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Interventions and Persons

Samia A. Hurst, Geneva University Medical School

Rosoff’s proposals for short-term rationing at times of drug shortages rightly exclude the possibility of giving priority to “people such as senior hospital administrators or medical staff, major donors to the institution (or their family members), important political figures” (Rosoff 2012). Indeed, this is what we intended by the criterion of reciprocity, which is cited by Rosoff in his article. Rather than a call for compensation, this criterion aims to ensure that it is a patient’s clinical situation, rather than her social position, which serves as a basis for resource allocation. As we put it then: “The demand for reciprocity cannot dictate that reciprocity should be literally feasible at the given moment a rationing decision must be made. . . . It should however be the case that if the patient who is about to forgo a resource were in the opposite situation, in the situation of the patient who will benefit from the sacrifice, the clinician would, upon reflection, be willing to parse out the necessary resource to her” (Hurst and Danis 2007, 259).

Short-term rationing in hospitals, and indeed any kind of rationing, should be restricted to placing limits on (certain kinds of) interventions, and not on persons. Rosoff’s arguments on this point could be strengthened. This is particularly important at a time when others have argued in favor of a degree of priority based on contributions of individuals to society (Schneiderman 2011). Moreover, social status is reported as a criterion for resource allocation and, although the reported rate is low, it is likely to be underestimated due to social acceptability bias (Hurst et al. 2006).

At least four arguments could be put forward:

First, because persons faced with the prospect of being denied a lifesaving drug will “use all their financial resources and political voice to obtain the needed treatment” (Goodman 2012), any limits that targets persons is likely to follow the path of least resistance and lead to the exclusion of the most vulnerable (Hurst 2008). This would be wrong because health care resources are de facto shared resources and should as such be regarded as a common good to which rules of cooperative fairness will need to apply (Rawls 2001).

Second, health care is not only a shared resource but also a collective endeavor that cannot be sustained as anything else. Any exclusion based on social characteristics is imprudent: It risks the unraveling of the collective support that medical institutions need.

Third, even if one were to accept the premise that priority could be given based on the basis of contribution to the health system, it would be unfairly simplistic to give priority based on financial contributions to a hospital. Such preferment would disregard the fact that contributions to medicine are manifold and made by a great number of different persons—sponsors, but also, among others, health professionals, drug and device manufacturers, researchers, cleaners, cooks, postal service workers, computer technicians, taxpayers, and research subjects. Even in a country such as the United States, where coverage is not universal, health care is nevertheless a collective endeavor. The uninsured pay taxes, some of which contribute financially to hospitals, state insurance programs, and medical research. They also—very likely disproportionately—contribute to medical progress as research subjects ( Pace et al. 2003). Given the number of other examples, defining a category of those who have made a particular contribution of the kind that could theoretically warrant priority would be arbitrary.

Fourth, even if it were admitted that we should give priority to those who contribute particularly greatly, rather than to those who contribute something, differences would only exceptionally be so great as to warrant priority in what may be a life or death situation. One could even argue that it would never be so great because individuals contribute to the level of their abilities and choices, making any merit involved rather arbitrary (Young 1992).

Although individual merit of “people such as senior hospital administrators or medical staff, major donors to the institution (or their family members), important political figures” (Rosoff 2012) might be generally undeniable, then, and although hospitals might be inclined to give such contributors priority for other reasons (Hurst and Mauron 2008), their merit would be an erroneous and imprudent basis for priority, may be called into question, and could in fact not be so great as to warrant such a difference in prioritization.

REFERENCES


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Influences are potentially great. For example, patients who scope of consequences and resulting harm from secondary (IOM 2009, 52–54). In the case of rationing scarce drugs, the interest, including the scope of the resulting consequences greater harm is a result of the influence of the secondary unconscious biases and conflicts of interest by the commit-

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or professional relationships with patients who are being evaluated as to whether they should receive a scarce drug. There should be no financial, personal, or professional repercussions from the health care organization to committee members who follow policy guidelines. Full support of the hospital leadership is a must. In addition, quality of care ratings of physicians by the hospital and of physicians and the hospital by insurance companies and government and accreditation agencies should account for variations from standard treatment protocols and expected patient outcomes that are the result of drug shortages.

All identifying information about individual patients should be removed from materials reviewed by the committee. This includes not only names, physicians, and unit location, but also sex, age, race, ethnicity, religion, marital status, children, occupation, address, insurance or lack of it, and any other information not medically relevant to the selection process to help eliminate conscious and unconscious biases of committee members toward a particular patient or group. Random numbers can be used to identify patients.

Including hospital and medical staff in the policy development, implementation, and evaluation process from the start, along with full transparency, can help promote buy-in and acceptance of the policy and process. Stressing the evidence-based medical indications selection method and fairness of the process that is not to be swayed by


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Philip Rosoff in “Unpredictable Drug Shortages: An Ethical Framework for Short-Term Rationing in Hospitals” presents an objective ethical allocation policy for scarce pharmaceuticals that goes beyond procurement and distribution issues (Rosoff 2012). However, its successful practical adaptation by hospitals requires further discussion of the avoidance of conscious and unconscious biases and conflicts of interest for all involved in the actual allocation decisions, along with a similarly precisely defined appeals process. The emotional impact of this decision-making process on panel members, particularly when reasonable treatment alternatives are not available and the denial of access to a scarce drug may result in the worsening of a patient’s disease, should be assessed and be part of this ethical framework. Psychological support, care, and counseling for committee members should be provided to help avoid burnout and reluctance to adhere to the policy.

Principle components of Rosoff’s policy include transparency and fairness. Transparency for Rosoff refers to both the methods by which the decision process occurs and the individuals making the decisions. Transparency is essential for trust and acceptance of the policy by all, as lack of transparency was a major criticism of the Seattle dialysis selection committee (Broome 1984, 39). Fairness requires similar patients to be treated the same (Rosoff 2012). However, these require the complete avoidance of conscious and unconscious biases and conflicts of interest by the committee members, which may be hard to achieve.

Conflicts of interest are believed to be more severe when greater harm is a result of the influence of the secondary interest, including the scope of the resulting consequences (IOM 2009, 52–54). In the case of rationing scarce drugs, the scope of consequences and resulting harm from secondary influences are potentially great. For example, patients who may not benefit from a drug receive it, while patients who meet evidence-based medical criteria and may benefit do not. Scarce resources can be wasted. Trust and credibility of the policy may be lost, resulting in staff, physicians, and patients being unwilling to participate in the process.

To decrease conflicts of interest, committee members should recuse themselves if they have any current or past personal or professional relationships with patients who are being evaluated as to whether they should receive a scarce drug. There should be no financial, personal, or professional repercussions from the health care organization to committee members who follow policy guidelines. Full support of the hospital leadership is a must. In addition, quality of care ratings of physicians by the hospital and of physicians and the hospital by insurance companies and government and accreditation agencies should account for variations from standard treatment protocols and expected patient outcomes that are the result of drug shortages.

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