

patients immediate access to worldwide information about healthcare policies and choices. This means that within a short time implicit rationing will be impossible. Explicitness is the inevitable direction for priorities and rationing. Clinicians and political leaders will be wise to shape the process rather than waiting to have it forced on them. I believe that this is the best climate for practice. But even if it is not it is nevertheless the direction all societies will be moving in.

### How to make rationing work

Setting healthcare priorities and rationing is an unavoidably messy, conflict ridden, ultimately tragic social process.<sup>5</sup> Different societies will conduct the process in accord with their own political culture. But whatever approach a society chooses, it is not likely to succeed without some form of deliberation among the concerned stakeholders.<sup>6</sup>

We in the United States have conducted a social experiment in which we tried to shape health care without explicit priorities or deliberative process. Motivated by the reluctance of the medical profession to accept the need for priorities and rationing, and the conviction held by influential physicians that ethical clinicians must advocate any intervention of possible benefit to their patients,<sup>7</sup> the United States has experimented with what is best described as an adversarial system of priority setting. We have asked our insurance companies—the United States version of district health authorities—to set priorities for us.

Here is how the adversarial form of managed care works. Physicians recommend services for their patients. Insurers decide whether the service will be covered. Physicians act as pure advocates. Insurers make decisions in the light of the available funds. Physicians hold to fidelity. Insurers take care of stewardship.

The United States's experience shows that this adversarial approach results in a high degree of public distrust of the system itself.<sup>8</sup> How could it be otherwise? Since patients largely trust their clinicians then of course they distrust a system in which their clinicians petition the insurer for coverage and get turned down. Whether or not the insurance decisions and policies can be justified by ethical reasoning and cost effectiveness analyses, splitting fidelity from stewardship and placing them in opposing camps invites patients to see their clinicians as impotent and the system as unfair. A system that splits fidelity from stewardship simply doesn't work.

The American system commits itself to providing medically necessary treatment. We have skirted, however, the fundamental question of how to define medical necessity. Is any intervention that physicians believe will benefit their patients medically necessary? Many doctors define the term this way. Does medically necessary mean worthwhile in the light of the available resources and needs of the population? Many insurers define the term more like this. Except in the state of Oregon, however, the United States has had no open debate on what standards we will use for necessity in medical practice. In the absence of debate, the public, sensing the wide disparity among definitions and realising that unacknowledged rationing decisions are being made, has responded with anger, cynicism, and distrust.

To create the necessary dialogue about priorities and rationing, societies must learn how to do what a

popular book on corporate management calls “replacing the tyranny of the OR with the genius of the AND.”<sup>9</sup> American clinicians call the managers who concern themselves with budgets and priorities bean counters. A British physician told me that management is the syphilis of the NHS. I am sure that clinicians from other countries can add choice terms in other languages. And I am equally sure that managers have just as many disparaging terms for clinicians.

Until clinicians, managers, and other stakeholders find a common language for deliberating together about priorities and rationing, we cannot expect the public to understand and accept limit setting policies.<sup>10</sup>

### Conclusions

I believe that our path towards societal resolution of the conflicts between individual and community needs and desires demands more of the heart than the brain. Clinicians are inextricably in the midst of these conflicts. Our distress with priorities and rationing must be understood as crucial data on a social process, not as resistance to be overcome. Patients and society need clinicians to love both the individual and the collective and need to join with them in deliberating about solutions to this painful but ultimately unavoidable conflict of the heart. The key requirements are an expanded healthcare ethic<sup>11</sup> and courageous political leadership.

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### Corrections

#### Obituary

In the obituary of Dr Andrew Swan (22 August, p 545) his widow should have been named as Philippa, not Patricia.

#### Lessons from New York's tuberculosis epidemic

In the editorial by Richard Coker (5 September, p 616) the third sentence of the fifth paragraph should have read: “The success of New York's public health measures was highlighted by the fall in the number of children developing tuberculosis (from 146 cases in 1990 to 45 in 1997) and the fall in the total number of cases of multidrug resistant tuberculosis, such that in 1997 there were only 56 cases of multidrug resistant tuberculosis (from a peak of 441 in 1992).”

#### Book review

Irvine Loudon and John Horder were editors (not authors) of *General Practice Under the National Health Service* (reviewed 1 August, p 357). The book had a third editor (omitted in the review), Charles Webster.