
Bedside Rationing of Health Care Services

The unwillingness of third-party payers to explicitly say how they will contain health care costs means that the only way to decrease the inflationary effects of expensive medical advances is through implicit health care rationing. This will increase pressure on clinicians to ration at the bedside. If third-party payers increase their use of utilization review, this will increase bedside rationing, because clinicians will eventually have to decide whether to accept the recommendations of utilization reviewers. If third-party payers increase their use of capitation, this will only succeed through bedside rationing.

Even when third-party payers are willing to explicitly ration health care, they will still rely, at least in part, on bedside rationing. Outside the U.S., for example, many governments rely on relatively fixed budgets to control health care spending. Often, the spending limits are well known, which makes clinicians more likely to accept bedside rationing. For example, 87 percent of physicians surveyed in the United Kingdom agreed that “rationing of prescribed drugs should take the form of individual clinical decisions as part of the general practitioner-patient relationship, rather than depending on whether the practice has over or under spent its prescribing budget.”¹ In short, not only is rationing here to stay, bedside rationing is here to stay, too.

Deciding Which Services to Ration at the Bedside

Given the methodologic and moral limitations of cost-effectiveness analysis (CEA), what should clinicians do? How should they go about identifying marginally beneficial services which they can appropriately withhold from their patients? Clinicians have several points to keep in mind as they struggle to decide which services, if any, they will ration.

First, despite imperfections, CEA is a good place to start identifying marginally beneficial services to ration. CEA offers a reference point for comparing and judging medical interventions. With so many beneficial interventions to offer patients, CEA gives us an idea about how much money we must spend to get a certain amount of benefit. Clinicians should familiarize themselves with how to interpret cost-effectiveness analyses. Clinical schools and training programs should teach clinicians how to interpret CEAs. Knowing something about the basic science of CEA measurement is as important for clinicians as knowing the basic science of the Krebs cycle, and probably more important than knowing the Latin terms they are forced to memorize in anatomy class.

Second, clinicians need to be aware of CEA’s limitations. For example, CEA undervalues the benefits of life-saving treatments and of interventions directed at improving the health of people with severe illness or disability. If a life-saving therapy is equally cost-effective as non life-saving therapy, the life-saving therapy is probably more important to the public.

When a little girl falls into a well, no one asks how much it will cost to get her out; we simply do what we can to save her. The public places special importance of directing resources to identifiably and desperately ill patients. Indeed, bedside rationing is *inappropriate* when deciding whether to offer life-saving treatments to specific patients.

In recent years, there has been significant debate about whether doctors can ever morally justify a decision to refuse a life-saving treatment to a patient on the grounds that the treatment is “futile.” Experts disagree about what chance of success qualifies as “futile.”²⁻⁴ They agree that interventions with no chance of success are futile. But such interventions are extremely rare. While intensive care unit (ICU) care for someone recently decapitated is obviously futile, most of the time it is impossible to say that ICU treatment has a zero percent chance of success. No series of similar cases will prove that the next case will turn out the same way, so even if the last 100 patients admitted to the ICU with a similar illness have died, the next one may survive.³

However, one concept has been virtually absent from debates about futility—economics.⁵ This absence is informative. Although it is difficult to define what percent chance of success is “futile,” most interventions which approach zero percent chance of success are extremely cost-ineffective. If ICU treatment has a less than one percent chance of benefiting a patient, at a cost of tens of thousands of dollars per patient treated, the math is not too difficult. The cost per year of life saved will be extremely high.

Nevertheless, few people have wanted to frame futility debates in economic terms. Most people do not think decisions about whether to attempt life-saving therapy for identifiably ill patients should be based on cost. In contrast, decisions about whether, for example, to adopt new but expensive advances in Pap smear technology are based almost solely on their cost-effectiveness.

In short, when deciding whether to offer specific patients potentially life-saving surgery, ICU care, or other such treatments, American society has decided that money should not influence decisions. Thus, in these settings, it would be inappropriate to ration at

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the bedside. Instead, these decisions should be based on the balance of burdens and benefits to the patients, based on patients' values whenever possible.

If any rationing is to occur when deciding whether to offer expensive, potentially life-saving treatment to an identifiably ill patient, this rationing should not be done at the bedside; it should not be based on the discretion of an individual clinician. Instead, this rationing decision should be made at a higher level by a health care system or by government. It should be based on some kind of community consensus that this type of patient should not receive this type of expensive treatment.

Bedside Decisions

This is not to suggest that bedside rationing should be absent from ICUs. Many times bedside rationing can occur in these settings, such as in daily decisions about whether to order certain blood tests or X-rays. Bedside rationing is inappropriate when deciding whether to admit a specific patient to intensive care, not in deciding whether a low yield diagnostic test is worthwhile to do once the patient has been admitted to the intensive care unit.

I once took over the care of a patient whose previous primary care physician had tried to withhold blood products from him, on the basis that this man's quality of life was not good enough to justify his ongoing transfusion needs. This patient was seriously ill with severe congestive heart failure and a chronic bleeding disorder in his colon. He was ornery, and his family was even worse. Rumor had it that his family was trying to keep him alive only so they could collect his disability checks.

Although this was an incredibly challenging man to care for, it was totally inappropriate for this clinician to withhold blood products from him. I do not know how cost-effective it was to transfuse this patient. But I do know that his wife shared a bed with him, even though he was frequently incontinent of urine and stool. No disability check would compel most of us to do that. And I also know that this man and his wife loved each other very much; it was important for them to be with each other as long as possible. So even though this man's quality of life looked dismal to many clinicians taking care of him, he still enjoyed his life. When trying to conserve medical resources, clinicians need to be cautious about making judgments about whether a specific patient's quality of life is good enough to deserve resources.

Contrast the clinician in this case with one who decides not to aggressively pursue cholesterol lowering medications in patients at low risk of developing heart disease. Evidence is accumulating that most of us could decrease our risk of heart attack by taking cholesterol lowering medications. But people at low risk of developing heart disease—those without a family history of heart disease, who are not obese, and do not have high blood pressure or diabetes—receive these benefits infrequently.⁶

If a person only has a one percent lifetime chance of heart disease, therapy cannot reduce the heart attack risk by a large amount. For these low-risk people, the cost-effectiveness of cholesterol reduction is minimal. Clinicians who decide not to push for cholesterol reduction in these people will save the health care system significant money, while only having a small effect on the health of the population. Clinicians who ration cholesterol medications to low-risk patients are not making life and death decisions based on a patient's perceived quality of life. They are making population based decisions (with some attention to patients' specific factors) about whether scarce health care dollars are best spent on preventing MIs in people unlikely to ever have them.

Another consideration is in order when rationing at the bedside: clinicians need to pay attention to the organizational context of their rationing decisions. Rationing within the VA system is different than rationing at a for-profit health care company. This affects the justifiability and appropriateness of rationing decisions. (Indeed, clinicians need to get much more aggressive about debating institutional rationing policies and institutional financial policies. If health care companies want to aggressively maximize profits, clinicians need to step in to remind the institution of other priorities.)

Conclusion

Most issues about how to ration at the bedside have not been sorted out satisfactorily. For example, the role of informed consent in bedside rationing is not well understood. Research might illuminate how well clinicians can discuss these issues with patients and whether such discussions improve or harm clinician-patient relationships. But in the meantime, clinicians need to decide for themselves how and when to discuss cost containment efforts with their patients. We have been debating whether rationing is necessary for so long that we have not spent much time discussing how to ration. Ultimately, clinicians need to decide for themselves what their threshold is for offering small benefits to patients, and when they should discuss patients' out-of-pocket costs. But, with time, this personal judgment will, we hope, be informed by rational public debate, and even data, about bedside rationing. ■

Notes & References

- 1 Baines DL, et al. The ethics of resource allocation: the views of general practitioners in Lincolnshire, U.K. *Social Science and Medicine*. 1998;47:1555-64.
- 2 Lantos JD, et al. The illusion of futility in clinical practice. *The American Journal of Medicine*. 1989;87:81-84.
- 3 Schneiderman LJ, Jecker NS, and Jonsen AR. Medical futility: its meaning and ethical implications. *Annals of Internal Medicine*. 1990;112:949-54.
- 4 Truog RD, Brett SA, and Frader J. The problem with futility. *New England Journal of Medicine*. 1992;326:1560-64.
- 5 Jecker NS and Schneiderman LJ. Futility and rationing. *The American Journal of Medicine*. 1992;92:189-96.
- 6 Pearson TA. Lipid-lowering therapy in low-risk patients. *Journal of the American Medical Association*. 1998;279:1659-60.