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Ethics Dispatch

"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."

- *Ludwig Wittgenstein*

Hot Topic: The Cost of Healthcare and COVID-19

The high cost of healthcare in the United States has many persons hesitant to seek care. This is especially true during the COVID-19 pandemic. In a recent blog post by the California Health Care Foundation, a COVID "long hauler" notes: "You do sometimes feel like you're up against the wall of, 'Do I go into more medical debt, or do I just suffer and hope things get better?'"

Indeed, daily COVID cases have skyrocketed since the start of the pandemic. Hospitals across the U.S. are overwhelmed as more and more individuals seek care from the recent Omicron surge, with the Delta variant still present. And as individuals seek care for all sorts of medical problems, some are faced with an apparent trade-off: seek care and incur the financial burdens associated with U.S. healthcare or forego treatment and risk suffering COVID complications.

Bankrupt and Uninsured

The issues surrounding the cost of U.S. healthcare are, of course, no surprise. America has the worst health outcomes among rich nations, despite spending twice as much on healthcare than any of them. According to the Harvard Gazette, this is largely due to the administrative costs of healthcare as well as the high cost of pharmaceuticals.

Roughly one-third of all bankruptcies are "medical bankruptcies" among people with insurance. One article stipulates that around 530,000 families in the U.S. will resort to bankruptcy due to medical bills. Despite all this spending and indebtedness, the Harvard Gazette notes that a recent study found that around 45,000 Americans die annually due to lack of health insurance. According to Dr. Andrew Wilper, the lead author of the study:

> The uninsured have a higher risk of death when compared to the privately insured, even after taking into account socioeconomics, health behaviors, and baseline health.

Economic, Ethical or Both?

To complicate matters further, the COVID-19 pandemic also comes with a high cost to the U.S. healthcare economy. A recent article in the Journal of the American Medical Association suggests:

> The estimated cumulative financial costs of the COVID-19 pandemic related to the lost output and health reduction . . . is estimated at more than 16 trillion, or roughly 90% of annual GDP of the United States.

Though much of the data supporting this estimate are still under investigation, a moment's reflection will help get the point across. Consider the following scenario:

Suppose Michael, a laborer at a meat packing plant, becomes sick with COVID-19. Suppose, further, that Michael suffers mild-to-severe symptoms from his infection, is in and out of the hospital, and subsequently misses work for several weeks. If we multiply Michael's case by 10 million, then this amounts to 10 million people out of work for weeks, which ultimately impacts both their productivity and their spending, thus affecting negatively the country's GDP. That doesn't include the immeasurable costs, economically but especially emotionally, of more than 62 million COVID cases and more than 840,000 deaths. Individual loss of health during pandemic or anytime, the loss of healthcare insurance with lack of healthcare, and any unnecessarily tragic loss of life—all are expensive costs to the U.S. as a nation.

These costs invite the question: In what way, if at all, is the cost of healthcare significant to ethical decision-making? In other words, is the exorbitant cost of healthcare in the United States an *ethical issue*, or economic only?

Case Study

A 55-year-old, male-identifying patient is admitted to the hospital from ER for respiratory distress and other distressing symptoms that had come on rather quickly. The patient's name is Tom.

After undergoing a battery of diagnostic tests over two days as an inpatient, Tom is found to have congestive heart failure that is related to some other problems diagnosed, all potentially treatable. His condition is serious enough that he likely would die without treatment. A cardiologist recommends therapy options. Something that seems especially promising for Tom's particular condition is a relatively new invasive procedure in tandem with a medication recently approved by the FDA.

In an attempt to be fully transparent—and because the hospital will want to be paid—the attending physician asks the team's financial counselor to disclose and discuss with Tom and his family all anticipated and potential costs associated with this recommended treatment regimen. They have already been informed by the cardiologist of risks, along with a high likelihood that this could save Tom's life and significantly improve his quality of life. But treatment costs of this sort are high also. And, his heart doctor reminds Tom, "time is of the essence." Therapies should commence now before it's too late.

Tom's wife and two sons are urging him to agree to treatment, whatever the cost. Tom hesitates, however. He is a self-employed farmer who found healthcare insurance options unaffordable, while he also has too much income and assets to qualify for subsidized insurance plans, much less Medicaid. He is a decade off from being old enough for Medicare and hasn't been considered disabled. With recommended cardiac therapies, he is apt to be able to do farm work again. So additional treatment costs will all be out of pocket, as is this ER visit and hospital admission.

Following medical advice at this point literally would mean losing the family farm, Tom believes; and based on what the financial counselor had said, it is a realistic belief. For Tom, this could

constitute an intolerable loss of property and possessions that have been in his family for four generations. He has fully intended someday to pass on everything, and hopefully a bit more, to his sons. Besides, without the farm, what will Tom do for a living for the next decade or more until he is of retirement age?

Tom's family understands the financial risks; but the sons tell their dad they would rather have him alive than to inherit the farm. The cardiologist and team feel badly about their patient's impending financial crisis, and of course they also badly want to save their patient's life.

Tom asks to be discharged home and asks God for a miracle. Is there anything else, ethically, that ought to be asked or done?

Bioethics in the News

Artificial Intelligence Can Discriminate on the Basis of Race, Gender & Age
Combatting COVID-19 with Combat Veteran Tactics
Xenotransplantation: Three Areas of Concern
On Why Shaming the Unvaccinated Has to Stop

Ethical Musings: Why *Care* About the Cost of Healthcare?

Some issues related to the cost of healthcare in America are clear (as noted above). What may be less clear, is why the high cost of healthcare matters ethically.

Truth is, healthcare costs pose a wide array of ethics questions, many of which have been explored at length in the bioethics literature. A somewhat recent article by Fleck (2018) argues, for instance, that the cost-effectiveness of healthcare should be determined by healthcare justice considerations. Leisinger and Schmitt (2011) highlight the ethical significance of the relationship between poverty, health and access to healthcare. A 1992 paper by Shelton and Janosi explore and put forward potential constraints to private sector healthcare costs.

Whose Responsibility?

The cost of healthcare in the U.S. also poses the following question: Why should Hospital Ethics Committee members, in that role, care about the cost of healthcare for their patients? Most all of us might worry about healthcare costs for ourselves and our families, even if we are reasonably well insured. There are always out-of-pocket expenses and increasingly high deductibles. But while on the job, and in the role of ethics committee member, are those costs for patients a relevant concern? Is there any responsibility to bear?

One might argue that healthcare providers should care about the high cost of healthcare because transparency with full disclosure about costs is essential to informed consent or refusal of treatment options. Worries about treatment costs, realistic or imagined, also could potentially impede a patient's ability to make well informed decisions about their care. If a patient is confused, distracted or worried about the high cost of their treatment, it is also more difficult to

articulate preferences, especially in situations where "time is of the essence." Transparency, disclosure, informed consent and patients' preferences all matter to healthcare ethics.

In the case study scenario above, if Tom's medical team is cognizant of treatment costs and implications financially for their patient and his family, it can help them be more compassionate and empathically helpful in a shared decision-making process. When Tom is well informed about the costs of life-saving treatment, he figures those costs into his autonomous decision. While his values and decisions are not shared by other stakeholders, even by members of his own family, the principle of respect for patient autonomy places most weight on the expressed wishes of the one whose body is being treated, saved or lost. Ethics committees rightly are concerned about such matters as compassion, empathy, shared decision making, and respect for patient autonomy. All such ethics concerns are correlated in specific contexts with the high cost of healthcare.

Noncompliance vs. Nonadherence

Consideration of treatment costs may help to nuance our understanding of a patient's preferences and goals of care, both of which are important ethics concerns. In Tom's case, his declining of recommended therapies might be perceived by the cardiology team as non-compliance, which is pejoratively understood as the behavior of a bad patient. But is Tom's declining of a specific, expensive treatment option necessarily an act of noncompliance, much less "bad"? Perhaps not.

Noncompliance, or nonadherence, implies a patient's failure to follow a prescribed course of treatment aimed at achieving goals of care mutually agreed upon. We could say that a "bad" patient, one nonadherent, states agreement with a goal that they seem to comprehend relative to prescribed treatment, but then inexplicably fails to follow through. Tom's case is different. He has made an informed decision NOT to accept recommended therapies, and does so on rational, even reasonable, grounds related to what it would financially cost him and his family. He has never agreed to the recommended course of treatment, therefore he has no duty to adhere to it. He is not nonadherent, even if his value-laden decision is frustrating for care providers. From an ethics perspective, it is important to understand these distinctions and for ethics consultants to be able to enable such understanding by various stakeholders, especially those feeling frustrated.

Too Great a Burden?

Furthermore, Tom's case complexifies the idea that giving and receiving medical care promotes a patient's well-being. Let us suppose that Tom hesitantly agrees to the expensive procedure and medication, which saves his life but results in the loss of farm and vocation. Given the significance of these losses to Tom, how does the (admittedly, lifesaving) medical care received affect his quality of life thereafter? It is possible that Tom could find a way to live happily ever after, but possible also that he becomes depressed and even suicidal for having lost both farm and farming vocation. How would he spend the remaining years of his life?

Excellent medical care often promotes patient well-being; but sometimes, due to financial costs entailed and burdens borne, it results instead in the loss of a patient's happiness, thus diminishing their overall well-being. Arguably, this complexity ought to matter to those for whom ethics matters.