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BIOETHICAL DECISIONS AND OPPORTUNITY COSTS

*The Honorable Justice Michael D. Kirby, CMG**

In this essay, I propose to analyze the varied ethical and other criteria by which decisions are made (at both *macro* and *micro* levels, as economists would term it) concerning the distribution of scarce resources available for health care in the community. In part, my topic is relevant to the amazing advances of science and technology in our generation. These advances, whether in the realm of *in vitro* fertilization, scans, nuclear magnetic resonance, heart and liver transplants, or renal dialysis, present quandries to the medical community and to the taxpayer. They are problems that have not always been clearly faced even though, as I will show, their resolution sometimes involves literally life and death matters. Changes in social attitudes, partly reflected in the decisions of the courts, have tended to replace assured and self-confident decisions of the medical profession with a growing insistence by patients upon their right to know and choose, or, particularly when vital decisions are made affecting their medical treatment. The central focus of my subject, then, is the interrelationship between the amazing developments of medical science and the scarce resources that are available to spread the fruits of those developments throughout the community to the many patients who might, however fleetingly, benefit from them.

I. THE SAGE AND MCNAIR-WILSON DILEMMAS

The Case of Sage

Early in 1983, Mr. Derek Sage, then aged forty-two, came under the care of the renal unit of the Churchill Hospital at Oxford, England. Mr. Sage had a history of psychiatric illness, hypertension and impaired renal function. His right kidney did not function and his left kidney was defective. He lived at Simon House, an Oxford hostel for single homeless men. By March of 1984, the functioning of his kidneys had become so poor that he required dialysis. Immediately after this treatment began, however, his mental state deteriorated. He spent a period of months in a psychiatric hospital, regu-

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larly being brought to the renal unit for dialysis. His behavior became "increasingly disruptive" when he visited the unit. A previously suspected brain tumor was re-explored and extensive areas of cerebral damage were discovered. He became demented. His mental age was put at about three years. He did not respond to simple questions. At times he was violent, generally uncooperative, dirty, incontinent of urine and feces, unable to take medication reliably, and unable to adhere to a prescribed diet. He exposed himself and masturbated while being examined. A great part of his life was spent under sedation, particularly when he was being dialyzed. His blood pressure was not properly controlled.¹

The renal unit staff came slowly but surely to the painful conclusion that the treatment by dialysis was a "failure." The dialysis sessions were proving a torment to both the patient and medical staff, as well as affecting the unit's capacity to deal with other patients.²

When Mr. Sage arrived at the unit for routine dialysis on December 28, 1984, the nurses on duty told the consultant in charge that in their view the continuation of his treatment was "not in the patient's best interest." The consultant, it seems, expected "fierce opposition" to any decision to end the treatment. The decision to end treatment was made, however, and it was made without consulting the hostel staff or the general practitioner who had been treating Mr. Sage. "Friends" of Mr. Sage learned of the decision on December 31, 1984. They were shocked and angry.³ They asserted that there was a "reasonable quality of life" that could be enjoyed by Mr. Sage, and they begged the consultant to change his mind. He declined to do so. Opportunity for review of the decision was referred to the local medical authority. However, the decision had to be made promptly since, without dialysis, the patient would soon die. It was at this stage that the director of the hostel for homeless men, in which Mr. Sage had spent his life, approached the President of the British Kidney Patient Association. An appeal was made, not to the courts (as would probably have occurred in the United States of America) but to the High Court of Public Opinion. Items began to appear in the media.⁴ The British Kidney Patient Association took this unlikely and seemingly unattractive patient as a symbol and an example of the scarce resources available in Britain for the treatment of patients requiring dialysis.⁵ A Labour member of Parliament called for an independent inquiry

1. Brahams, *When Is Discontinuation of Dialysis Justified?*, 1985 *THE LANCET* 176 (Jan. 19, 1985), and 8,371 *THE TIMES* (London) 7 (weekly ed. 1985).

2. See Brahams, *supra* note 1, at 176.

3. *Id.*

4. *Id.* at 177.

5. *Id.*

into the issue of allowing some kidney patients to die because doctors believed that it was "not worth keeping them alive."⁶ The Oxfordshire District Health Authority defended the decision. It asserted that the results in Mr. Sage's case had been reached "purely on medical grounds," and it dismissed the claim that his treatment had been cut off after two years because he was "dirty and difficult." The Authority also dismissed the suggestion that the County was practicing "passive euthanasia." However, a spokesman did concede, in a rather British way,

He will not take his tablets to keep his blood pressure down. Possibly if he had come from a better background and stable home he would still be treated.⁷

It was pointed out that, far from being unduly parsimonious in the provision of dialysis, Oxford's provision for kidney dialysis was actually higher than the national average in Britain. Furthermore, the Oxford Authority had a policy of continuing to treat patients who had a high risk of dying.⁸

The British Kidney Patients Association was unconvinced. It offered to pay the four hundred pounds a week necessary for dialysis to keep Mr. Sage alive. The President of the Association declared:

You cannot say this man's life is more valuable or worthier than another man's life. Can you imagine what this terrible case must mean to dialysis [sic] patients?⁹

Springing to the defense of the Government, the Under-Secretary of State for Health, Mr. John Patten, told the House of Commons that the National Health Service in England provided places for thirty-three people in a million to have dialysis, compared with only twenty-four in a million five years earlier. The Government intended, he said, to increase the provision to forty places in a million by 1987. However, even at this figure the British level was among the lowest in Europe. In the United States, nearly ninety places in a million were provided. Typical figures for other parts of Europe were Belgium, sixty-one; Spain, sixty-one; West Germany, fifty-six; Austria, fifty-four; Norway, fifty-four; The Netherlands, forty-six; and France, forty-four.¹⁰

The Case of McNair-Wilson

Contrasting the case of Mr. Sage with the case of Michael McNair-Wilson

6. 8,371 THE TIMES (London) 7 (weekly ed. 1985).

7. *Id.*

8. *Id.*

9. *Id.* See also Brahams, *End-Stage Renal Failure: The Doctor's Duty and The Patient's Right*, 1984 THE LANCET 386.

10. 62,031 THE TIMES (London) Jan. 9, 1985, at 3, col. 3.

would be beneficial. He is a man aged fifty-four years who has been the Conservative member of Parliament for Newbury, not far from Oxford, since 1974. On November 8, 1984, Mr. McNair-Wilson made a moving speech to the House of Commons. Among other things, he said:

Since last January, I have been the victim of a rare kidney disease. Without kidney dialysis, I would be a dead man. The NHS met my need for treatment without requiring me to show that I had funds to pay for it. It operated on supply and need, not supply and demand. That will always remain true of the NHS. That is why it is such a precious asset to us all."¹¹

The contrast between these two cases could not be more stark. Yet it merely illustrates the statistical extremes which exist by reference to two individual cases. I would not want you to think that Mr. Sage was alone in his predicament. The British Kidney Patient Association maintains that between two thousand and three thousand people a year die in the United Kingdom from renal failure and the Association asserts that many of these deaths are unnecessary.¹² The facilities for dialysis (not to mention renal transplantation) vary greatly from one area of the country to the other. Of course, the older one is, the more complications he may have and the less, it seems, is the chance of obtaining treatment by dialysis. *The London Times* made an important point, aggregating the experience of Mr. Sage in an editorial provocatively titled, "Prolonging Low Life."¹³

It would be a mistake to think of the case of Mr. Derek Sage, the kidney dialysis patient, as unique. He is unusual only because his treatment was stopped after it had been [sic] begun and because someone else has been found to start it up again. Every year in Britain several hundred kidney patients die without ever being offered treatment even though they could perfectly well be saved in the present state of the medical art, and would be saved in almost any other country in Europe or North America. But usually doctors make a long face and explain to the patients that unfortunately their case is not suitable for dialysis or transplant. They seldom add . . . that the patient's unsuitability may reside principally in the intractable symptom of having passed his 45th birthday."¹⁴

The inexorable calendar, and the passing of the years, it seems, is the criterion (or at least one of the criteria) for the distribution of scarce resources. Is this a proper principle? Is it an acceptable approach, when the business of life and death is concerned with the application of the fundamental eco-

11. *The Guardian*, Jan. 9, 1985, at 10, col. 3.

12. 1984 *THE LANCET* 386.

13. 62,031 *THE TIMES* (London), Jan. 9, 1985, at 11, col. 1.

14. *Id.*

conomic problem: the allocation of scarce resources? The students of economics learn of the "economic problem" in their first lecture. But the community tarries before acknowledging the application of the economic problem to matters so intangible as justice or so essential and personal as life and death. Yet apply it does. And never more so than in our generation.

II. OTHER CASES

The cases for the application of what I will not call the "Sage Principle" abound in present society. They are rarely acknowledged and little discussed. Yet they certainly exist.

Liver Transplants

Recently a decision was made to establish a liver transplant center at the Royal Prince Alfred Hospital in Sydney. Earlier in the year there was much debate in Australia concerning the cooperation, or lack of it, between the states of Victoria and Queensland.¹⁵ But the debate stemmed, in part, from the competition of various medical teams for the privilege and obligation of the National Liver Transplant Unit, as this country's resources were unable to support, at least initially, more than one.

CT Scanners

These were first introduced in about 1979 when there was a serious shortage of the scanners as well as the places that could be made available for use of the equipment. Thus, the only answer was to ration the accessibility to this new medical tool. In theory, these early scanners in Australia were provided to the major teaching hospitals only—and it was asserted that they would be available there to provide a service to the surrounding district. In practice, the rationing which took place frequently depended upon whether the patient's doctor was attached to the hospital fortunate enough to have the CT scanner. It is one thing for government health administrators to lay down broad and equitable principles; it is another for the people on the spot, with control of the facility, to ignore their institutional loyalties and time honoured ways of doing things. Yet access to the CT scanner is terribly important and has been so ever since its early availability. According to the *British Medical Journal*¹⁶ there is, as yet, relatively little information on the influence of CT on patient management in oncology. However, reported studies indicate that CT directly alters clinical decisions in fourteen to thirty percent of patients. The author, extracting this information from

15. The Sydney Morning Herald, Feb. 1, 1985, at 3, col. 1.

16. 1984 BRIT. MED. J. 527.

United Kingdom statistics, suggests that further evaluation of the CT scanner in the management of cancer is appropriate because of the high cost of the technology, by inference its rationing and, as yet, its limited availability to patients.¹⁷

Nuclear Magnetic Resonance

There is now another development which should be mentioned. This is the advent of Nuclear Magnetic Resonance (NMR). This is a new marvel of technology which provides for more sensitive examination than even the CT scanner. It is particularly useful in the diagnosis of benign tumors at the back of the brain. It can help in differential diagnosis, taking the technology one step beyond the remarkable advance of the CT. A recent essay in the *Medical Journal of Australia* under the title "Magnetic Resonance Imaging" (MRI)—the same thing as NMR—calls attention to the recommendation of the Australian National Health Technology Advisory Panel to the Federal Minister of Health in May, 1984, that three MRI units should be promptly purchased, installed and evaluated in teaching hospitals in Brisbane, Sydney, and Perth. The total cost of these units would be \$9.9 million. However, the Budget Cabinet in Australia decided in 1984 not to fund the purchase and evaluation of MRI for the three sites mentioned. This decision was made despite the support of the Committee, the favor of the Australian Medical Association and the Royal Australasian College of Radiologists, and the advocacy of the Federal Minister for Health, Dr. Blewett, and his Department.¹⁸ Moreover, a decision was, it seems, made that no fee would be provided in the medical benefits schedule for private MRI. The consequence is that we have no MRI (NMR) units in Australia at all. The comment of the Royal Australasian College of Radiologists was tart:

These decisions are unconscionable and the College cannot condone the consequence: the Australian public is not obtaining access to the most effective diagnostic services. Patients have already flown to the United States for MRI investigations."¹⁹

Resources are scarce. Times are hard. The downturn of the Australian dollar will not make the purchase of overseas high technology in medicine any easier. But the case vividly illustrates the economic problem that must be faced when decisions are made concerning new technology. Increasingly government officials and the medical literature are calling attention to the economic implications of the installation of new technology both in coun-

17. *Id.*

18. Royal Australian College of Radiologists, *Magnetic Resonance Imaging (MRI) in Australia*, 142 *AUSTRALIA MÉD. J.* 60 (1985).

19. *Id.*

tries and in particular hospitals and medical institutions of those countries.²⁰ One of the problems attracting special attention is the lack of a rational plan for the distribution of new and advanced technology, so that equipment which becomes common-place in private offices (even if not supported by Medicare benefits) is often unavailable in the most prestigious medical centers of the country because of limitations in public funding decisions, as illustrated by the MRI decision in Australia.

I have moved from the *micro* case of Mr. Sage and Mr. McNair-Wilson to the *macro* problem of high tech and national budgetary decisions. But such *macro* decisions have their ripple effect. Ultimately, they affect the lives of ordinary people. For such people, either the tumor will be discovered early or it will not. Either the dialysis will be made available or it will not. Either the CT scan will be used or it will not. Either the *in vitro* fertilization program will be available or it will be denied. Either the heart or liver transplant will be ventured or it will not. Criteria do exist for these decisions. But all too often they are silent criteria hidden behind what the *London Times* has described as the doctor's "long face" and the general assertion that the patient "is not suitable" for the treatment in question, or that the procedure that might be so beneficial is "not available" either generally or in his case.

III. THE LAW

What do lawyers have to contribute to this debate? In the United States there is a much higher level of provision of intensive care than in Britain and, seemingly, Australia.²¹ There is also a much higher level of dialysis. But not everybody welcomes this provision of expensive care. Somewhat self-contentedly, the *British Medical Journal* declared that the difference of 15 percent acute hospital beds in the United States compared to only 1 percent in Britain represented evidence of the "inappropriate use of intensive care" in the United States.²² Perhaps more relevant to the Sage case, *Time Magazine* declared recently:

The only real precedent for federal intervention is Congress's decision in 1972 to pay 80% of the ruinous cost of kidney transplants and dialysis for anyone whose kidneys fail. Congress expected to pay nearly \$140 million for 5,000 to 7,000 dialysis patients. The first year's bill came to \$241 million for 10,300 patients. In a dec-

20. See Margulis, *White House Lecture, Radiologic Imaging: Changing Costs, Greater Benefits*, 136 AM. J. ROENTGENOLOGY 657 (1981); Evens, *Economic Implications of a New Technology Installation: a CT Model* 136 AM. J. ROENTGENOLOGY 673 (1981).

21. Jennett, *Inappropriate Use of Intensive Care* 289 BRIT. MED. J. 6460, 1709 (1984).

22. *Id.*

ade the number of patients has soared 82,000—including dying cancer victims and nursing octogenarians—at a cost of \$2 billion, which accounts for 10% of all Medicare payments for physicians.²³

In the United States, at least some of the great care that is taken to provide the full panoply of medical facilities, whatever the age and quality of life of the patient, may be attributed to the ever increasing number of medical malpractice suits.²⁴ While these should not be exaggerated,²⁵ they do represent a haunting concern that stimulates the medical profession into the provision of facilities and treatment that might not be afforded in other countries. As well, there are decisions such as those of Congress. In a sense, the litigation and the Congressional decision reflect American attitudes toward the individual human life in the United States. Indeed, it is now being suggested that there may even be constitutional bases for insisting upon the right to treatment.²⁶ I do not pause to analyze these American developments. We seem further away from a Bill of Rights in this country than ever. More relevant are decisions and opinions on the law in the United Kingdom. The Sage case has directed attention to a previously unknown and unreported decision of the English Court of Appeal in 1980.²⁷

The case involved four people living in Staffordshire. They had gone to Court urging that the health services were insufficient in their area. They sought a declaration that the Secretary of State had not fulfilled his duties to provide a comprehensive health service. The complainants were two elderly ladies, an elderly man, and a girl who had all been on the waiting list for orthopedic surgery for some years. The complaint was supported by doctors in the area, including a consultant surgeon.²⁸ As far back as 1965, the surgeon's duties were to organize a comprehensive orthopedic and accident service for the area, which was an expanding one with a large population. Plans had been made to upgrade a hospital, which included replacing some old huts. But the cost estimates for achieving this had risen every year. The result was that although the project had been approved, it could not be com-

23. Friedrich, *One Miracle, Many Doubts*, TIME, Dec. 10, 1984, at 72.

24. See N.Y. Times, Feb. 15, 1985, at A1, col. 2, discussing the American Medical Association's Third Report by Special Task force on Professional Liability and Insurance.

25. See Kirky, *Negligence and The Physician*, 14 AUSTL. & N.Z. J. MED. 867 (1984).

26. Appelbaum, *Is the Need for Treatment Constitutionally Acceptable as a Basis for Civil Commitment?* J. MED. & HEALTH CARE (1984).

27. See Brahams, *Enforcing a Duty to Care for Patients in the NHS*, 1984 THE LANCET 1224. The case was also discussed in *Rationing of Resources*, 290 BRIT. MED. J. 374 (1985); R v. Secretary of State for Social Services, West Midlands Regional Health Authority, & Birmingham AHA, et al., THE LANCET, Nov. 24, 1984, at 1224.

28. See *supra* note 27.

menced within cost limits. The Minister of the day, Dr. David Owen, explained in 1975 that it was necessary to cut expenditures. His predicament was not dissimilar to that of Dr. Blewett. The result was that the hospital could not "command sufficient regional priority to start within the next 10 years." Indeed, by 1978 the proposal for expansion was put off indefinitely.²⁹

The legal case was based upon the statutory duty of the Secretary of State, under the English National Health Service Act of 1977, to provide throughout the country "to such extent as he considers necessary to meet all reasonable requirements" medical and hospital facilities. It was argued that this duty, imposed by the parliament, had to be fulfilled.³⁰

Lord Denning, in his judgment dismissing the appeal, said:

It cannot be supposed that the Secretary of State has to provide all the latest equipment . . . [and] it cannot be supposed that the Secretary of State has to provide all the kidney machines which are asked for, or for all the new developments, such as heart transplants, in every case where people would benefit from them.³¹

Lord Bridge, during argument, said that if the patient's contention was right, a startling conclusion emerged; namely, that the Ministers of State had been "in flagrant breach of duty under the statute for ten years and that this had gone (rather surprisingly) unnoticed by parliament." He added,

I feel extremely sorry for the particular applicants in this case, who have had to wait a long time, not being emergency cases, for necessary surgery. They share that misfortune with thousands up and down the country. I only hope that they have not been encouraged to think that these proceedings offered any real prospect that this court could enhance the standards of the NHS, because any such encouragement would be based upon manifest illusion.³²

The legal correspondent for the *Lancet* commented:

It was perhaps unrealistic to hope that the courts could intervene in what must be seen as a political judgment of priorities. Had they done so, the government could easily have amended the Act, although it would have forced a debate in parliament. But what of it? The position has remained the same under successive governments faced with the Mr. Micawber syndrome, and the misery of patients (and staff) is unchanged.³³

29. *Id.*

30. *Id.*

31. *Id.*

32. See Brahams, *supra* note 27, at 1224.

33. *Id.* at 1225.

The Economist took the occasion of its analysis of this problem to point out the necessity of rationing and queuing in any medical health service. The consequence can be under-treatment of the inarticulate. It is by rationing against the inarticulate that Britain's National Health Service now unfortunately works, and almost every saintly Briton assumes that his NHS is the envy of the world. That assumption drives intelligent inquiring foreigners berserk. One party, a visiting American Congressman, found a young English woman who had waited eight years after an accident for plastic surgery to remove facial scars that had by then blighted most of her youth. Asked sympathetically for her comments on the NHS, "Oh, its a wonderful system we have in Britain," she replied. "You know our medical care is all free."³⁴

IV. THE *TRIAGE* AT WORK

At some time prior to the wars of Napoleon it became a common practice at the battle front to have a *Triage* Master. His was the duty to stand in front of the first field hospitals. It was he who rejected some casualties as insufficiently wounded to require treatment. Others, he decided, needed a poultice. These he sent to the left. He rejected others with a belly wound as incapable of being saved. By his fiat these were sent to the dying sheds. They were sometimes admitted to a great tent where the surgeons could concentrate their limited resources before anaesthesia.³⁵ A Canadian judge told the recent World Congress on Law and Medicine in New Delhi:

No matter how it is done, triage is a cruel procedure, perhaps an immoral one, but it is generally recognized as necessary and I suggest inescapable. Whenever the State is involved one of the forces which must influence the politicians is money . . . and I tell you that in an undisguised and very direct way our politicians, by their laws, are going to ultimately decide upon all our rights both legal and medical: they do now, will continue and I think must engage in the massive practice of *triage*, which in our case is not applicable only to the wounded nigh to death on the battle field, but also to those in peril of their life, because they are accused of crime in society which, if it finds them guilty, will demand their death.³⁶

With perfect equality, this judge pointed to the *triage* in the law as well as in medicine. It operates by delay, queuing or rationing, or by classification.

34. See generally Macrae, *Health Care International*, 291 *ECONOMIST* 17, 19 (April 28, 1984); *American Survey: A Time for Tourniquet on Medical Costs*, 294 *ECONOMIST* 19, 20 (Feb. 2, 1985).

35. Smith, *Triage: Endgame Realities*, 1 *J. CONTEMP. HEALTH L. & POL'Y* 143 (1985).

36. Locke, *Law, Medicine and the Ultimate Power of Decision*, Remarks before The World Congress on Law and Medicine, New Delhi, India (Feb. 22, 1985).

It is the operation in the matters of justice and of life and death of the economic problem. A decision to provide one service represents a decision to deny another. The loss of the other services represents the opportunity cost. This decision is rarely faced squarely and candidly. Only now are we beginning to face openly and to debate the consequences of the failure to provide legal services for people in the courts and the failure to provide high tech diagnostic aids and other facilities to people in the hospital ward.

A Modern Privilege

One judge, who was both a physician and lawyer (Sir Roger Ormrod) has suggested that the considerations of cost-benefit in individual medical decisions "cannot be completely ignored."³⁷

In reaching the present state of practice [on life support systems] two significant steps were taken implicitly by the medical profession, and it is as well to make them explicit. It recognised that it is concerned with something more than the maintenance of life in the sense of cellular chemistry, and so implicitly accepted the concept of "quality of life" from which it has, in the past, always fought shy, for obvious reasons. It also has implicitly accepted that considerations of cost-benefit cannot be completely ignored. In the last few years both phrases have begun to appear in print with increasing frequency as the profession gradually comes to terms with them. Ten or fifteen years ago, mere mention of either was enough to precipitate an emotional response from most doctors. Now they are explicit and can be discussed and debated rationally—an important advance from many points of view.³⁸

According to Sir Roger Ormrod this advance is desirable and it emphasizes the great privilege of rational choice which is open to modern man. But the comments on the recent Sage case in England, at least in the popular journals, are not as sure. The *Times* editorial pointed out that there was "no safe dividing line between medical and social criteria." Indeed, it suggested that a medical practitioner who sought strictly to exclude from consideration the feelings of the children of a patient with a young family, for instance, would only be guilty of another sort of cruelty.³⁹ The *Guardian* newspaper, in its editorial, contrasted the treatment of Mr. Sage and Mr. McNair-Wilson by observing:

Did any of the doctors who saved Mr. McNair-Wilson ever stop to think whether they were improving the quality of his life by treat-

37. Ormrod, *A Lawyer Looks at Medical Ethics* 46 MEDICO L. J. 18 (1978).

38. *Id.* at 28.

39. 62,031 THE TIMES (London), Jan. 9, 1985, at 11, col. 1.

ing him? Did they reflect on whether it might be officious of them to equip him to return to the government backbenchers? Of course, they didn't and of course, they were right not to do so. They treated Mr. McNair-Wilson because he needed to be treated, and for exactly the same reason that they treated Mr. Sage. It is simply impossible that doctors should choose which of us is more worthy of medical treatment because of the way that we live.⁴⁰

The debates continue to rage in the medical and popular literature about these cases. At one level the discussion is addressed to whether the discontinuation of dialysis was justified in the particular case of Mr. Sage.⁴¹ At another level consideration has been given to the legal duty of the doctor to provide care for his patient and even the risk that the doctor who tells a patient that his condition is "untreatable," knowing that it *could* be treated if only there were more facilities, may be committing a crime, possibly conspiracy to attempt the manslaughter of the patient.⁴² I do not enter this debate or the debate about the civil rights of a patient denied full and frank disclosure by his treating physician. It is important, however, to call attention to the latest decision of the House of Lords on February 21, 1985, which suggests that doctors have a legal duty to inform patients of "substantial risks" involved in medical treatment, though not every risk however small.⁴³ By inference the extent of the patient's right to know available diagnostic and treating procedures appears to have been extended by this important new decision. Although English law, which remains most influential in this country, has not gone as far as the doctrines of "informed consent" in the United States,⁴⁴ the decision of the House of Lords appears to have edged it gently in the same direction.

CONCLUSIONS

What conclusions should be drawn from this discussion of budget choices and bedside decisions? A number can, I suggest, be mentioned.

Duty to Patient

First, the guiding principle must always be the medical practitioner's duty to the patient and respect for the patient's autonomy as an individual human

40. *The Guardian*, Jan. 9, 1985, at 10, col. 4.

41. See Brahams, *supra* note 1, at 176.

42. See Brahams, *supra* note 9, at 386.

43. See discussion of *Sidaway v. Bethlem Royal Hospital & Maudesley Hospital Health Authority*, in *THE TIMES* (London), Feb. 22, 1985, at 28, col. 1. See also Grubb, *A Survey of Medical Malpractice Law in England: Crisis? What Crisis*, 1 *J. CONTEMP. HEALTH L. & POL'Y* 75 (1985).

44. G. SMITH, *GENETICS, ETHICS AND THE LAW* 3 (1981).

being. This is the guiding principle that has activated the House of Lords in its most recent decision.⁴⁵ It actuates most of the legal decisions on medical treatment. It is relevant in this area because of the possibility that advances in medical technology may present facilities that would be especially useful in a particular case but which are not available. Endless speculation and the exclusion of every possible diagnosis are not required of the reasonably careful medical practitioner. But if a decision were reasonably made that a particular facility ought to be available to the patient, it does not seem appropriate to judge the provision of that facility or its denial by reference to an evaluation of economic considerations and an assessment of the patient's likely quality of life, without involving the patient or his representatives in that decision.

The responsibility of decision

Ultimately, someone must take responsibility for the decisions that are made. Desirably, in our form of political government, the *macro* decisions should be made by elected representatives. Thus, in Australia, the provision (or non-provision) of nuclear magnetic resonance or the expenditure of large sums on expensive programmes such as *in vitro* fertilisation or heart and liver transplant units, are made by Ministers and governments (and ultimately parliaments) advised by expert committees. It is desirable that the ultimate responsibility should be identified in order that there be accountability. The increasing propensity to take the exercise of ministerial discretions to the courts, and especially to the Federal Court of Australia, under the *Administrative Decisions (Judicial Review) Act* of 1977 may mean that in the future, in this country, the exercise of discretion by Ministers to provide funds (or not to provide funds) will be scrutinized in the courts, at least to the extent of ensuring that only relevant considerations have been taken into account and that no irrelevant considerations have infected the ministerial decision.⁴⁶

The privilege of choice

At least now, as Lord Justice Ormrod has said, these issues are out in the open. No longer is the long face (of "the Thunderer") or a vague generality sufficient. Yet, the opening up of the criteria for rationing and queuing expensive medical facilities brings its own problems. In the past, there was a tendency simply to accept the sad decision because of trust in the judgment

45. See *supra* note 43.

46. Cf. *Beaumont in Santa Sabine College v. Ryan, Minister for Education for the Commonwealth of Australia*, No. — slip. op. at — (Federal Court of Australia, Jan. 17, 1985).

and decency of the individual practitioner involved. In the future it is unlikely that such unquestioning acceptance will survive. Instead, it is likely that patients and their representative groups, such as the Kidney Association, will bring out into the open the uncomfortable fact that an arbitrary birth date may have been chosen or some idiosyncratic judgment of "quality of life" has been made that excludes the dirty and unpleasant while providing facilities to the articulate, influential, and clean. At the very least, the value of the Sage case is to force us to confront squarely the cruel necessity of rationing and the obligation to identify in the future, more clearly than we have in the past, the criteria by which that rationing is to take place in individual cases. To consider in general terms the need to economize, the economic problem and the modern *triage* may be intellectually acceptable. But when its impact is upon a loved one, or even (as in Mr. Sage's case) someone not particularly loved but at least defended by a few champions, the decision is harder to make. Someone must make the decision. Criteria must exist. Perhaps we can solve the dialysis problem. But every year will bring more and more expensive technology which simply cannot be provided in Bourke and Wilcania or even, as in the case of NMR, *anywhere* in Australia. Governments are elected to make these decisions at the national level. But doctors are not elected. They are not even given special training in these matters. They may no longer resort to the sheet anchor of a commonly accepted religion or generally accepted community ethics. To what, then, will they resort as their criteria for decision making? If it is to be "quality of life," that expression must be given greater clarity and articulation.⁴⁷ For in its generality may lurk the danger of prejudice, bias, or even unconscious antipathy and non-identification with a patient like Mr. Sage.

Deserving the privilege

In part, the economic problem can be addressed by improving our efficiency in the distribution of medical resources. In part, we must always test ourselves (as the British have now begun to do in the matter of dialysis) by comparing our expenditures with countries we would regard as similar in ethical and professional standards and economic capacity. In part, we must engage the attention of the professional colleges and of the medical educators so that such decisions are made in a structured and conceptually acceptable way and not by rude rules of thumb merely asserted, the details of which are hidden from the patient. In secrecy lies obfuscation of decision-making. If the apportionments are brought out into the open, political and

47. See generally Smith, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis?*, 63 NEB. L. REV. 709 (1984).

professional pressure may be applied to have them changed: to increase resources or to reapportion community expenditure for use on prevention rather than treatment *ex post*. We may wish to introduce procedures so that decisions are not idiosyncratic but are shared by medical teams and made according to previously stated and clearly available criteria which ensure equality of treatment and diminish the risk of disadvantaging the poor and the inarticulate in the provision of health care. Enough has been said to show that the great medical issues that face Australia in the decade ahead will include the rational and principled apportionment of the scarce resources available for the medical treatment of precious individuals. On a national level important decisions will be made, as they should be, ultimately by politicians. At the bedside, important decisions will continue to be made by medical practitioners.

The appeal of this essay is for greater clarity and openness in both the principles and procedures of decisionmaking, and a more precise recognition by all of us of the hard choices, national and individual, that daily must be made. Lord Justice Ormrod has declared that this is a great privilege and an opportunity that is now available to us. But it is only so if we deserve to have it. And we only deserve to have it if we make our decisions by reference to ethical principles that we have bothered to think about, and to identify and constantly rescrutinize and test, against changing community standards.

There is nothing especially new in any of this, for in his DOCTORS DILEMMA, George Bernard Shaw—you will recollect—presented Dr. Sir Colenso Rigeon. Sir Colenso had a new wonder drug, and his dilemma was: which of his patients, so deserving, should get it.⁴⁸ The arbitrary *triage* of a youthful birthdate, or one based upon background, wealth, education or social station are, at the least, suspect. New rules must be found for the *Triage* Master of today. Now that we know that he exists, this is the beginning of wisdom.⁴⁹

48. G.B. SHAW, DOCTOR'S DILEMMA 116 (1911).

49. See *supra* note 36.

