Who gets what?

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Before Terri Schiavo, there was Robert and Tracy Latimer. While both cases dealt with euthanasia, the circumstances differed greatly. One involved the withdrawal of a feeding tube – a passive acceptance of death. The other involved a father poisoning his severely disabled daughter with vehicle exhaust fumes – an active pronouncement of death, or as some would say, murder. Both cases are linked by their ability to polarize the population and for their intense media scrutiny. The media has focused our attention on the issue of assisted suicide and the many nuances contained therein, including what form it ought to take, at what point is it ever acceptable, the inability of a patient to give consent, and what is reasonable if the patient is a child. In the case of Robert Latimer, however, there has been little, if any, attention paid to a central issue: prevention. Tracy Latimer was not born with a heritable disease, but with severe cerebral palsy from anoxic brain injury during birth in a hospital in North Battleford, Saskatchewan, in November 1980. When Robert Latimer was asked about his past regrets, he had no words about assisted suicide. Instead, he regretted his daughter ever having been born with cerebral palsy. He lamented that the hospital's only form of fetal monitoring – heart rate assessment – was not functional on that fateful day.

In this sense, the origins of the Latimer case shed light on the responsibility for quality of care and availability of resources. Should the hospital not have had a backup fetal heart rate monitor? It also should be a sobering reminder of the consequences of poor decisions for those administrators responsible for resource allocation.

Resource allocation and its less palatable cousin, rationing, are major issues in contemporary medical practice. They are practiced at all levels in the clinical arena. According to Dr Peter Ubel, Professor of Internal Medicine and Director of the Center for Behavioral and Decision Sciences in Medicine at the University of Michigan, physicians can and should practice bedside rationing as a means to contain costs in the short and medium term. Dr Ubel argues that this form of cost containment is the lesser of all evils, as other means would

more seriously compromise quality of care for all patients. Limits to bedside rationing are set. They include rationing of therapies and tests with high costs and only marginal benefits, as well as educating physicians on the cost effectiveness of therapies. Critics, however, charge that relaxing the 'physician as patient advocate' responsibility, inherent in bedside rationing, jeopardizes the trust between physician and patient. It also opens the door to discrimination based on ability to pay for a service. Furthermore, if two physicians came to different conclusions for two similar patients, would this not amount to injustice through inequity? The introduction of bedside rationing makes the possibility of arbitrary decisions more likely.

Resource allocation for the purposes of health at a policy level is no less difficult for those involved or less controversial. It has broader implications than merely the delivery of diagnostic or therapeutic services. In northern Ontario communities, for example, health resource allocation may be better utilized by improving housing conditions and ensuring clean water rather than by acquiring an MRI scanner. Yet the demonstration of need is only one principle that guides resource allocation. Other ethical principles of scarce resource allocation, also known as distributive justice, must be considered. These include equity, societal contribution, ability to pay, patient effort and merit. Different societies will value these components differently and in different ways. For example, should we value an individual's future or past contributions? Should this even be a criterion at all?

In an ideal world, there would be no scarcity of resources. To those not involved in decision-making, decisions often appear arbitrary or even politically motivated. For example, shuttling patients within a province to centres with shorter waiting times for a procedure is not a 'care guarantee' for timely care but rather an abject failure of planning initial resource allocation. While the consideration of the principles of distributive justice frequently raises more questions than it answers, these principles must be adhered to if we truly live in an egalitarian society.

Selected sites:

1. The Medical Post
www.medicalpost.com/mpcontent/article.jsp?content=/content/EXTRACT/RAWART/3637/67A.html	4. The Centre for Professional and Applied Ethics
www.umanitoba.ca/centres/ethics/articles/article5.html
2. American Medical Association
www.ama-assn.org/ama/pub/category/11529.html	5. Australian Government National Health and Medical Research Council
www.nhmrc.gov.au/publications/_files/e24.pdf
3. American Nurses Association
www.nursingworld.org/ojin/topic8/topic8_5.htm	

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