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# My Patient and Values in the Paradigm of Health-Care Reform



At a time when the Canadian health-care system is at the centre of controversy, physicians must keep in mind their responsibility to patients.

By Monique Camerlain, MD, FRCPC

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*“. . . You want a heart! You don't know how lucky you are not to have one.”*

*– The Wizard of Oz speaking to the Tin Man.*

*“A people that values its privileges above its principles soon loses both.”*

*– D.D. Eisenhower*

**M**rs. C is a 49-year-old patient who has had methotrexate-resistant rheumatoid arthritis since 1992. She is married, has a teenage son, and does accounting and secretarial work. She was an accomplished pianist, but was forced to give up the piano after reconstructive surgery for ruptured extensor tendons of the fingers of her right hand.

She suffers from morning stiffness of more than two hours duration, and her fatigue onset is in the early afternoon. Her disease is uncontrolled, despite combination therapy

with hydrochloroquine sulfate and methotrexate.

Mrs. C is depressed. She grieves over her functional deterioration. She has increasing difficulty keeping up with her professional responsibilities and her household tasks. She has given up practically every leisure activity because of her pain and constant fatigue.

Mrs. C was recently accepted by Health Canada, as a candidate for a humanitarian project with infliximab. Her response was impressive. At week six of her therapy, her morning stiffness lasted less than 30 minutes. Her fatigue was gone and her energy level had increased so that she described feeling better than she had in more than 10 years. The number of tender and swollen joints was significantly improved. She had gone bicycling with her husband over the week-end, something that she had not been able to do for the last few years.

Table 1

**% increase and 2000 sales**

Drug	Sales in Millions (2000)	% Increase
Celocoxib	\$ 2015.5	58 %
Rofecoxib	\$ 1518.0	360.7 %
Etanercept	\$500.4	84.4 %
Alendronate	\$704.3	27.6 %
Raloxifene	\$399	57.3 %

Adapted from: The National Institute for Health Care Management Prescription Drugs Expenditure 2000: The Upward Trend Continues. NIHCM, Washington DC, May, 2001.<sup>1</sup>

The National Institute for Health Care Management recently has highlighted anti-arthritic drugs, as a category in which expenditure has skyrocketed in the U.S.<sup>1</sup>

Spending on these medications totalled \$6.19 billion in 2000, up by 40%, from \$4.4 billion in 1999, and making anti-arthritic drugs number five, on their list of their list prescription drug expenditures.

This report adds that the two coxibs, celecoxib and rofecoxib have together contributed to over 57.1% of the \$6.19 billion anti-arthritic market, in less than two years. They are followed by the anti-TNF product etanercept. Its sales jumped 84.4% to \$500.4 million, despite the fact that the injectable drug's average price was \$998 per dose (see Table 1).

This trend is likely to continue, with an increase in diagnosis of these chronic conditions in the aging population.<sup>2</sup> New agents also are coming to the market, including:

- The new coxibs, valdecoxib and etoricoxib;
  - The anti-TNF, infliximab;
  - The interleukine-I antagonist, anakinra;
- and

- Drugs for the treatment of osteoporosis, such as the recombinant parathyroid hormone teriparatide.

As I rejoiced with my patient, Mrs. C, whose life had been transformed by a \$15,000-a-year biotechnology product, I recalled the admonitions of the Clair Commission, just a few months ago in Quebec: the arrival of sophisticated and costly diagnostic tools, and treatments, will force crucial and constant ethical choices.<sup>3</sup>

Double-blind, placebo-controlled studies have shown the efficacy of my patient's treatment in methotrexate-resistant rheumatoid arthritis. At two years, this drug is known to stop radiographic progression of the disease. Additionally, there is a correlation between functional disability as measured by the Health Assessment Questionnaire, and the work capacity, hospitalization, and mortality in these patients.<sup>4,5</sup> Infliximab has been shown to be cost-effective largely as a result of the decrease in need for costly surgical procedures.<sup>6</sup>

How will this knowledge affect legislators in their acceptance of costly medications on formularies, at a time when critical and constant ethical choices have to be made, at a time when the cost of anti-arthritic drugs is

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Table 2

## CMS statement of the ethics of medicine

### Physician-patient relationship

1. The physician's primary inviolate role is as an active advocate for each patient's care and well-being.
2. The physician should treat each patient with honesty, compassion, and respect for individual autonomy.
3. The physician's commitment to patients includes health education and continuity of care.

### Physician-physician relationship

4. Physicians have a responsibility to maintain moral integrity, intellectual honesty, and clinical competence.
5. Physicians, as stewards of medical knowledge, have an obligation to educate and share information with colleagues, including physicians in-training.

### Relationship of physician to systems of care

6. The physician's duty of patient advocacy should not be altered by the system of health-care delivery in which the physician practices.
7. Physicians should resolve conflicts of interest in a way that gives primacy to the patient's interest.
8. Physicians should provide knowledgeable input into organisational decisions on the allocation of medical resources and the process of health-care delivery.

### Relationship of physician to society

9. Physicians have an obligation to serve health-care needs of all members of society.
10. Physicians have an ethical obligation to participate in the formation of health-care policy.
11. Physicians have an ethical obligation to preserve and protect the trust bestowed by society.

skyrocketing? What is our duty toward our patients and towards society with these medications?

Mrs C and her response to a costly biological agent serves as an example for a basic ethical dilemma. She illustrates the conflicts between the needs of individual patients, and the needs of society to manage the costs of health care in the face of increasing demand and rapid advances in new, expensive technologies. By extension however, we need to be aware that managing costs also means managing (perhaps defining) who gets access, what people have access to and at what cost. This is how and where ethical conflicts arise. It is under this scenario that it may be helpful to revise three of the principles in

the Canadian Health Act — namely, accessibility, comprehensiveness and universality — and to ask how we can remain true to these principles, assuming that they still hold as desired values in our health-care system.

Nuala Patricia Kenny, former deputy Minister of Health in Nova Scotia, and professor of ethics at Dalhousie University, states that the health-care system carries in itself the moral fibre of a nation.<sup>7</sup>

Physicians are the end-stage allocators of almost 80% of health-care resources. Margaret Somerville, founding director of the Centre for Medicine, Ethics and Law at McGill University, says, ethically and legally, the treating physician has a primary obligation of personal care to the individual

patient.<sup>8</sup> The physician must not place the interests of others before those of the patient, or allow the interests of others to be taken into account, if doing so would conflict with any primary interests of the patient. This is not to say, that physicians cannot act to save health-care resources. She says they may indeed have ethical obligations to do so. These obligations, however, are secondary to those owed to the patient.<sup>8</sup>

The Council of Medical Specialty Societies has recently issued a consensus statement of 11 principles, framed in terms of physicians' relationships vis-à-vis the ethics of medicine (see Table 2).<sup>9</sup> This statement acknowledges that the physician's obligations to both individual patients and society are currently in conflict. Until this conflict is resolved, physicians should remain focused on the patient, the foundation of the profession's ethical obligation.

We are to advocate for each patient's care and well-being and, thus, we are obligated to highlight this concern during the formation of health policy. We cannot act as double agents. We alone are sworn to serve a sacred doctor-patient relationship.

In terms of our diverse ethical relationships with other physicians, institutions and society, we are to step forward and to promote the paradigm of a patient-centred health-care reform based on values, rather than cost containment (Figure 1). We must participate in the development of policies, models of disease management, guidelines and new partnerships between patients, caregivers, government and industry. For who will put the sacred doctor patient-relationship at the center of health-care reform, if we are not willing to speak about the pain, the hopes, and the rights of an individual patient?<sup>10</sup> **Dx**

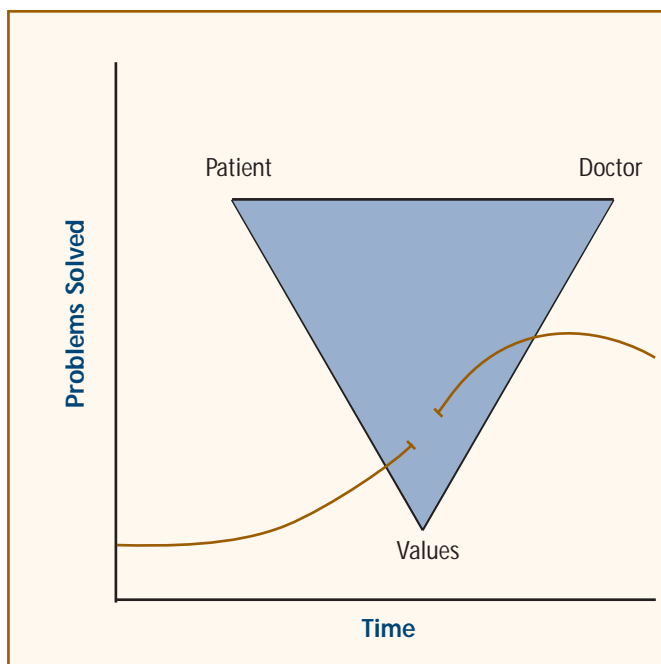


Figure 1. Paradigm of health-care reform. Patient centred, based on values.

Adapted from: Barker JA: *Paradigms: The Business of Discovering the Future*. Harper Collins, New York, 1992.

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