The Ethics of Avoiding Nonbeneficial Healthcare

Unnecessary treatment has both financial and moral implications.

One of the most vexing ethical challenges for healthcare executives focuses on the allocation of resources.ACHE’s annual “Top Issues Confronting Hospitals” CEO survey has ranked “financial challenges” as a top concern for the last eight years. Because resources are finite—despite significant demand—an executive or a group of professionals within the organization must be able to answer the question, “How should limited resources be distributed?” As well as the parallel question, “How can organizations contain costs?”

Ethicists have offered different rationales for the basis of allocating limited resources by applying various understandings of distributive justice. Such discussions often focus on what comprises a patient’s fair share of healthcare resources. This communitarian approach can run counter to the physician’s fiduciary commitment to provide every individual patient with any needed and appropriate care.

The long-standing assumption underlying all debates about resource allocation is that resources are limited, so rationing of beneficial care is inevitable. In a 2012 article in the New England Journal of Medicine (NEJM), “From an Ethics of Rationing to an Ethics of Waste Avoidance,” Howard Brody, MD, a family physician and ethicist, argues that we ought to review this line of thinking in order to focus on the ethical responsibility of waste avoidance—that is, the avoidance of nonbeneficial care.

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Brody draws attention to the need for physicians to recognize the ethics of waste avoidance as an important counter approach to the challenges associated with the allocation of resources. He correctly shifts the focus from denying care to the inappropriate use of medical resources—the abuse of which leads to a high level of spending and prompts the need for rationed care.

The need for avoiding waste, or nonbeneficial care, cannot be exaggerated. Donald M. Berwick, MD, and Andrew D. Hackbarth have indicated in their article “Eliminating Waste in U.S. Health Care” (Journal of the American Medical Association [JAMA], 2012) that estimates suggest up to one-third of all health spending is wasted. That number represents not only some low-hanging fruit but a major portion of healthcare spending.

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The application of nonbeneficial interventions runs contrary to health organizations’ basic values in two fundamental ways. First, by wasting financial resources—providing services at high costs with little to no unit of benefit delivered—an organization undermines its own obligation to efficiency and fairness. Secondly, a physician’s patient care commitment and the organization’s values mandate that healthcare professionals only act in the patient’s interest and avoid harm. Offering nonbeneficial interventions can mislead patients, and when accepted can cause complications, producing false positives that can take clinicians down a path of further and unnecessary actions.

Brody makes a noteworthy connection between avoiding interventions that do not benefit patients and the ethics surrounding medical futility. Medical futility is frequently discussed within the context of patients or family members demanding interventions that physicians know to be nonbeneficial based on empirical
data. Thus, performing an intervention that is futile based solely on the patient’s demand would violate the physician’s integrity to act only in the patient’s best interest. Similarly, would it not violate the basic tenets of professionalism for physicians to offer and provide a treatment that is inappropriate, based on either economic self-interest or poor evidence?

Because their recommendations to patients drive healthcare expenditures, physicians will need to play a major role in reducing the incidence of inappropriate interventions. As noted by Christine K. Cassel, MD, and James A. Guest, JD, in “Choosing Wisely” (JAMA, 2012), “physicians do not always have the most current effectiveness data, and despite acting in good faith, they can recommend diagnostic or therapeutic interventions that are no longer considered essential.”

The authors also emphasize that physicians could benefit from improved communication skills when discussing intervention issues with patients, especially regarding interventions that yield limited or marginal benefits. The application of shared decision making, including the use of current decision tools, can assist in the deliberative process.

**Addressing Overtreatment**

In order to address the imperative to reduce waste in spending and promote robust two-way conversations between physicians and patients, many medical specialty societies have joined with the American Board of Internal Medicine and Consumer Reports, the nonprofit consumer organization, to foster the Choosing Wisely campaign (www.choosingwisely.org). As Cassel and Guest denote, many specialty groups in this growing campaign have developed lists of five treatments and tests that are regularly used in that specialty and which should be reevaluated by both patients and physicians.

The concept of developing the specialty “list of five” grew out of a proposal by Howard Brody in “Medicine’s Ethical Responsibility for Health Care Reform—The Top Five List” (NEJM, 2010) to “restrict ourselves to the most egregious causes of waste…[so] we are genuinely protecting patients’ interests and not simply rationing healthcare.”

Examples of the treatments and tests on the lists of five include: the unnecessary use of CT scans and other imaging procedures for uncomplicated headaches; antibiotics for mild sinus infections; and X-rays, CT scans or MRIs for lower back pain. The various professional societies indicate that their lists do allow for potential exceptions—such as the use of imaging for lower back pain—when the physician suspects a serious underlying condition or when the pain has not lessened in six weeks.

The origins of the Choosing Wisely campaign are not only economically driven. Yes, there is an economic benefit in reducing waste, but the real driver for such a movement is ethical. The campaign reaffirms the professional commitment to social justice by acting in the patient’s best interest, avoiding harm and promoting the cost-effective allocation of limited resources and true patient autonomy by providing an accurate understanding of the limited benefits of such interventions.

The Choosing Wisely effort has centered not only on actions taken by physicians but also on patients, empowering them with greater knowledge of healthcare treatments. This effort results in a more honest dialogue between patients and physicians of the potential benefits and harms of various interventions. To foster enhanced communication within the physician–patient relationship, Consumer Reports is disseminating consumer-friendly adaptations of the various medical specialty lists.

**Leaders’ Role**

The ethically grounded drive to reduce nonbeneficial healthcare should be expanded beyond the role of physicians and patients: Executives and the organizational context must also play a vital role. Because the delivery of healthcare services occurs within the context of an organizational structure and system for the delivery of care, executives should be aware of existing practice patterns in relation to professional standards. This point seems obvious; however, too often one reads a headline: “Hospital Chain’s Inquiry Cited Unneeded Treatment … Excessive and Risky.” Or one reads of CEOs presented with practice pattern data regarding extreme variations in the use of interventions, such as at end of life, and they seem surprised and unaware of what is occurring in their own facility.

Executives, in collaboration with other healthcare leaders, should ensure adherence to clinical practice guidelines suggested by the Choosing Wisely campaign. No longer can executives be unaware of
deviation from clinical practice standards. System-oriented strategies are needed to ensure executives can be confident ethically grounded care is consistently delivered, such as:

- Establishing local clinical practice guidelines based on the specialty society criteria
- Developing methods for documenting and monitoring the implementation of practice guidelines
- Reviewing outcome measurement data and providing feedback to clinicians
- Facilitating shared decision-making education, including the use of decision tools
- Developing, monitoring and reporting the clinical application of shared decision making
- Creating a mechanism and procedure by which health professionals can discuss actions that potentially contribute to waste without retribution

The moral obligation to avoid non-beneficial interventions cannot be clearer. What is less clear is how it will be achieved. Further empirical research will aid physicians regarding what is truly beneficial care, however—as indicated in the Choosing Wisely movement—there is sufficient data today to guide physicians.

Through outreach, such as the Consumer Reports efforts, there can be improved physician-patient communication, but the moral obligation is not limited to clinicians and patients. Executives need to join the movement, despite economic pressures, and ensure systems are in place in their organization to provide only beneficial care—thus achieving real alignment between the organization’s mission and values and professionalism. ▲

William A. Nelson, PhD, is an associate professor at Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine. He also serves as adviser to the ACHE Ethics Committee. Dr. Nelson can be reached at william.a.nelson@dartmouth.edu.