International Journal of Surgery (2006) 4, 150—152

ELSEVIER

INTERNATIONAL JOURNAL OF SURGERY

journal homepage: www.int-journal-surgery.com

Rationing within Healthcare

Should obese patients be denied knee surgery? A patient perspective Maintenance of the machine—measurement and values

Professor C.E.M Joad[1] was a stickler for precise definition. This one-time civil servant turned head of philosophy department at Birkbeck College, London, and author of several philosophy books, was a well-known and colourful contributor to the BBC popular *Brains Trust* radio programme in the 1940s. He is remembered for his catchphrase: ''It all depends what you mean by....'' His concern for equity and fairness seems to have been less well developed. He was sacked from the *Brains Trust* for being convicted of ''unlawfully travelling on the railway without having previously paid his fare with intent to avoid payment''. He was unrepentant, indeed quite proud of this—happy to tell others how to avoid paying. These sparse details suggest different societal attitudes, behaviours and values in that post-war, birth-of-the-UK National Health Service (NHS) era only 60 years ago.

It does indeed ''all depend what we mean by'' ''obesity'' and ''knee surgery''. These terms require definition, meaningful measurement and interpretation and consideration against a wide background if we are to debate this question properly. Body mass index (BMI) is unsatisfactory, meaningless by itself. Evidence shows that the risks are greater for obese patients undergoing surgery, with unique problems in terms of surgeons' access to the joint. Wear is proportional to the load.[2] We should take care to consider all the elements and factors that might affect the answer we should give today for treatment of such individuals in a specific healthcare setting. This particular call for rationing must not be considered in isolation, but against the total picture of cost benefit and harm in both personal and economic terms, insofar that the decision ultimately impinges upon all patients within the public health programme. This is the unenviable, poorly understood task of NICE (National Institute for Health and Clinical Excellence), which, after considering evidence and its quality, must deliver decisions about provision of, say, herceptin, interferon, macugen, etc. in a just and equitable manner, obliged to turn a deaf ear to the preferential clamour of breast cancer patients, sufferers of multiple sclerosis, or age-related macular degeneration, and statements by ministers stepping outside their remit. Emphasis on benefit at the expense of harm, either in individual instances, or overall generally, is an unjust bias that must be avoided. Cost to the NHS and to the patient has to be considered if we are to have sensible, equitable healthcare, as has the ratio of money spent between prevention, health education and treatment. The role of GPs needs re-shaping: are they there to tend the sick or to achieve ''maximum points'' from the GP contract? Margaret McCartney describes it thus: ''adding up of hours, the itemisation of what we did, where we were and at what time we did it has made medicine ugly.''[3]

The man-in-the-street may view knee surgery and other replacement of joints simply as a routine, mechanical matter: removal of the faulty, worn-out joint followed by replacement with a man-made device, just like a motorcycle mechanic who might be asked to replace a worn-out piston rod. It is not so.[2] But even a contract between motorcycle owner and mechanic for attention to an inanimate machine is not devoid of values and judgments. Robert M. Pirsig explores this philosophy in his insightful book: ''Zen and the art of motorcycle maintenance'', subtitled ''an enquiry into values''.[4] Before beginning, Pirsig quotes:

And what is good, Phaedrus,

And what is not good —

Need we ask anyone to tell us these things?

We are led to see that the willingness by another person to repair the motorcycle can be coloured by his view of the owner's attitude to, and sense of responsibility for the machine. Furthermore, an owner's cavalier attitude to maintenance, or absent or low level of self-maintenance

1743-9191/$ - see front matter © 2006 Surgical Associates Ltd. Published by Elsevier Ltd. All rights reserved.
doi:10.1016/j.ijsu.2006.06.005

for town usage, even where garages and mechanics are plentiful, may be rightly judged as an unacceptable, unwise and an inadequate attitude, but more so if the machine is to be driven to its limits in unpopulated regions. To be ignorant and irresponsible in the latter circumstance could be termed feckless in the extreme. Because the need here is greater, and the consequences more serious, should the mechanic be criticised more severely or pilloried if he refuses to repair? The mechanic who appreciates the wonders of finely tuned engineering might rightly tell the owner he will not waste his time and skills repairing a machine that has been abused due to ignorance and attitudinal problems, no matter what money he is offered, particularly if the problem is likely to re-occur if the unrepentant owner refuses to consider the consequences of his intransigence, when the damage will be worse than it might have been because of fundamental neglect. There is an obvious need here for a meeting of minds, a better relationship, and interaction with understanding, rather than the build-up of irritation and stubbornness that is the likely reaction. The forces of supply and demand play a significant rôle.

Relationships are changing in the practice of medicine. The professionalism of doctors is being attacked and eroded.[5] Patients are being encouraged to become more responsible, better informed, more involved in their own health management, and to share decision-making with their doctors. Bearing this in mind, is it not ironic, then, just when there is a move away from 'compliance' to 'concordance' with respect to patients' medicine-taking, doctors are being prevented from using their clinical judgement in an over-regulated, politicised climate, forced to adhere to conflicting guidelines, meet targets, and practise in fear of litigation and reprimanded for non-compliance?[6] A BMJ editorial [7] concluded: ''The biggest challenge for concordance and the most difficult to research will be a change in values.'' How are constructive relationships between patient and doctor to develop against this contradictory, restrictive background? Courage and action are needed by everyone in the face of attempts by policy makers to impose an unwanted consumerist view of medicine on a society that prefers to build relationships. Trust in doctors remains high. Doctors need to resist becoming technicians and reject the materialistic and mechanistic view of healthcare being imposed on society, where patients are being encouraged to 'shop around'. Doctors should be able to use their clinical judgement, with due regard to the overall circumstances of each particular case. Patients need to use their own initiative and be proactive in improving the quality of consultations. They must learn to recognise uncertainty; speak up and ask questions; seek honest answers.[8]

In the UK, realisation is dawning that the NHS cannot provide everything that all patients might need or demand. Costly new interventions, such as the new class of monoclonal antibody drugs, reduce the overall number of patients that can be treated from a finite budget. Waste and top level mismanagement of allocation of resources; over-regulation; poor prioritisation; 'belief' rather than good evidence plus judgement dictating provision; and the influence of commercial interests; are rife. The high profile of some diseases, such as breast cancer for example, given undue publicity by individual patients, patient groups and the media—at the expense of others—causes distortion of perception, inequitable use of funding for research,[9] and inequitable provision of treatment. Research shows that some diseases, such as cancer, receive a level of funding out of proportion to the amount of illness they cause whereas others, such as respiratory illnesses, are severely under-funded. Cancer research takes 28 percent of the money although cancer accounts for only 16 percent of disease. The geographical distribution of funds is also uneven. This indicates a serious lack of control, with policies driven by ideology and belief, and by those who shout loudest.

How then are doctors to provide humane medicine when hedged in by economic and bureaucratic nightmares? Is it fair either to them, or to the ordinary people who use their own publicly funded NHS, that guidelines should dictate what they may or may not do? How are we to build better relationships and understanding, and foster a return to respect, common sense and sound values if doctors are not to be allowed to make good clinical judgments, based on their experience, expertise and good quality evidence? How can a black and white answer to the question whether obese patients should be denied knee surgery be given when no two patients, and no two consultations are the same?

Decisions, choices, ethics, rights and responsibilities

Reality can be very different: attempting to put theory into practice exposes complex ethical dilemmas. Let us consider the ethics of two contrasting hypothetical cases of obese patients seeking knee replacement from the same doctor in east Suffolk, UK. This doctor, like all others, is in a position of accountability for resource distribution, best served by using available NHS funds, currently under intense pressure, for treatments based on solid evidence.[10] He knows that for obese patients, there is evidence that joint replacement operations carry increased risk of complications; that the joint is more likely to wear out quickly; or that catastrophic failure, causing serious ongoing costs both to the patient and the NHS is more likely.[2]

His first patient is a 35-year-old 6 ft tall ex-rugby player, married, no children, a white-collar, sedentary worker. He has a BMI of 32. He appreciates the factors that are causing increasing weight gain and is keen to receive advice to get him in good shape for surgery. He is used to training regimes, and acknowledges his own responsibility to modify diet and 'train' to ensure a successful operation and maximise benefit thereafter from a replacement knee-joint, to prevent unpleasant complications or failure and extra costs personally, and to the NHS.

The doctor's second patient is a woman of 45, widowed, with three teenage children, living on the fourth floor of a tower block where the lifts often break down. She works on an assembly line in a local factory and has no car. She suffers from asthma and depression. She worries that she will lose her job as she is finding it increasingly difficult to move about, and is in pain. She is short and plump (BMI 33) with a high ratio of fat to lean and a large waist measurement. She has little enthusiasm,

time, or energy to spare to consider re-planning diets for herself and her fickle family on a small budget; taking exercise; or for participating in the specialist clinic activities that the doctor is running to deal with obese patients with lower limb joint pains. Her immediate domestic and concomitant health problems prevent any consideration of her past irresponsibility or, indeed, of future action on her part to prevent failure. She just wants the job done even though warned that the plumpness of her short legs would make the surgeon's task difficult, the operation more dangerous and her recovery more prone to problems.

How is the doctor to deal with these two different cases, justify his decisions with respect to resource allocation in the NHS, and, above all ''do no harm'' to these two patients? Both patients have a BMI in excess of 30, which is the east Suffolk upper limit for patients who may be considered for joint replacement surgery.[11] Ethical action and accountability for resource use are uncomfortable bedfellows in this particular surgery. The doctor has an unenviable and difficult task.

Conclusion

Patients' trust in doctors remains high: let those of us who can, campaign to free them from the stifling, morale-sapping tyranny of bureaucratically imposed guidelines. It is time for a revolution against the ugly form-filling, the one-size-fits-no-one dictats, the untrusting bureaucratic regulation to achieve 'compliance' of the worst sort, and against everything that prevents doctors blending compassion, art and science in their only-human attempts to do what is best for every single patient, and equitably for all patients.

''*This above all: to thine own self be true*.''

Shakespeare. Hamlet, I.iii.58

References

1. http://www.spartacus.schoolnet.co.uk/Jjoad.htm.
2. Wood JB. Is it fair to allow obese patients to undergo joint replacement surgery? Is it fair to tell them to lose weight? *BMA News*; 2006 March 18.
3. McCartney M. Facing up to a difficult question: what am I worth? Financial Times Weekend 2006;W11 April 29/April 30.
4. Pirsig RM. *Zen and the art of motorcycle maintenance. An enquiry into values*. Vintage: The Bodley Head; 1974 [vintage edition 1991].
5. Royal College of Physicians. Doctors in society: medical professionalism in a changing world; December 2005.
6. Thornton H. Informed consent. In: Querci della Rovere G, Warren R, Benson JR, editors. *Early breast cancer, from screening to multidisciplinary management*. 2nd ed. Taylor & Francis Medical Books; 2006. p. 472–4.
7. Jones G. Prescribing and taking medicines. Concordance is a fine theory but is mostly not being practiced. *BMJ* 2003; **327**:819.
8. Evans I, Thornton H, Chalmers I. *Testing treatments: better research for better healthcare*. British Library, ISBN 0-7123-4909-X; May 2006. p. 101.
9. UK Health Research Analysis. UK Clinical Research Collaboration. *Report*, http://www.ukcrc.org/; 24th May 2006.
10. Baum M, Ashcroft F, Berry C, Born G, Black J. Doctors' campaign against alternative therapies. The Times Online 2006; May 23; http://www.timesonline.co.uk/article/08122–219198500.html [accessed 1st June 2006].
11. Editorial. The weighty matter of care for all. *Lancet* 2006; **367**:876.

Hazel Thornton
31 Regent Street, Rowhedge, Colchester, Essex, CO5 7EA, UK
Tel.: +44 1206 728178; fax: +44 1206 728911.
E-mail address: hazelcagct@keme.co.uk

5 June 2006