Health-care reform must respect patient autonomy

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As President Obama and Congress weigh changes in the nation's health care system they must avoid creating a system where physicians are financially motivated to pressure patients into mandated treatments that conflict with their values and needs, two Beth Israel Deaconess Medical Center physicians warn.

Writing in the Aug. 6 edition of the New England Journal of Medicine, Pamela Hartzband, MD, and Jerome Groopman, MD, caution that health care reform carries with it the potential to create a clash between two recent trends in medicine - the humanism movement that focuses on individual values, goals and preferences - and the move toward evidence-based practice where data and guidelines standardize therapies and procedures.

In particular, they raise concern over the potential to include mandated rather than recommended treatment guidelines as part of Medicare reforms. Mandated treatments have been proposed as part of "value-based purchasing" and "pay for performance."

"These guidelines will have the unintended consequence of misaligning the goals of doctors and patients," they write. "Physicians will face a new conflict-of-interest: they will be financially motivated to pressure patients into accepting a mandated treatment regardless of whether it is compatible with their values or preferences or to avoid caring for patients who refuse the mandated treatment."

Not only are there serious ethical concerns about mandated guidelines, but also significant scientific limitations to this approach to treatment. "Because guidelines are derived from clinical studies carried out in selected groups of patients and their statistical conclusions are based on study populations, they may not apply to an individual patient, especially if he or she has coexisting conditions."

Hartzband and Groopman believe the skills associated with medical humanism - specifically dignity for individuals and families and the autonomy to make their own decisions - will play an even bigger role in a reformed health care universe as people who previously relied on emergency rooms or other acute care facilities are brought into the mainstream.

"These groups … are disproportionately composed of poor Americans, members of racial and ethnic minorities, recent immigrants and young adults. Complex psychological, sociological and cultural factors will challenge the successful integration of these groups into the health care system."

Yet this "shared decision-making" model of medical treatment could be on a collision course with the cost containment goals of reform. One particular area of conflict could be in decisions surrounding end-of-life care.

"As we develop scientific guidelines that reflect what will surely be highly charged conclusions about which treatments are actually beneficial at this stage, we will need to draw on medical humanism to apply information in ways that are compatible with the cultural and religious values of our diverse population.

Hartzband and Groopman suggest the concept of shared decision-making be applied to the deliberative process. All national guidelines should

acknowledge dissenting opinions of experts and should indicate the specific population studied. This information is essential to enable physicians to judge how guidelines should apply to individual patients.

They also caution against the potential for guidelines to be influenced by financial support from pharmaceutical or devices companies as is allowed under current practice.

"In order to assure the public that there is no potential for a conflict-of-interest that would taint the guidelines, an independent government body should be established to develop guidelines without industry support - analogous to the role of the Food and Drug Administration as an unbiased party of the approval of treatments."

Source: Beth Israel Deaconess Medical Center