martin S. Begun, Thomas C. Chalmers, M.D., Rabbi Marc A. Gellman, Ph.D., Ira Greifer, M.D., and Rabbi Moshe D. Tendler, Ph.D.

Questions were posed by members of the audience and were read by the moderator.

Question: The last speaker mentioned that triage is in principle evil. Rabbi Tendler mentions that, as far as Jewish law is concerned, a different ethical basis is applied to society than that applied to the individual. Could you please elaborate?

Gellman: The basic premise, as far as Jewish law is concerned, is that triage at all levels—societal or individual—is evil. Jewish law dictates, when confronted with the ordering of giving aid to people, be it medical or financial, that the question is who gets help first. It is never a decision between someone getting help and someone else being left out. The classic example of two people in the desert—if they share the water and live today, they chance what is going to happen tomorrow—applies not only to individuals but to society as well. It is very rare in Jewish practice that any community would say we're going to help one group of individuals and leave others out.

Social Management of Smoking

Question: Dr. Chalmers raised an interesting point about the sociologic and economic problems that are created by the bad habits of luxury in our society. It is true that the surgeon general has recognized that smoking may be harmful to your health. But government has not chosen to do anything about it. There are precedents in history in which government recognized that people indulge in habits of luxury which, on the whole, were detrimental to the health of society. Therefore, government should recognize that individuals may choose to indulge in habits which the government cannot legislate against, as was tried in prohibition. At least the government can ask people to bear the cost of the extra medical expense. That would be a way of paying back society for the individual's bad habits of luxury. If you choose the habit, why not pay for it? Precedents have been set for heavily taxing tobacco and heavily taxing alcohol or gambling. If government can recognize that people will do these things and that it is not ethical to legislate against them, at least have the people pay part of the expense of the extra cost to society which is generated by these bad habits.

Tendler: The point raised is intriguing, as is the whole issue of triage. Triage began, as Dr. Chalmers correctly said, with a chronic lack of funds. Can an individual direct triage decisions because he or she can afford it when others cannot? In a triage situation, could you argue for another incubator to be added to the neonate unit because your community can afford to direct funds to that need? It's your money, you can do what you want with it. When you extend this to a societal level, what you are essentially saying is, Could the rich of society demand that the concerns of society be directed to their interests? You may say, tax tobacco so that the cost of lung surgery or emphysema is covered by the people who smoke. It is a valid point, but, nevertheless, is it ethical to allow such a thing to happen? Essentially, what we're saying is that society will now accept the decision of smokers. They want to get lung cancer and so society will minister to their needs because they will pay society to set up more clinics and more pulmonary surgery units. Does society not have an obligation to avoid the ethical decisions of the individual? Can society say, you're not going to get operated on if you get lung cancer? The surgeon general has issued an ethical ruling that smoking is dangerous to your health. Yet Con-
gress votes increased support to the tobacco lobbies. This is where the ethical issue of triage comes in. I would be very upset about individuals directing social concerns, let alone allocation of funds, for what is basically a decision of society. This is unethical behavior.

Chalmers: There may be a more ethical solution to the smoking disease problem. Twenty years ago, if you went to a medical meeting, 90% of the doctors smoked over a pack a day. If you go to a medical meeting now, it's probably around 5%. That is not because doctors are necessarily more intelligent than the 50% of the adults who continue to smoke. Doctors are just better educated. They have been taught about what happens to you if you smoke too much. They have quit smoking. Therein lies the solution to the smoking problem. The trouble with raising taxes is that it just creates bootlegging. What we should be doing, with the tax or with other federal funds, is a more intensive antismoking campaign.

Money Sources and Research Results

Greifer: Both Dr. Tendler and Dr. Chalmers quoted from Leo Alexander. It is of interest to me that your subject was ethics in governmental institutions. The paper in The New England Journal of Medicine cited in respect to rehabilitation of patients on dialysis commented that basically half the patients were not rehabilitated, and that since they were not rehabilitated, why keep them alive in the first place? I am upset about the ethics of an institution accepting money to do such a study when, in fact, it knows what the outcome would be. In a sense, ethics would be used by those forces which might want to reduce or set a standard or set the social conscience against it. The first step in the progression Leo Alexander described has certainly taken effect in this country already. Is it ethical for the government to do this? Is it ethical for an institution to accept funds to do this knowing in advance that maybe they know the outcome? Should we kill off patients with arthritis because they can't go back to work? They're costing the government a lot of money to keep them alive. Is this logical?

Question: Martin Begun and Rabbi Tendler said something about problems with rich people directing things. You spoke at great length about industry and academic institutions. But what about rich people who have foundations, such as the Rockefeller Foundation and the Ford Foundation? How does an institution sort out ethically and how do foundations behave ethically?

Begun: Foundations, as a matter of record, are similar to government. There are fewer strings on foundation gifts for basic research than one would suppose. It's the private philanthropist, the corporation, which we're going to have to contend with more and more as the corporate world begins to see certain economic benefits from academic and basic science activity. It is the corporation that is going to contractually demand a greater voice in how a physician conducts basic research and how that research is marketed. In my experience, foundations are just like the National Institutes of Health. There may be one or two exceptions to that rule but with the more renowned foundations, the person accepting a grant knows exactly what the framework for utilization of that money is. There are no hidden surprises. Both the protocol and what the terms of acceptance are, are known. You can operate in a free-wheeling academic environment with research funds from a foundation as well as from any governmentally sponsored research program.

Question: Dr. Chalmers, how are we going to handle the growing number of foreign governments giving money to academic institutions?

Chalmers: The impoverished institution is going to face a lot of ethical dilemmas in the next few years. Foreign money is really no different from American money. It is money that is the root of the evil that we are talking about. People don't usually give money unless they want something in return, with the exception of some foundations and the federal government. Industry doesn't really give money unless there is some string attached. We must build many barriers to protect the sciences.

For example, there are two methods by which pharmaceutical firms have blundered clinical trials in the last few years. One company gave $5 million to a nonprofit foundation on the condition that a clinical trial of the company's drug be set up. The contract called for the appointment of a policy board that would make decisions about the protocol, about whether to undertake the study, how to conduct it, and when to conclude it. The conclusions drawn were to be totally independent of the pharmaceutical house. The company, as part of the contract, agreed they would not use any of the results of the study for advertising purposes unless the results were published, and agreed that the decision to publish would be entirely up to the policy board. This is a way in which industry money can be used for the good of the company.
In contrast is another study in which the group running the study was beholden to the pharmaceutical firm throughout. The data were analyzed by the pharmaceutical firm. The paper was written by the pharmaceutical firm and published with the support of the policy advisory board—supposedly independent people. After the study was published, the Food and Drug Administration refused to approve the drug because irregularities in interpretation of the data had been so blatant that there was no reason at all to advocate use of the drug. Yet the conclusion of the study was that the drug is highly useful and should be used right away.

These two cases are quite different and not necessarily venal in their outcome. The second pharmaceutical firm did not recognize the importance of bias in the interpretation of data. People who made their living in the firm looked at the data and concluded it was a great drug. Outside neutral groups analyzing the data concluded that the drug was not a great drug at all. This is what I mean by unconscious bias. The only way to control it is to put definite barriers between the source of the funding and the results.

Undoubtedly there are rare instances of people doing NIH-supported research fudging their data to get positive results. Some do it consciously. But I suspect most do it unconsciously because of the researcher's overwhelming need to get certain results in order to make a living. The problem exists with federal or foundation funding. It is much worse in the direct hands of the industry that is involved. That's why there is all the fuss about Massachusetts General Hospital's use of the $50 million from a pharmaceutical company. I think the fuss would be there whether it was an American company or a German one.

Reaching Institutions

Question: Without education, we're not only going to fudge results, but fudge the whole ability to function properly in our society. What method could be used to begin to educate institutions? Government is beyond, beneath, or above education. You can't educate our president any more. It's not going to do him any good.

Chalmers: A project studying massive doses of steroids for treating aseptic shock in intensive care units was refused by the funding agency. The agency was impressed with the protocol, but there's no money for the proposal. The time just doesn't seem right to get money for such a grant. I asked the proposal author, "What's going on now? Are people using massive doses of steroids for septic shock?" He said, "There are two schools of thought. Some use it and some don't." I said, "What will a doctor do? You're now in a position to train younger physicians. What will you tell your residents to do when they have a case of septic shock?" He said, "I don't know yet. I'm waiting for my results to come in from my study but I can't fund the study. I don't know what to do." No one objects to paying for the steroids or for the care for these patients in intensive care units, one of the most expensive areas in hospitals. Yet nobody, including third-party payers such as Blue Cross, Blue Shield, and insurance companies, has a way to reach institutions. You could say how much money would be saved if the study were funded and how much treatment would be better. Some patients would not be treated with steroids, others would be. The result is that limited resources would get better mileage. Yet we don't seem to have an open channel of communication. We can talk to medical students and maybe even to government. Somehow, there is no way for the individual who has a point of view to speak to institutions, unless he happens to head that institution. This is a frustrating breakdown of communications, which must somehow be opened up again.

The ethical values of an institution are those of the people who run it. The institution has no ethics and no morals other than that of its people. For this case there is a simple solution. A relatively easy study can be done. You might give or you might not give the steroids. You can record the results without any extra costs, whether the patient lives or dies. You don't know which one has the better chance of living or dying, so the study can be done at no cost. Because the third-party payers will pay for steroidal treatment at the moment, although perhaps not in the future, the research is just a matter of the doctor working a little harder to go around more often, to be on call night and day, to come in when the patient is in septic shock. Since reality, not theory, is what determines ethics, you have to be up all night. But surely institutions would save a good deal of money in one year by getting the results of a study.

Greifer: A few years ago, a paper described the ethics of triage and the ethics of constant medical practice. Can we deliver everything that we have in our heads? The answer is no, for several reasons. Not only have we changed, but also the institutions in which we live have changed. Years ago, young doctors worked every other night or
Triage of Patients

Greifer: Most discussions of triage involve the principle first come, first served, based on which patients have been thought qualified for care based on medical knowledge. My question is, Is that medical knowledge in any way influenced? The first cut is not based on whether an individual can qualify for care based on medical knowledge itself, but is influenced a great deal by the availability of resources. You may say all qualified people will be cared for, but who makes that list?

Tendler: As Dr. Gellman correctly pointed out, the tradition of Judaism indeed does not allow for selection of patients on the basis of so-called respective worth. Yet he cited this very complex and difficult example.

Major ethical-moral distinctions may be needed between an individual being asked to make a decision and society being asked to make a decision. Societal factors may have entirely different axioms to go by. I suggest that the discussion in the Talmud of selection of people is never on a one-to-one basis, but, rather, when society must make decisions. These are triage decisions. The issue at hand is, does society have a right to preserve values as a society? Do the same factors which come into play—not choosing one individual life over another individual—apply? Does this apply to legislation, to departments, to institutions? This is our topic.

My father-in-law, Rabbi Feinstein, was asked for an opinion in a strange case of triage. Now it is not considered strange but then it was the first such case. Penicillin had just arrived in Israel. There were eight meningitis cases at Hadassah Hospital. Rabbi Herzog didn't want to take responsibility on himself to rule on this case, so he called Rabbi Feinstein in New York and asked him to join in a discussion of what should be done. Penicillin was available. There was enough for 11 injections. Who should receive it? Without a 30-second hesitation, Rabbi Feinstein answered, "The first bed you come to."

The question is theoretically valid. Given that ten people will die tomorrow for the want of treatment, should I let five die because I fear that tomorrow five, or ten, more patients will come? Obviously in a real situation, you have to treat the patients that are ready to die now. You can save them. You can't say, I'll let you die for someone else. I think your question has real merit when you are speaking about the funding of hospital programs. A community health education program can give tremendous benefit in ten years if we stop smoking instantly today. We most likely would have enough money to fund all our medical needs. Should we spend money for poking away at that problem, educating the populace? Should we spend it all for building more intensive-care beds, more pediatric units with nobody waiting at the moment or dying from lack of care?

I have two future concerns; one is the immediate future and one is the future future. This is where the ethics and morals of the institution, or the individuals who run the the institution, come into play. The needs of society can justify a future future for you without neglecting the immediate future. But no ethical system will allow you to neglect the immediate needs of a patient waiting now for your care.

Budgeting for Future Needs

Question: Rabbi Tendler, is a hospital permitted to base expenditure on caseload? Is it obligated to exhaust all available funds on all present patients? Does the hospital take into account that next week there will be X number of patients requiring treatment? The entire monthly budget may be at my disposal now. Does the hospital use that budget in the first week that patients present themselves, or does the hospital have a choice in expenditure?

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tion, permitted to stop treatment—I mean pain-killers or supportive treatment? What if the patient asks for it?

Gellman: The answer to the last question is no. The reason is that I didn't specify the exact dimensions of what I mean by therapeutic hope because it takes us into the area of euthanasia. It does require further definition. There are two definitions for therapeutic hope, a lenient and a strict tradition. The lenient tradition says that as long as there is no possibility of cure, of reversing the condition, that the person is actually devoid of therapeutic hope and any medical procedure to be conducted would be classified as experimental or, if not experimental certainly not of therapeutic value. I would not endorse such a liberal tradition, though neither would I say that no case could be made for it.

The more conservative position on therapeutic hope would require that the person actually have entered the death process. Again, the traditional definition of death is when death is expected within 72 hours or so—an almost immediate situation, really a virtually certain diagnosis. As long as any possibility of extending life for any amount of time, through any treatment, exists, the doctor is still under obligation to heal. Such acts, even though they cannot reverse the condition, would simply extend life. These acts would be obligatory on the doctor. The doctor is required to treat. I would endorse this position.

Medical Ethics as a Discipline

Gribetz: There is a dilemma now of establishing ethics as a discipline. There are many institutions around the world that have what are known as ethics rounds. They make rounds at the bedside and discuss the very question that you raised, plus others. It is believed now by many of us in medicine that ethics rounds should include the doctor, the parents if it's a child, or the relatives, the nurses, the medical students, the house officers, the social workers, sometimes the lawyer of the hospital (for obvious reasons), and the ethicists—the rabbi or priest. There are very difficult decisions to make because many factors enter into a decision. The contention of the ethicists is that if you bring these problems into the open, even in individual cases, consensus develops from such a discussion.

What we're all saying is society is deciding. Society is the group of people who are around the bedside of the particular patient. This is beginning to happen more and more. No longer can a doctor go to a bedside by himself and turn off a machine or withhold treatment or make some other decision. We're way past that. Society now demands that it take part in the decision.