Effective Resource Management: An ethical evaluation

by

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Reference is made to the "Effective Resource Management" (ERM) package provided by the Southern Tasmanian Division of General Practice dated September 2005 and the request for an evaluation of the ethical issues.

Ethics & Relationships

In providing an ethical evaluation, it is important to recognise that we understand ethics not just in terms of moral rules, principles or even virtues. We may understand all of these ways of approaching ethics in terms of relationships. My understanding of the ERM model is that it suggests that it is by virtue of the enhanced nature of the relationships that GPs have with their local community that they can deliver a more effective resource management model than what is argued to be a more distant model. On the other hand, the challenge associated with implementing such a change would be to ensure that the relationships are perceived as being equitable and financially effective from not just the perspective of GPs, but also the key stakeholders in the local community, especially consumers/patients.

Hence, it is suggested that an effective and ethical ERM model will emphasise the primacy of relationships with stakeholders, and ensure that these are recognised in structural ways.

Contested Ethics & Literature

In exploring the devolution of responsibility for such resources allocation to general practioners, it is important to recognize that there are a variety of perspectives with regard to such models. These include not just published perspectives but also the concerns highlighted by stakeholders. For example, there are the publicly stated concerns of the AMA based in part upon a variety of articles in the overseas literature. My reading of the proposal developed by the Division and subsequent conversations is that there has been a significant attempt to take into account those particular concerns.

Likewise, whilst organisations like the Consumers' Health Forum of Australia (CHF) do not have a stated policy, my discussions with consumer stakeholders and appreciation of the literature on consumer rights suggests a stance by such stakeholders of a significant degree of caution with regard to a change to the status quo. In addition, we need to recognize that current arrangements exist,

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not in order to produce an inflexible bureaucracy, but indeed as a consequence of legislation which seeks to deliver public policy, which will provide benefits for the entire community.

Accordingly, any such proposal needs to demonstrate that it meets the overarching requirements of common good/ public interest**.**

Reviewing Aspects of the Literature

An overarching overview of some of the ethical issues in general practice maybe found in the publication *General Practice in Australia 2004*. In addition, a literature review found a variety of articles in addition to the survey of the literature provided by me. These provide cautionary lessons but also provide some ways forward.

For example, O'Reilly *et al* (1998) provide a retrospective study of the effect of fund holding in the NHS reforms of the UK. This article points to some activity to remove patients as well as significant cautionary note "that public perception is that financial factors motivate fund holders to remove patients from their list." They also cite the US literature. Feldman et al (1998) explore the US situation and suggest "Physicians believe managed care is having significant impact on many of their professional obligations." Here I need to indicate my understanding that the ERM model provided is significantly different from the US situation.

However one particularly noteworthy issue worthy of further exploration is the finding that "women physicians were significantly more like to report negative effects of managed care in areas of physician-patient relationship, effect of limitations on quality of care, and on the effects on managed care on the time available to spend with patients. "(1998: 1631). There is significant literature to do with the effect of gender on ethical decision-making and any model in the Australian situation would do well to explore these dimensions.

Likewise, within the US literature Rayburn (2004) and Degnim (1999) explore the difficulties within the US situation and the impact upon the physician-patient relationship. Whilst a very different context, this literature does point to the importance of attending to relationships and perceptions of those relationships in moving with such a model. This is also attested to by Beutow & Docherty (2005).

Within the Australian literature, Paul Fitzgerald (2001) questions the role of corporate-big business interests in impinging upon the doctor-patient relationship, and such a critique of corporatisation maybe seen to have relevance for the Australian situation. Such things are also explored by Van Der Weyden (2001) in his editorial in the MJA .

Within the *BMJ*, in exploring the UK and US situation, Fairfield *et al* sum up the positive and negative indications of managed care for health systems as follows:

Positive:
Better outcomes,
Lower cost, better quality (evidence-based medicine)
Improved allocation of resources
Seamless care

Negative:
Increased cost and time
Need to overcome resistance to change
Blocked innovation
Research and education at risk
Vulnerable populations at risk. (Fairfield, et al ,1997)

This article also goes onto to summarize the implications for clinicians and patients.

Evaluating the ERM Model

Accordingly, whilst a literature review flags particular issues, there is no doubt that the authors of the ERM model have been mindful of these particular issues in the current model, which maybe seen a hybrid of models, drawing upon the precautionary lessons of several different health systems. I particularly note the voluntary nature of the involvement GP's in such a process and also that such a model doesn't just focus pharmaceuticals but does exercise a variety of other issues, which could be taken on board. For example, in terms of dietary advice and physiotherapy. Such a model does however raise the issue of not just providing an evidence-based approach to utilising resources for non-pharmaceutical treatment but indeed raises very significant issues of having agreed-upon structures/ processes for setting upon how such resources allocation will occur.

For example, where there is difference of opinion in terms of the effectiveness of massage, qualifications of a particular therapist or indeed a variety of alternative modalities. It is not clear in the proposal whether or not alternatives such as aids and appliances are entertained. There are a variety of alternatives to medication that could certainly be fruitfully discussed and have significant potential benefit for the community.

The fact that all of the possible circumstances is not considered in this proposal is not itself necessarily a failure. It would require a significant book to come with a variety of rules, and this would obviously re-invent the system of inflexible rules that this model is seeking to transcend. Rather, the situation makes clear the need for clear structures within which some of theses dispositions can be notified.

Conclusion

Accordingly, rather than suggesting that this proposal is either inherently ethical or unethical I offer a conclusion it is worth proceeding with care. In attending to the important ethical dimensions to the ERM I recommend the following:

1. That incorporation of consumer/community participation is valuable not just as a reference group level but indeed would be worthy consideration at the level of governance.

2. That the medico-legal and ethical skills issues that may well arise merit the participation of specialists in the area in rolling out such a program.

3. That in further developing the program, some further attention is given to the limitations to the use of such resources (For example, is it intended that vitamin therapy and other alternatives/complimentary therapies be included? Some stakeholders may well regard these in a different way from the more clearly demonstrated impact of such of treatments as physiotherapy).

4. That there be a recognition of impact upon other professional groups associated with such a model and incorporation of such perspectives/skills in a structural way.

5. That the medical ethical principles of first of all of doing no harm, and doing good, whilst attending to justice, be incorporated into the overarching governance arrangements of the ERM. Accordingly if the corporate model is written in accordance with dominant accounts of medical ethics (giving due regard to the principals espoused by the AMA) then it will help to not just resolve conflict but also help to focus the governance and management arrangements on solutions, which are in accordance with medical ethics.

6. That the model be delivered in such a way that patients know and are guaranteed that they are not disadvantaged by such a model and are able to provide feedback in a model of continuous improvement and action research.

Accordingly, it maybe seen that there is no doubt that there are potential benefits associated with this model, but also some issues of structure and relationships which need to be attended to in seeking to foster an ERM that is in accordance with the finest principles of medical ethics. Rather than any proposal being inherently ethical or unethical, it certainly may be seen that this model learns from previous practice and seeks to introduce arrangements which are geared at patient care. There are many potential benefits. It is the structural arrangements associated with such a delivery of a model which will help to deliver justice to all parties.

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