The greatest good

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The other day I met a little boy named Jeudi. Jeudi is a 3-year-old boy with a congenital heart defect—literally, a very small boy with a very big heart. And he needs surgery—soon.

Unfortunately, Jeudi lives in Haiti, one of the lowest income countries in the world. Even before the earthquake in 2010, health care in Haiti was vastly inadequate. Many expensive, curative treatments for individuals, including cardiac surgery for Jeudi, are simply not available.

The system

When health care resources are limited, difficult decisions on allocation of those resources need to be made. With a limited pool of funds, what can provide the greatest good for the greatest number? To help quantify the most cost-effective use of scarce resources, organizations such as the World Health Organization (WHO) and the World Bank sometimes have to use a cold, hard utilitarian calculus.[1] They look at which conditions contribute most to the country's disease burden, measured in disability-adjusted life years (DALYs), then calculate how much it would cost to avert 1 lost DALY using different interventions. Childhood vaccinations cost $1 to $5 per DALY averted, malaria prevention costs $2 to $24, and HIV or AIDS prevention and treatment costs $6 to $377 per DALY averted. In comparison, a coronary artery bypass costs $37 000 per DALY averted.

In general, these calculations favour interventions aimed at illness prevention and population health instead of individual-based care. Immunization, access to clean water, and controlling the spread of communicable diseases such as tuberculosis and HIV are usually given priority when governments and aid organizations need to provide cost-effective care to large numbers of people with small amounts of funding.

In Canada, too, government policy makers and health economists try to guide our decisions about cost-effective use of our health care dollars: low-cost alternative medications, judicious use of investigations and treatments, illness prevention, and lifestyle management. These recommendations necessarily consider not just the whole patient but the whole population *and* the long term. Although the numbers are different, here in Canada, promoting public health—preventing diseases through lifestyle management, preventive health maintenance, and environmental protection—makes more sense than treating diseases once they appear. Should we spend $37 000 per DALY for a coronary artery bypass graft or as little as $175 per DALY for advocating smoking cessation? Even in a country as rich as Canada we need to consider these numbers.

Fortunately, in Canada we have a functioning public health system to carry out much of this important work and a largely educated population that understands the importance of health maintenance. As family physicians, we offer many preventive health measures to our patients in the office, but our system is still primarily dependent on patients presenting to us, usually when they are already sick. If population-based care is such a bargain, why aren't we doing more of it? Even though I believe strongly in the principles of prevention and public health on both a personal and professional level, it is challenging to practise family medicine with these principles and with the bigger picture always in mind.

One reason for the difficulty is the disconnect between the policy makers considering these large population-based issues and the practitioners sitting in the offices with their patients. Each side has a different perspective and a different ethical principle to uphold. While a health economist is considering the principles of justice and equity—being fair or just to the wider community in terms of the consequences of an action—an individual practitioner is expected to practise beneficence, actions intended to benefit the patient. The government policy expert has to consider cost-effectiveness whereas physicians have almost free reign to help their individual patients no matter the cost.

Balancing act

As physicians, we do what we do, for the most part, because we like helping people and doing so is one of the great rewards of practising medicine. We are mandated to advocate for our patients—in particular, for the patient sitting before us at any given time. "Fixing" problems can sometimes provide us with more immediate gratification than working hard for years to prevent some nebulous future disease that might or might not affect the patient. Regularly preaching the benefits of lifestyle modification can sometimes feel like an exercise in futility and waiting for patients to come to us when they are not well is easier than developing systems to seek them out and invite them in when they are feeling healthy. Though considering the needs of the population is important, not many patients would want to think that their doctors are not placing their individual needs above all else.

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So in the office, we sometimes choose to look at the greatest good for a population of 1. We elbow our patients to the front of the line, order batteries of expensive tests (usually without knowing how much they cost), and sometimes give patients the "strongest" medicine, rather than the most cost-effective, first-line option. Sometimes our own personal biases or experiences, excessive pressure from patients, pharmaceutical marketing, or fears of litigation affect our decisions. Sometimes the immediate and direct power to heal and help outweighs all else because this is someone's life—then the only rule is the Golden Rule.

Fortunately, in a rich country like Canada, we can, arguably, afford to do both: quality public health and excellent individualized patient care—at least for now. It would be unimaginable to have to even consider denying a 3-year-old patient life-saving heart surgery simply because it is not cost-effective on a population-wide scale.

Sadly, despite the promises of universal human rights, the resources to provide even these basic public health services are often lacking in countries such as Haiti. The situation is complicated by the politics of donors and governments and is hindered by the failure to address underlying determinants of health such as poverty and lack of education. However unimaginable, this is the very real world of Jeudi and at least a billion others. His only hope lies in the kindness of strangers, in the random meeting of this little boy and our little group. This realization is a painful reminder of the terrible unfairness of our world.

The human factor

In other places I worked, I met patients like Jeudi every day and I simply had to accept that we could not help them all. Although I would have loved to take each one under my wing and give them all the care they deserved, there were simply too many patients and no place to take them. I could offer little more than palliation (and sometimes not even that); then, suppressing a terrible pull at my heart, could only move on to the next bed, hoping to find a patient with something more treatable.

With Jeudi, I was told that funding could be found and donors would come forward. It felt like we were being given an incredible opportunity—to right a very small part of this very big wrong. But how does one justify spending $20 000 on 1 child when the same money could be used to help so many others in his community? For Jeudi, there seems to be only 1 right answer: when to do nothing is to let him die. All of the rational economic theories and the cost-benefit analyses become meaningless in the face of this little boy.

Very few people are immune to this powerful effect. Some accuse aid agencies of using emotionally or politically "hot" topics, like malnourished children or the HIV epidemic, to appeal to donors. I suspect this is true, but not wrong. If we can awaken people's inherent desire to care by touching a human part of them, it can benefit both donor and recipient. Donors, like doctors, want to help and they like to do so in a very personal, individual way—sponsoring individual children, buying goats or chickens, or paying for a child's heart surgery.

One starfish among many

A parable tells of a Buddhist monk walking along a beach strewn with thousands of starfish that had washed onto shore during a storm. When he picks one up and throws it back into the sea to live, his disciple asks, "Why did you do that? What difference can it possibly make?" The monk replies, "For that one starfish, it makes all the difference in the world."

The plan to help our little starfish, Jeudi, is not part of a big, sustainable plan. It is not consistent with any long-term visions or goals of an organization. Jeudi will get his surgery because our humanity demands it. Jeudi's story highlights the dilemma faced regularly by practitioners in low-income countries: whether to focus resources on populations or individuals. The heart says, "Save the starfish," but the head says, "Do what is best for the community."

A similar problem exists here in Canada too, although on a vastly different scale and much easier to ignore. Our human nature, training, and the design of our health care system all drive us to focus on caring for individuals. One of the pillars of family medicine asserts that the individual patient-physician relationship is central to the family physician's role. However, another pillar states that we are also responsible for the health of a defined patient population.[2] Lessons from other parts of the world remind us that population-based health promotion is also generally very cost-effective. Even in Canada, our health care resources are finite and we have an ethical responsibility to use these resources responsibly and fairly to benefit *everyone* in our population, not just the squeaky wheels. In our important role as gatekeepers, family physicians have the power to help sustain the system by being mindful of opportunities for promoting the greatest good for the greatest number in our practice population, while continuing to provide for individual patient needs. Regardless of where we practice, physicians will encounter situations in which the interests of population and patient conflict. Acknowledging this reality and identifying the ethical principles involved is the first step toward addressing these dilemmas when they arise.

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Competing interests
None declared

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