The ethics of clinical pathways and cost control

James W. Jones, MD, PhD, MHA,a Laurence B. McCullough, PhD,b and Bruce W. Richman, MA,c
Columbia, Mo; and Houston, Tex

You are the Chief of Vascular Surgery in a large community hospital that has been experiencing financial difficulties. Your division has been cited by the Utilization Review Committee for excessive lengths of stay in the ICU and hospital wards. After weeks of deliberations, with minimal input from surgeons, you are directed by the hospital Executive Committee to implement a fast-track clinical pathway for all patients undergoing major vascular procedures. Your staff surgeons believe that the data suggesting excessive lengths of stay are flawed and that the new directive may significantly increase postoperative morbidity and mortality. Your most responsible ethical action is which of the following?

A. Resign from the hospital staff.
B. Direct your surgeons to implement the administration’s policy.
C. Inform the administration that you consider fast-tracking unethical and will not cooperate.
D. Insist that the mandated fast-track policy be rewritten with input of vascular surgeons.
E. Leak the story to the press.

Like physicians in all specialties, surgeons are increasingly answerable for the cost of patient care. Demand for accountability comes from many of the most powerful blocs in our society, including government and insurance interests, who are responding to evidence of resurging increases in the cost of care. Private payers are trying to control costs to remain profitable and competitive. Public payers, such as Medicare and Medicaid, are responding to determined resistance to additional taxes.

Most surgeons believe that their responsibility to practice medicine economically is becoming secondary to their responsibility to practice medicine effectively.1 Surgeons can take no satisfaction from minimizing hospital costs if they have done so by minimizing the quality of patient care. The virtue of integrity informs our professional standards of moral and intellectual excellence and ethically compels us to be guided in our decisions by clinical evidence.2 This means attention to clinical outcome as well as to clinical process.

The Clinical Pathways program originated as a quality improvement process with the development of disease-specific algorithms. These algorithms are designed to promote standardization of diagnostic and therapeutic procedures and limit the kinds of variations that have historically been associated with errors, complications, and longer hospital and ICU stays, leading to higher per-patient costs. Clinical Pathways were intended to ensure that patients are treated in an efficient manner with methods long established as effective for particular conditions. Pathways were also designed to discourage expensive and potentially dangerous idiosyncratic forays off the beaten track by overly adventurous individual practitioners. Despite these many virtues, the Clinical Pathways program has sometimes found itself calcified into a rigid fast-track system designed to cut costs by mandating rapid hospital discharge once each step in the Pathways process has been implemented. Advocates claim quality improvement by citing early discharge as evidence of rapid recovery, but often without reference to whether some patients should be discharged when they are. Though Fast Tracking is sometimes effective in reducing such significant complications as nosocomial pneumonia, and some patients are delighted to return home earlier, the clinical response of all patients to the Clinical Pathways–Fast Track process is not equivalent, and for a few, early discharge is frightening, and even dangerous. Surgeons ethically must be instrumental in the design, practice, and surveillance of fast tracking; it is an important part of the surgical care responsibility.

Evidence-based surgery evaluates clinical care comprehensively, studying the outcomes as well as the processes of treatment. Neither measure alone yields comprehensive clinical information, and neither measure alone will ensure that the hospital will remain financially solvent and prepared to treat future patients. The claim that these vascular surgery patients have excessive lengths of stay is based on a process measure which has not been informed by the context of clinical outcome. Worse still, it ignores such other process measures as severity, procedural complexity,
comorbidities, and individual patient histories. Isolating a process of care as a goal of care, and overlooking the health of the patient as the goal of care, will likely be a fast route to the hospital’s financial demise as well as the patient’s. Concentration first upon clinical outcome and then clinical processes to achieve the primary goal honors the hospital’s legitimate concern for financial strength because it subsumes it; the healthiest possible patients have fewer complications, will be the least expensive to treat, will refer friends and family, file fewer tort claims, and return for additional episodes of care when the need arises.

Choice A, resigning your hospital position to protest the mandatory fast-track policy, is precipitous. It displays an abundance of personal rigidity, an unwillingness to negotiate in good faith, and ultimately deprives needy patients and the hospital which sustains your community of your rare and valuable services. It violates the virtues of courage and fortitude.

By selecting choice B and directing your surgical staff to accept and implement the mandatory fast-track policy, you abrogate your responsibility to patients to see that their care is your primary professional goal. You also fail in your leadership role as the division chief by not making your professional staff’s clinical concerns important to the hospital administration. Although it is not inherently unethical to support your administration’s efforts to contain costs and ensure the hospital’s function within the community, it is inconsistent with your role as an ethical surgeon to knowingly do so at the expense of good clinical care.

Although fast-tracking may be entirely consistent with good care for many patients, its mandatory implementation for all patients will certainly deprive some who respond more slowly or encounter postoperative complications of essential inpatient services. Choice C is inappropriate because the clinical pathways fast-track model is not in and of itself unethical; it becomes so only when it is indiscriminately applied as a cost-saving measure without regard to each patient’s individual clinical response.

Choice D, insisting that the administration renegotiate the fast-track policy with significant input from the vascular surgeons whose patients it affects, is the most clinically and ethically responsible position. This provides the professional staff with an opportunity to educate the administrators about significant clinical consequences of their ill-advised decision, to assume the surgeon’s proper ethical role as patient fiduciary, and to provide the hospital with a defensible policy for containing costs in appropriate cases while continuing to serve the legitimate health-care interests of patients.

Choice E, taking the issue to the press, virtually ensures that any subsequent negotiations between the surgeons and the administration will be acrimonious, defensive, and based more in a desire to preserve reputations and image than in guaranteeing good care. It is furthermore likely that a complex issue will be reduced to fit a headline and thereby distorted. Most importantly, a misunderstanding of methods among people of mutual good will and common motives is likely to be mischaracterized as a morality tale, and the public’s trust in your local hospital seriously damaged. In that event, financial ruin will become more likely, there will be one less place to practice high-quality surgery, and the entire community will suffer.

This case presents an ethical obligation frequently disregarded by surgeons. The vascular surgeons should have been attentive and proactive concerning cost control much earlier. It is common for hospital management to issue edicts affecting surgical practice through committees having minimal surgical participation. It is a preventative ethical duty for surgeons to interact organizationally outside the operating room in matters of this sort. Externally imposed policies and procedures usually occur after repeated attempts to overcome appeals to professional autonomy and the resistance to change and accountability that such appeals often generate. Professional autonomy should never be the fundamental ethical concern of physicians in response to cost control; assumption of co-fiduciary responsibility, in the absence of which professional autonomy is stripped of its moral authority, should be.

REFERENCES