# The paradox of medical necessity

**Samantha Godwin & Brian D. Earp**

"Medical necessity" is often used to explain or justify certain decisions. In clinical settings, the concept may be invoked as a reason why a given medication or surgery has been authorized, or—if *not* medically necessary according to some standard—why it has been denied. At the level of healthcare systems, medical necessity may be used to explain why some tests or treatments should be covered by insurance (or a national healthcare plan), while other tests or treatments should be regarded as luxury goods (1). In political discourses, services that are deemed medically necessary may be afforded categorical priority over services that further other dimensions of human wellbeing, though the latter may be no less important. Finally, in ethical arguments, medical necessity may be treated as a special exception to an otherwise generally stated moral rule (for example, a rule forbidding certain types of bodily interference with persons who lack capacity)(2).

But what *is* medical necessity? What *makes* something medically necessary? Despite its ubiquitous use in so many contexts and discourses, the substantive meaning of the term remains elusive. Taken at face value, however, the concept appears to be a teleological one (3): "medically necessary" as necessary *for something*. And yet, the main candidates for that *something* tend to be underdefined in one of two ways.

The first way is under-definition due to recursion: that is, when the object of the implicit 'necessary for' is defined in terms of ideas like these: "healthcare"; "medical care"; "disease" (as distinct from, say, undesired conditions generally)(4); "medicine" (or its "proper scope")(5); "normal functioning"(6); the goals of the medical profession; the judgment of healthcare professionals. But these terms are often defined primarily in relation to one another. So for example, if we take medically necessary to mean something like necessary *for* the restoration of normal functioning—where deviations from normal functioning are defined in terms of disease, or diagnosed according to

what medical professionals claim are the maladies for which their care is proper or necessary, we end up with a situation that is not very clarifying (4,7).

The second way is under-definition due to overbreadth: that is, where medical necessity is glossed as necessary for the promotion of welfare, human capabilities, or "health" (especially when defined broadly to include the elimination of all manner of suffering or the enhancement of wellbeing with no principled limits)(8). This second way of under-defining the term makes that which is medically necessary dependent on what is (thought to be) necessary for people more broadly—without making clear (a) why particular purported necessities should be characterized as "medical" (as opposed to, say, "cosmetic" or "psychosocial")(9) or (b) how "necessary" capabilities or welfare should be understood beyond what general theories of capabilities and welfare argue.

These two forms of under-definition, combined, may account for a seeming paradox (or at least, a peculiar incongruity) in discussions of medical necessity. On the one hand, medical necessity is spoken of as if it requires no further explanation – it has an uncontroversial, shared meaning, and its presence or absence is determined by value-neutral, conventional, scientific, or technical characteristics. On the other hand, to declare something a medical necessity is often, maybe usually, tantamount to saying that it must be done, or at least it must be made available. We don't usually react to the invocation of purely technical concepts—like "mammal" or "infrared"—as determining how a policy question should be resolved; and we usually that think those concepts that might—like "rights" or "justice"—are eminently contestable and subject to the widest scrutiny.

Medical necessity and nearby notions (e.g., "medicine", "health", "healthcare", "disease") are frequently employed as means of framing the terms of policy disagreements to suggest a (seemingly) inescapable normative conclusion (10–12). The way this seems to work is through a kind of sleight-of-hand that bypasses arguments about priorities and values that might otherwise have seemed central to resolving the policy question or disagreement. The first part of this rhetorical strategy is that an element of a preferred policy is presented as definitionally belonging to one of those categories, where the categories themselves are cast as apolitically descriptive, even scientific. The second part is that these terms are able to pass as apolitical, not because they are in fact free of normativity, but because everyone agrees on their normative valence: health is good, disease is bad.

This can be seen in some of the most politically contentious biomedical debates (13). The pro-choice slogan "abortion is healthcare" requires no follow-up line to develop the observation into an argument. *Surely*, you would not oppose healthcare. Abortion rights opponents, in turn, adopt "pregnancy is not a disease" as both a rebuttal slogan and implied argument. *Surely*, it would be wrong for a healthcare worker to prevent or end a non-diseased, healthy state. Both slogans exploit the loaded ambiguity of "healthcare" and "disease."

It is, of course, both trivially true that abortions are performed by healthcare workers in healthcare settings, and that pregnancy is not a disease (except on very broad accounts of the term that include basically any unwanted physical condition). It should also be obvious that the mere fact that healthcare workers do something does not imply that they ought to, or that what healthcare workers ought to do should be limited to treating the set of conditions they happen to classify as diseases.

Less politically-charged discourse about healthcare topics and policy is often developed along similar lines. A great deal has been written on whether or not aging is a disease, rather than merely a cause or risk factor of other diseases. Although this is sometimes discussed in purely conceptual terms, most of the interest seems to follow from belief that if aging *is* regarded as a disease, then directing resources to developing medical treatments for it is justified, and perhaps an imperative (14).

Indeed, once an intervention is recognized as addressing a "health need," as Ben Davies observes, it is more likely to be taken seriously and harder to cut from a budget – especially if it is also seen as a "medical need" (see Box 1). Accordingly, medical necessity often functions, in effect, as a kind of rhetorical intensifier in policy arguments. In other words: to say that a need is a health need is to say it is an *important* need; and to say it is a matter of medical necessity is to say it is a *very* important need indeed.

**Box 1**. Health need and medical need: Davies'(7) distinction

In Davies' model, medical needs are those needs that are best addressed by medical means (e.g., drugs, surgery), whereas many health needs can be better addressed by non-medical means (e.g., exercise, diet). Of course, some healthcare systems, like the British NHS, aim to address both types of need in one way or another. At the same time, however, it may often seem that what counts as a "healthcare procedure" or a "medical means" of doing something is more a matter of social and

> institutional convention than anything else. And this convention, in turn, may partly have to do with assumptions about which professionals count as *medical* professionals (clinical psychologists, nutritionists, yes?; personal trainers, social workers, no?). Thus, even a definitional distinction seems difficult to maintain against political pressure to change it.

However, for such a rhetorical maneuver to be morally persuasive, "medical necessity" must carry normative content beyond just signaling that something is important. People do not tend *only* to assert that a service is healthcare or that a problem is a disease when arguing for why issue should be funded or taken seriously. Instead, they go at lengths to show that it is relevantly analogous to what people already broadly agree are medical needs. Thus, people arguing in this way would likely not suggest that the terms "health" and "medical necessity" should be taken as mere substitutes for "important human needs"—rather, they seem to think there is a substance to "health" and "medical necessity" that is more broadly regarded as very important [for discussion, see (15)].

This brings us back to the question from before: the question of what medical necessity *is*. What concept or concepts does "medical necessity" properly refer to, or alternatively, in virtue of what is something medically necessary or not medically necessary? It may be that a coherent and adequate account of how "medical necessity" should be conceptualized reduces to one or more concepts of what it is to be "medical" and one or more concepts of what it is to be a "necessity." A deflationary account of the concept might suggest that "medical necessity" has been mistakenly endowed with a normative significance that it does not properly possess.

Alternatively, it might be that medical necessity as a concept can and should be understood as greater than the sum of its parts. We might think that a serviceable concept of medical necessity should be able to explain why the medical treatment we recognize as necessary is a medical necessity, as Emma Prendergast suggests in this issue(4). It might be that a core part of what an account of medical necessity should do is to tell us, at least in part, what we *ought* to use medical care for, and one that cannot does not fit its purpose.

Another type of question pertains to what the term or concept of medical necessity *does*, what it accomplishes in practical settings. It may be that in some contexts, people using the term 'medical necessity' are referring to a well construed concept of medical necessity, whether their use of the

concept is appropriate or inappropriate. In other contexts, the term 'medical necessity' may be used as a term of art that bears some relation to medical necessity, but via a definition we would not normally recognize as picking out medical necessity as such. This usage of the *phrase* as a term of art may thus have an impact that can be distinguished from what the *concept* of medical necessity does.

For example, many healthcare plans will define medical necessity for coverage purposes, at least in part, in terms of a physician's clinical judgment. This definition of medical necessity may do most of the work that the term "medical necessity" performs in many situations. However, presumably such a use has purchase because it is thought to give a reason to believe that there *is* a medical necessity, not because a physician's judgment is necessary or sufficient for medical necessity. Similarly, as John Ioannidis suggests in this issue, regulatory endorsement may likewise be treated as if it is equivalent to medical necessity. And yet, he argues, the state of medical evidence for many proposed treatments (as filtered up to doctors, policy makers, and the wider public) has such a poor signal-to-noise ratio that this use of "medical necessity" (i.e., its being available and largely accepted) enables corporate actors to shape the regulatory and media environments to their liking—and handsome profit—at the cost of people's actual healthcare needs, and at the expense of society in general (16).

A third set of questions pertains to what *ought* to follow from medical necessity, or what the belief in the presence (or absence) of medical necessity ought to trigger normatively. There might be good normative reason to think that medical necessities really ought to prompt a greater amount of concern, and resource allocation, than other human necessities or desires such as food, housing, education, social company, and emotional wellbeing (i.e., needs that seem clearly relevant to health and wellbeing, but which are not themselves clearly medical in nature). Or, it might make more sense to think, as Ben Davies suggests in this issue, that well defined medical need does not intrinsically count for more than other types of needs (7).

In addition to the papers by Davies, Ioannidis, and Prendergast, this issue features Rebecca Brown and Andrea Mulligan on 'maternal request' caesarean sections (17); Zsuzsanna Chappell and Sofia Jeppsson on 'normalisation' in psychiatry (18); Evie Kendal on the necessity of abortion (19); Richard Gibson on surgical amputation as a potential treatment for bodily integrity dysphoria (3); and Seppe Segers and Michiel De Proost on the concept of medical necessity in relation to new and disruptive technologies (20). Together, these essays explore the what *is*, what *does*, and what *should*

dimensions of medical necessity, using live examples from ongoing debates, to shed much needed light on a notoriously murky yet increasingly influential concept.

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