Editorial

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Did My Buddy Do the Right Thing?

A friend of mine, who's a cardiologist at a county hospital a few states away, was very agitated when I caught up with him recently. He was very upset over an adverse outcome experienced by one of his patients, and he was really beating up on himself over the patient's demise. I listened carefully to his tale of woe, and then I told him that he was blaming himself for no good reason whatsoever. In fact, from my perspective as a medical administrator, he had done exactly the right thing in the management of this particular patient.

Let me explain. My friend was caring for an elderly debilitated patient who had just been admitted with his third acute myocardial infarction. The patient did not do well after this major cardiac insult and proceeded rapidly into florid heart failure. This is where my friend's dilemma came in. He thought that there was an outside chance, perhaps in the range of 5% to 10%, that his patient might pull through if an intra-aortic balloon pump could be inserted promptly. But, he encountered unexpected resistance from the hospital's intensive care unit (ICU) nurses. Although they were theoretically trained in the management of intra-aortic balloon pumps, the nurses used the modality so infrequently that they did not feel qualified to manage such a patient. My friend tried to persuade them that this was their opportunity to bring their skills up to speed, but he could not overcome their concern that they were not qualified to manage such a patient.

THE DILEMMA

My friend thus found himself on the horns of a dilemma, with 2 unpleasant options at hand. On the one hand, he could have insisted that the patient be transferred to a nearby tertiary facility where an intra-aortic balloon pump would not severely tax the nursing staff. The alternative would be to simply try to manage the patient at his own facility without such a pump.

At first blush, this decision might appear to be a no-brainer. After all, isn't a physician's first responsibility to optimize the care and management of the individual patient in front of him? Shouldn't any available treatment be utilized as aggressively as possible, without regard to the dollar cost? Actually, it's considerably more complicated than that in my view.

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You see, the county hospital where my friend works has a fixed budget each year, and the hospital has to take care of all those unfortunate souls who come through its doors using that budget. Only a small number of patients have any sort of insurance coverage, so almost all of the time the county taxpayers wind up footing the bill for care. The board of supervisors has always been stingy with the hospital, and so the fixed budget each year is always stretched very thin. Unfortunately, that means that there is an unforgiving zero-sum game at work here: The money spent on any 1 patient, whether wisely or not, is money that is not available to spend taking care of other patients. That is true, regardless of whether those other patients might include some on whom the money might be better spent in the sense that their prognosis may be more favorable and, hence, they might derive more benefit from the health care expenditure.

DISTRIBUTIVE JUSTICE

Physicians, in general, and certainly intense patient care advocates, like my friend in particular, are often repelled and, sometimes, appalled by such thinking. But the reality is that the principle of distributive justice must be factored into the situation my friend was facing with his patient. His county hospital had a fixed budget that it had to spread among thousands of deserving patients. Would it really be fair to the other patients to spend a large sum of money purchasing very expensive care, including the intra-aortic pump, on a single patient with a very poor prognosis to begin with?

Remember, my friend estimated, before the issue of the availability of the pump came up, that there was only a 5% to 10% chance of survival, even with this very aggressive and expensive intervention. Perhaps this case is a bit more clear-cut than some

others that might come down the pike. What if the chances of survival with the pump were 20% to 30% or 30% to 40%?

Obviously, there comes a point at which it may well be justified to put the financial issues on the back burner and simply lunge for a possibly heroic life-saving rescue. But I would submit that, as stewards of a very finite pot of financial resources, we physicians and other providers cannot divorce ourselves from an awareness of the basic principle of distributive justice. In many cases, the decision is taken out of the hands of the individual practitioners and made by a more "objective" administrative type such as myself. As it turns out, however, my friend was fully empowered to transfer the patient over to the tertiary hospital and run up the bill if he saw fit. The very difficult decision not to do so was his and his alone.

But my friend went against some of his more primal instincts and did factor in the principle of distributive justice. He decided to treat the patient at his own facility without a balloon pump. As expected, the patient deteriorated quite rapidly and died on his second hospital day. My friend felt very badly indeed, even though the outcome was exactly as expected.

One can argue that a partial solution lies in retraining the county hospital ICU nurses so they will feel more comfortable the next time a physician wants to put in a balloon pump. My friend is actively working to make that happen. But given the existing circumstances that my friend faced, I would posit that a very strong case can be that he did exactly the right thing. In an era where there are simply not enough resources to do everything we would like to do for every patient, regardless of prognosis, painful decisions and choices must be made. My friend made his and, to my way of thinking, he made the right choice. ●

Author disclosures

The author reports no actual or potential conflicts of interest with regard to this editorial.

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