



Clinical ethics and cost containment: promises and pitfalls

EARLY EXPERIENCE with life-sustaining treatment taught the sobering lesson that aggressive interventions such as cardiopulmonary resuscitation too often failed to achieve the humanistic goals of medicine, ie, preserving life that is worthwhile to the patient.^{1,2} After two decades of debate we have reached a national consensus that, under the right circumstances, virtually any life-sustaining intervention could be withheld or withdrawn. The “right circumstances” involve respecting patients as persons and are defined by two moral principles: patient self-determination and the duty not to harm.

■ See Kanoti et al, p. 591

While focusing our moral attention on the interests of individual patients, we have glanced nervously at the problems of cost and limited resources looming on the horizon. Conventional ethical wisdom insists that such broader social issues should not corrupt our obligations to individual patients.³ But the storm clouds have moved in; issues of cost and limited resources increasingly affect patient care decisions. Inevitably, the linkage between letting people die and saving resources will become more explicit in both clinical practice and public policy.

Such a linkage need not compromise health professionals' responsibility to individual patients. Efforts to improve the efficiency of the health care system may sometimes enhance the quality of care for individual patients, and vice versa. If concerns about the cost of care direct attention to promoting patient autonomy and best interests, everyone gains. If promoting patient autonomy and best interests reduces health care costs, so much the better. On the other

hand, pursuit of both cost effectiveness and patient-centered goals will sometimes be incompatible.

The study by Kanoti et al⁴ in this issue of the *Cleveland Clinic Journal of Medicine* is one of the first efforts to demonstrate that responsible promotion of end-of-life decisions can reduce resource consumption in a costly group of patients—in this case, Medicare patients who die in the hospital after a stay of 15 days or more. After introducing new do-not-resuscitate (DNR) guidelines, the hospital ethics committee and the Department of Bioethics provided education and consultation to the staff. While the number of DNR orders written did not increase after implementing the policy, the orders were written earlier in the hospitalization of Medicare patients—who went on to die 21 days sooner, thus saving a projected 1,911 days of hospital care.

Although the study is probably correct in assuming that implementing the new policy helped reduce time-to-death of the Medicare patients, it does not prove a cause-and-effect relationship. Historical trends such as a general increased comfort with and awareness of DNR orders by health professionals may help explain the findings.

Even if the new policy was responsible for saving nearly 2,000 hospital days of expensive care, can we assume that this was, in balance, a good thing? To answer that question we must ask another: Were patients' wishes and best interests served by allowing them to die without resuscitation? Probably yes, but we arrive at that answer more by intuition and circumstantial evidence than by conclusive data. Cardiopulmonary resuscitation is rarely successful in sick, elderly patients. If they survive the initial resuscitation attempt, it is only to spend their last days or weeks in intensive care units. But cardiopulmonary resuscitation is not futile for every elderly patient.^{5,6} A positive interpretation of the study results would be buttressed

by explicit data demonstrating the soundness of clinical reasoning behind the DNR decisions.

As the authors acknowledge, it would also be reassuring to know that patients and families were involved in the decisions to forgo resuscitation. While the Cleveland Clinic Foundation's policy emphasizes the importance of patient and family participation in decision-making,⁷ this study made no note of the nature and frequency of such participation in DNR decisions. This leaves important questions unanswered. For example, were patients whose DNR orders were written earlier in the course of hospitalization more likely or less likely to have discussed those orders with their physicians? Were the discussions initiated by physicians or patients?

Another unanswered question concerns the effect of

ethics consultation in DNR cases. Presumably, an ethics consultant would facilitate compliance with the hospital policy's recommendation of patient and family involvement. How frequent were ethics consultations in the DNR cases? Were DNR decisions more likely to include patient and family when an ethics consultation was obtained?

The study by Kanoti and colleagues raises hopes that we can make end-of-life care more efficient and more ethical. As the goals of saving lives and saving money come into increasing conflict, attention to ethical details will become even more important.

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