Afterword

This volume is the third in a series examining consumer demand for ineffective intensive care—medical treatment that serves only to prolong a death spiral but is insisted upon by optimistic surrogates in the face of contrary advice by expert providers of intensive care.

Patients and their families demanding expensive and ill-advised medical care? How can this be, when evidence-based medicine ensures that prognoses are more accurate than at any other time in history?

There are several stock replies to the question of individuals demanding disproportionate health care resources at the expense of the whole population:

1. The problem can always be solved by better communication.
2. This demand doesn’t occur often enough to justify the public relations troubles that providers would experience if a protocol limiting such care were instituted.
3. Even when this excessive use of medical resources does occur, the money spent is inconsequential compared to the total expenditures for health care.
4. Physicians do not have an admirable track record of predicting death; there is always the potential for unexpected survival.
5. Health care consumers have a right to use as many resources as they wish, and society must foot the bill no matter the amount because this is the right thing to do in a prospering society.
6. Saying no is synonymous with “death panels” in terms of hastening the deaths of old, sick people to save money.

The mission of this volume was to address these issues in a multinational forum. Critical care physicians from ten countries reported on their resource allocation before the global financial crash of 2007–2008 and on their plans for resource allocation.

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in the following decade. Among these ten countries was the world’s largest con-
sumer of medical services, in both private practice and academic medicine: the
United States.

Data on use of medical resources in the non-American countries represented in
this book are no surprise. These countries endeavor to provide health care for all or
most of their populations using limited resources. In so doing, they must prioritize
health care expenses, just as other national budget items are prioritized. Some
enforceable form of rationing is used to fund universal health care for their citizens.
These multinational data also suggest that the funds for all national services will
diminish in the future, and collective belts will have to be tightened to maintain
health care coverage.

The United States, on the other hand, indemnifies only a portion of its popula-
tion, and at a high cost that increases yearly. The United States stands apart in
another way as well: it is unwilling or unable to say no to inappropriate use of funds
for the most expensive care rendered in medical facilities—intensive care.

The expert analysts considering these issues for this volume mostly arrived at
conclusions that have been expressed for years. Nearly every contributor to this
book agreed that there is a problem with inappropriate demands for ill-advised med-
ical services, especially at the end of life. The proposed remedies run the gamut
from better communication to various means of creative arm-twisting, but all the
authors stopped short of advocacy of saying no as an enforceable policy.

Dr. Sprung suggested that most recalcitrant surrogates will come around in time
if worn down by the usual process, but he stopped short of advocacy of saying no as
a matter of enforceable policy. He wrote: “Doctor’s actions not honoring patient or
family requests especially if based more on society’s needs than those of the indi-
vidual patient will undermine trust in the medical profession.” Drs. Rie and Chal-
fined described a health care system as it would be in a perfect world but stopped short of
describing objective means to regulate it. Drs. Kuiper and Hollenberg suggested that
it is appropriate to have a floor and a ceiling for medical care services, but they
stopped short of advocacy of saying no as an effective means of achieving that goal.

All the contributors to this volume agreed that some regulatory means are neces-
sary to maintain the integrity of a health care system, but none expressed a desire to
look unreasonable patients and their families in the eye and say no. Several authors
related that they do say no on occasion but always after the surrogates finally agree
to stopping ineffective intensive care. Saying no in the face of adamant refusal by
surrogates is another matter entirely, and few if any physicians will back down in
such situations. Many physicians are concerned about threats of legal action by sur-
rogates. Mr. Ross suggested that such lawsuits are unlikely but hastened to add that
there is no solid legal precedent protecting providers from legal threats.

The hypothetical Fair and Equitable Health Care Act (FEHCA) was created for
this volume to allow experts in the field of medical resource provision to evaluate
and criticize a system that prioritizes health care coverage by setting enforceable
limits. This plan was formulated to offer the most benefit to the most consumers and
is sensitive not to their desires or demands but to needs that are amenable to
indemnification.
Dr. Kilcullen suggested that the time has come to consider plans like the FEHCA as cost-effective methods of maximizing care and avoiding bankruptcy, and that such plans will have to be accepted, regardless of public expectations. Drs. Rie and Kofke proposed that the plan does not go far enough in its provisions, will not be accepted by the public, and will be watered down by the political process.

Dr. Whetstine, ethicist, suggested that saying no does not violate traditional ethical canons but would be a significant practical problem for a society that has become accustomed to entitlement. Expected customer service may trump resource allocation.

These criticisms are remarkably similar to criticisms of the Simpson–Bowles plan to spread the pain of cuts in the US budget. Everyone agreed cuts needed to be made, no one agreed on how to accomplish this, and so the economy continues its headlong rush to disaster.

The potential for financial collapse looms large for the rest of the world as well. Drs. Kuiper and Hollenberg suggested that the global village will adapt to the availability of fewer resources by accepting that universal health care does not mean coverage of all care desired by the consumer. Longer queues and limitations on the use of some resources because of cost are inevitable.

The resource pie has a finite volume and can be cut a finite number of ways. Fairness dictates that everyone has access to the pie, but the size of the slices cannot be dictated by consumer desire. Saying no will not only be effective for cost control, but also it will be mandatory. Drs. Kuiper and Hollenberg stopped short, however, of detailing precisely how decisions will be made about who will be covered for what, arguing that such issues depend on local considerations.

Traditionally in the United States, escalating health care costs have been accommodated through increased charges on the national credit card, avoidance of payment for medical services after they have been performed, and decreases in the pool of consumers by means of pricing care beyond their ability to pay. All these rationing devices became technically obsolete when the American Congress passed the Patient Protection and Affordable Care Act in March 2010.

Among other provisions, this legislation ends the private insurance industry’s propensity to discriminate against sicker patients, and will indemnify 96% of Americans in a portable manner. This means a lot more resources will be needed to support the expected additional 31 million medical consumers in an already overheated provision system.

Dr. Angus suggested that under such a system, American physicians will use technologically advanced command centers to direct cost-efficient bedside-care managers in the form of nurse practitioners. This approach will solve part of the problem, but the issue of limits and saying no continues to be avoided, and will not be resolved quietly.

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The current refusal by the United States Congress to cut spending and raise taxes will mean a static or decreasing amount of funds for rising health care expenses. Back in the day, the supply of clinical resources was limited by the ability of consumers to pay for it. Among other things, this meant the need for health care was provided by “teaching hospitals,” the likes of Bellevue, Cook Country, Grady, and Charity hospitals dedicated to serving the public at large cheaply and training house staff in the process. There were large 30-bed wards, no creature comforts, TV sets, physical or occupational therapy, and only rudimentary rehabilitation.

Patients were given the benefit of an augmented healing process for treatable diseases commensurate with cost constraints. Technology was sparse. Survival of the fittest ruled. If a patient became septic, or developed respiratory failure, they died. There were few stragglers to land in ICUs for months of expensive care to produce a relatively few survivors. Then with the advent of Medicare and Medicaid in 1965, money became available to finance the medical–industrial revolution, and survivors of formerly fatal diseases dramatically increased, as did the cost to get them there.

Now as we enter the probable inability to finance the inverse pyramid of cost, the reverse scenario is likely to occur. Expensive programs serving the fewest patients will become extremely difficult to fund, elective resources that expensively promote patient comfort will dry up. The attitude that health care providers must necessarily be well rested and comfortable may as well. It isn’t out of the question that we may return to 30 bed wards and patients’ families carrying out half the nursing load.

Private insurance companies compelled to suspend rating risks for illnesses will stop writing insurance, forcing indemnification onto the government. The tendency of the government to reimburse only a portion of providers’ expenses will result in more hospitals going out of business and more providers refusing to deal with government-insured patients. This downward spiral can be slowed by cost-efficient measures that sidestep the difficult issue of saying no, but such measures will only prolong the problem of too much demand and not enough resources.

Our inability or unwillingness to say no is an immovable object, and our inability to fund unlimited demand is an irresistible force. There is a strong likelihood that American health care will burst in totally unpredicted ways as the irresistible force meets the immovable object. We will all be observers of this process in our lifetime.
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