

Bedside rationing by physicians: the case against

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You are in a lifeboat, along with six others. The sea is stormy, and threatens to overwhelm the boat unless it can be lightened by 200 pounds. One of the passengers, a cancer researcher weighing 205 pounds, is on the verge of making a huge scientific break-through, which could potentially produce a life-saving vaccine. Another is a convicted serial rapist, but he weighs only 110 pounds. The third passenger, a woman of 35, has four young children and ...

For decades, this was the sort of artificial and somewhat silly scenario presented to introductory philosophy students. It was meant to focus the moral imagination of the students on difficult questions of utility maximization and justice. These days, philosophers prefer to take as their illustrative scenarios the somewhat more realistic problems associated with the rationing of scarce medical resources, such as time on dialysis machines.

Back to the endangered lifeboat passengers. Suppose that we were to add the following fact: there are three blocks of concrete in the bow of the lifeboat, each weighing 70 pounds. Would this fact be morally relevant? Even the least talented philosophy student to whom we might put the question would recognize immediately that before chucking anyone out of the boat, even the rapist, the passengers should dump the concrete blocks and see whether this does the trick.

I have a number of ethical objections to Peter Ubel's defense of bedside rationing of medical resources by physicians, but my first objection is that he ignores the blocks of concrete in the lifeboat. That is to say, by assuming uncritically that medical resources are scarce or too expensive or both and must, therefore, be rationed, he ignores the truly massive waste of resources currently built into the American health care system and, to a lesser degree, the Canadian system as well. Were this waste to be removed to any significant degree [in my analogy, if the concrete blocks were chucked out first], there might be no need to ration. Or, the need for

rationing might become a marginal problem resolvable by a variety of small measures instead of by the kind of quasi-revolution of medical values Ubel proposes.

It is beyond the scope of this paper to document properly the claims that (a) the American health care system is massively wasteful, and (b) that the Canadian system, though much less inefficient than the American, could become still more efficient. Nevertheless, a few background observations may suffice to put this issue on the agenda as something to be confronted *prior to* the implementation of any health care rationing scheme.

Robert Evans and his colleagues provide much useful data and analysis in support of both these claims (1989) and important additional supporting data is provided in a well-known study by Woolhandler and Himmelstein (1991). The Woolhandler study pegs the costs of health care administration in the United States at slightly over 24%, compared, for example, to a Canadian level of 11% and to a European level in the single digits. In part because of such “waste” (as I shall label it), and despite the very large size of the U.S. health care budget, tens of millions of American citizens are without any health care insurance whatsoever, and millions more are under-insured, with the consequence that serious illness would be, for millions of Americans, financially as well as physically ruinous.

These excessively high administrative costs in the United States are largely generated, Michael Rachlis argues, by the plurality of private insurance plans and the general fragmentation of the health care delivery system in America. Whereas in Canada there is a single-payer system in every province, the American system is one in which there are more than 1,500 “payers”. This translates as 1,500 sets of actuaries, 1,500 computer systems, 1,500 sets of highly paid executives, the necessity to develop highly detailed billing systems to apportion the costs correctly, and a confusing multiplicity of plans, all of which combine to drown the American system in paperwork (Rachlis, 1989). Moreover, in Ubel’s America, but also under the Canadian medicare system, health care costs get a powerful additional boost from the predominant fee-for-service system of physician remuneration. This system encourages over-doctoring, over-medicating, over-testing by offering perverse financial incentives for physicians to overuse technology.

Although the cost of health care is dramatically lower per capita in Canada than it is in the United States, it is nevertheless rising in both countries in such a way as to give some cause for concern. Here, too, however, the causes for this escalation include an array of systemic problems, many of which originate with the prevailing fee-for-service payment scheme in place for most Canadian and American physicians. Such a payment scheme is almost guaranteed to generate extremely high costs in many different parts of the health care system by generating such phenomena as: unjustifiably high rates of surgical procedures - appendectomies, hysterectomies, C-section deliveries, heart by-passes, cholecystectomies, etc. - as well as inappropriate prescription patterns and the ordering of vast quantities of unnecessary but very expensive diagnostic tests of every sort. [Rachlis, 1989] So, in Canada as well as in the United States, those concerned about the rate of increase of health care expenditure as a percentage of Gross Domestic Product could postpone for a very long time, if not indefinitely, the need to ration genuinely useful tests and treatments if they undertook to examine the health care system with a view to eliminating useless treatments - those which benefit no one.

Moreover, it is a crucially important but little-noted fact that in Canada the costs of our *public* health care system have *not* increased their share of our entire economy over the past quarter of a century. [Chernomas, 1999] That is, the soaring costs of health care in Canada can be attributed entirely to the sub-sectors which are part of the private system: primarily pharmaceuticals, but also long-term care, dental care, medical devices, and so on. By contrast, the three sub-sectors controlled by the Canadian public system - hospitals, physicians, and administrative costs - have not increased as a proportion of GDP.

Writing of the American health care system, Arnold Relman, former editor of *The New England Journal of Medicine* encapsulates the situation succinctly:

It is the way we [Americans] organize and fund the delivery of health care that rewards the profligate use of technology and stimulates demand for nonessential services; it is the system that allows duplication and waste of resources and produces excessive overhead costs. [1990]

This diagnosis contrasts sharply with Ubel's claim that the need to ration health care arises from "[t]he proliferation of new technologies being offered to patients with a wide range of illnesses". That is, if the critics are correct, then the problem of rapidly rising costs is generated, to a significant degree, both by the way the system is organized administratively and by the resultant inappropriate use of new technologies, rather than by the technologies themselves. If Ubel has mis-diagnosed the aetiology of the problem in America, and Canada, then his proposed solution is likely, in consequence, to be wide-of-the-mark.

Let us concede, however, if only for the sake of argument, that extensive health care rationing may be necessary in the foreseeable future even if North American governments are willing and able to implement all of the cost-saving reforms advocated by critics (such as Arnold Relman, in America, and Michael Rachlis, in Canada). The argument of this paper is that even if rationing of health care resources were to prove necessary, the scheme of bedside rationing by physicians, advocated by Ubel, would be ethically unacceptable. And for several different kinds of reasons.

Ubel himself identifies some of the serious moral objections that would arise were society to assign the task of resource rationing to physicians at the bedside, but he insists that

[t]hose who want to control health care costs must decide how they will trade-off between blunt obtrusive rules, that completely delineate physicians' behaviours, versus some amount of bedside rationing, that encourages physicians to reduce their use of marginally beneficial health care services.

In other words, Ubel is explicitly aware that there are moral problems with bedside rationing by physicians, and he recognizes, further, that "[t]he problems cannot be eliminated". He nevertheless expresses the hope that "they can be reduced" and he argues that the moral weaknesses of bedside rationing are worth accepting in order to avoid the more serious weaknesses of alternative rationing schemes.

It is my contention that the moral weaknesses of bedside rationing are more serious than Ubel recognizes, and that he underestimates the efficacy of the alternatives.

The moral weaknesses of bedside rationing:

i) loss of trust

The core principle of physician ethics, incorporated in every version of physician ethics for over two thousands years affirms, in one form of words or another, that “the life and health of my patient will be my first consideration”. [Declaration of Geneva] That is, a commitment to provide optimal care for one’s patients constitutes the moral foundation-stone of the practice of medicine.

Now, of course, “ought implies can”, as philosophers are wont to say, and if a physician lacks access to resources needed by his or her patients, then the physician is not held to be blameworthy when the care provided is sub-optimal. But were a physician deliberately to withhold optimal care from a patient, on the grounds that the physician judges it to be cost-effective for society, then the physician’s obligation to her patient would be subordinated to her obligation to society. Such conduct on the part of physicians (whether undertaken to save money for society or to benefit the doctor’s hospital or employer) would pose a serious risk of vitiating patient trust. That is, when patients came to realize that their doctors are no longer unqualified advocates of their best interests, they would lose trust in their doctors to an extent that would endanger the doctor-patient relationship.

Those worried about this possibility need not believe that the obligation to put the welfare of patients first must *always* trump a physician’s obligations to society. After all, a physician’s obligation to her patients is not absolute. Cases may arise in which almost everyone would concede that the physician’s obligation to protect society legitimately overrides her obligation to her individual patient. For example, the protection of society against the spread of a dangerous infectious diseases could ethically oblige a physician to report a particular patient to public health authorities, in violation of the principle of doctor-patient confidentiality.

Though not absolute, the obligation of physicians to advocate for their patients and to place their patients’ best interests above other considerations is so fundamental to the profession of medicine that those who propose to abridge it must bear a heavy burden of proof. Consider: What would a patient be likely to think if she were to discover that her physician had

prescribed for her (or for her child or parent or spouse) a pain-killing drug or a diagnostic test which was known by the physician to be sub-optimal - because the physician wanted to contain health care costs for the private insurance company, the hospital or the company by which she was employed?

There is some reason to believe that were such a practice to become widespread, as Ubel advocates it should, and were the public to become aware of it, as surely they would, there would ensue a serious erosion of trust between doctors and patients. Without a strong bond of trust, the ability of doctors to help their patients would be seriously compromised. [Katz]. Indeed, it is difficult to think of a more serious loss to the medical profession than such an erosion of trust in the doctor's fidelity to her patients' best interests. Ubel, himself, acknowledges that "[m]any aspects of health care depend on trusting interactions between patients and their providers". He sees the danger, but the rationing scheme he proposes, in my view, is unlikely to achieve his expressed goal of ensuring that "physicians ration in ways that do not greatly reduce patient trust." He seems to be conceding that if we follow his recommendation then some diminution of trust will be unavoidable, but at the same time he hopes that the reduction will not be great. For reasons explained below, this hope seems more pious rather than realistic. Macklin comes closer to the truth, I believe, when she writes that "urging or requiring physicians to ration medical services at the bedside would build in a permanent structural conflict, putting doctors in a perpetual quandry over which obligation should take precedence." (1993)

ii) arbitrary and discriminatory decisions

The likely consequences for good or ill of any health policy proposal will depend, to some considerable extent, upon the prevailing ethos and values of the society in which the proposal is embedded. North American society is marked by a worrying degree of many different kinds of social prejudice and social stigma. Blacks in the United States and First Nations people in Canada, for example, often believe, with good reason, that they are regarded by their fellow citizens as inferior, second-class, less deserving of respect and consideration when it comes to social benefits, including health care benefits. There is, as well, in North America, a widely prevalent dis-esteem for members of other minority groups, for immigrants, for elderly people, substance abusers, the mentally ill and the disabled. It would be

naive to believe that such prejudices are not at least as prevalent among health care professionals as among the general public. [In this connection, it is, perhaps, noteworthy, that during the Nazi era in Germany, doctors had the highest proportional representation in the Nazi party of any professional group. This should give us serious pause before we assign to doctors the awesome responsibility and discretion of deciding who should get optimal and who sub-optimal care.]

Again, Ubel is not unaware of the danger that his proposal for bedside rationing of health care resources by physicians will result in a plethora of arbitrary unfair, and discriminatory allocative decisions. “We need to find ways”, he suggests, to help physicians ration at the bedside, so that they will not do it haphazardly or in a discriminatory manner.” But if one accepts that physicians are scarcely immune to the discriminatory attitudes and prejudices so widely prevalent in North American society, and if one recognizes, further, that there is likely to be enormous variation among physicians in their willingness to ration resources to their patients, it follows, inevitably, that any scheme of the sort Ubel is proposing will result in a violation of the Aristotelian principle of justice, *viz.*, the principle that similar cases ought to be treated similarly, with its corollary that dissimilar treatment is appropriate for dissimilar cases.

An illustrative example may help. Widespread use of low osmolar contrast medium for certain radiologic tests would add significant costs to the health care system, but would result in less vomiting by patients and, in rare cases, might be life-saving. Suppose that we leave to physicians at the bedside such decisions as whether to utilize low osmolar contrast medium for their patients, advising physicians to take account the cost-effectiveness of the alternatives.

The overall costs to society of adopting the superior technology are cumulatively significant. The benefit to most patients will be slight: fewer pukes. If such decisions are left to the discretion of individual doctors, what is the likely outcome? Some doctors will conscientiously attempt to save money for the system, and will order the more expensive contrast medium only in those identifiable but rare cases in which the cheaper alternative could be dangerous to the patient. Other doctors will choose to act according to traditional medical ethics, disregard the extra costs of the low contrast medium, and order it for all their patients. Still other doctors will decide on a case-by-case basis. It would not be surprising if this latter group of doctors

were to order the cheaper, but sub-optimal, medium for their poor or elderly or minority or disabled patients, while ordering the optimal medium for their wealthy, powerful, high status patients (including other doctors). Physicians who would behave in this way need not, many of them, consciously understand the discriminatory nature of their resource allocation among their patients.

This kind of bedside rationing just doesn't seem fair, and certainly wouldn't be morally acceptable in the Canadian medicare system which promises (and largely keeps its promise) that equal access to basic health resources is a universal right of citizenship and that, in consequences, resources and care will be distributed exclusively according to medical need rather than according to income, status, power or prejudice. The best guarantee that ordinary citizens have that the health care they receive will be of high quality is that everyone, including society's economic and political elites, will receive the same quality of care. Ubel's proposal has the potentiality seriously to undermine this guarantee.

iii) physicians lack the necessary will, the training, the time, or the expertise to do accurate cost-benefit calculations at the patient's bedside

A moment's reflection reveals that very few doctors have received such an education in economics as would enable them successfully to perform the micro-allocative rationing which Ubel wants us to assign to them. Moreover, the kind of cost-benefit analysis which Ubel would have them undertake for each of their treatment decisions can not be successfully carried out without a large knowledge base. Many physicians, with busy practices, can scarcely keep up with the relevant medical literature, and willy nilly receive their ongoing education from such agencies as drug company representatives - a group not known for its disinterested and benevolent advice.

Consider: in order to make sensible bedside rationing decisions, physicians would need to know both the success/failure rates of each treatment option and the comparative costs, short term and long term, direct and indirect costs, associated with each alternative,. It seems likely that not one in a thousand physicians possesses such rationing knowledge and expertise or could easily acquire it.

Canadian governments, federal and provincial, and American health insurance companies, spend a small fortune to employ small armies of specialists to do such cost-benefit calculations, and still we are ignorant of the net benefits of many, perhaps most, medical procedures and drugs. It scarcely seems realistic to suppose that doctors can easily assimilate and apply such (often disputed, controversial, and fast-evolving) economic findings to individual cases.

A better alternative

In the end, Ubel's argument comes down to the claim that rationing is inevitable and that, whatever the limitations of bedside rationing, there is no better alternative. Social policy analyst, Raisa Deber, reports that she teaches her students to beware "the TINA (There is No Alternative) argument" because "it usually camouflages underlying assumptions, which are often debatable, and sometimes incorrect." (2000) In this last section of my response to Ubel, I want to consider a better alternative.

Rule-based rationing is a better alternative than bedside rationing. If/when rationing of health care resources must occur, it is far better that the rationing be done in a fair and open manner, according to publicly acceptable rules. In that way fairness prevails and is seen to prevail, and the physician's traditional role as advocate for her patients is protected. Ubel considers and rejects such a proposal, but none of his reasons for rejection strike me as persuasive.

Consider how rule-based rationing might apply to a doctor's decision to use low vs. high osmolar contrast medium. Suppose that society has decided that the expense of providing low osmolar contrast medium for every patient who could benefit would be too costly, given the minimal benefit that would be conferred. The rule, then, would be that every patient receives the cheaper contrast medium. As Ubel notes, this kind of rule will often be too simple, because there will be some patients for whom the benefits could be dramatic, for example, the small group of identifiable patients whose lives are at risk from the use of high osmolar contrast medium.

At this point, a sensible version of rule based rationing would introduce a qualification to the rule, one which permits patients whose lives

would otherwise be at risk to receive the more expensive medium. Often, it will be possible explicitly to delineate the exceptions, without introducing undue complexity. But, in those cases where this would generate unwieldy complexity, the rule could specify consensus criteria to be applied in deciding which exceptions are warranted. Doctors could be allowed to apply these criteria themselves or they could be allowed, on a case-by-case basis, to seek approval from an appropriate official. Practice patterns could be audited - something which should occur in any event, as part of the move towards quality assurance and evidence-based medicine - and those with questionable patterns could be held accountable.

Ubel believes, based on his reading of American experience, that this process would be unworkable in practice, largely because “rule based rationing systems are susceptible to physician ‘gaming’ ”. That is, he predicts that physicians will interpret rules in ways that benefit their patients. If he is right about this, then surely his own proposal for physician bedside rationing would be in even worse trouble, since it would leave physician discretion completely unfettered.

Perhaps what would be needed would be an education campaign among physicians, one which would explain clearly the need for limited rationing and the fairness of doing it according to professionally established rules which embody society’s best reconciliation of the values of justice, affordability, and benevolence.

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Abstract

Society should not accept the inevitability of rationing medical resources, at least not in the short term. Because of the high degree of waste and duplication which characterize the Canadian and, even more, the American, health care system the invitation to focus on rationing procedures known to be useful is likely to divert attention from the need to eliminate waste. If and when extensive rationing becomes necessary, however, Ubel's proposal that we adopt bedside rationing by physicians ought nevertheless to be rejected because it is ethically objectionable. Such a scheme would violate the bond of trust between doctor and patient, would lead to arbitrary and discriminatory decisions. Since most physicians lack both the time and the expertise to perform cost-benefit calculations properly, Ubel's scheme would be inefficient as well as unethical. There is a better alternative.