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JOURNAL DISCUSSION

Identifying Bedside Rationing

Taeho (Greg) Rhee

Ubel PA, Goold S. Recognizing bedside rationing: Clear cases and tough calls. *Ann Intern Med.* 1997;126(1):74-80.

In "Recognizing Bedside Rationing: Clear Cases and Tough Calls" [1], Ubel and Goold define bedside rationing as "the withholding by a physician of a medically beneficial service because of that service's cost to someone other than the patient" [2]. The practice is often controversial. As they write elsewhere, most cases of health care rationing are "morally charged" and entail "difficult decisions with potentially tragic consequences" [3]. It is critical for physicians to be able to understand bedside rationing and be able to recognize it in their own practices.

Ubel and Goold put forth three conditions that make withholding a service bedside rationing: "the physician must (1) withhold, withdraw, or fail to recommend a service that, in the physician's best clinical judgment, is in the patient's best medical interests; (2) act primarily to promote the financial interests of someone other than the patient (including an organization, society at large, and the physician himself or herself); and (3) have control over the use of the medically beneficial service" [2]. They provide an example in which bedside rationing was clearly occurring in 1997, when the article was written.

> A patient arrives at his local emergency department with the classic signs and symptoms of acute myocardial infarction. The emergency department physician decides to administer thrombolysis with streptokinase rather than tissue plasminogen activator even though the latter is slightly better for this type of heart attack. Tissue plasminogen activator costs 10 times as much as streptokinase, and the physician thinks that the benefits of this therapy are not worth the additional costs [2].

The example meets all three necessary conditions for bedside rationing. There are, however, many other cases in which bedside rationing is more difficult to identify. The authors give a more ambiguous example:

> A neurologist works at a county hospital that does not have a magnetic resonance image (MRI) scanner. The hospital puts money aside each year so that six patients can receive an MRI at a nearby hospital. A physician evaluates a patient who has a "soft indication"

> for an MRI. The physician could order an MRI for the patient. However, he knows that if he requests an MRI for this patient, he denies an MRI to another patient, who may need it more. Thus, he tells the patient that an MRI is unnecessary [4].

At first glance, this case may not seem to be an example of bedside rationing, since the scarcity of time slots and the hospital's limitation on the number of MRIs available each year is not the physician's doing [2]. But the physician does decide when and to whom to grant MRI access. From an economic standpoint, it may be justified to deny the MRI; yet the physician must still recognize this as a form of rationing. Furthermore, the physician has an ethical responsibility to inform the patient that the MRI is, above all, unavailable, not strictly useless.

Ubel and Goold suggest that physicians ask themselves three basic questions to identify whether their actions qualify as bedside rationing [2]. The first question is whether the service that is being withheld is in the patient's best medical interests. If not, then no rationing has occurred. If the answer is yes or unclear, the case involves some form of health care rationing and physicians should ask themselves the next question: is the service being withheld primarily to save money for someone other than the patient? If not, physicians are not engaged in bedside rationing. As Ubel and Goold point out, if the patient chooses a less expensive option due to the cost to him- or herself, the physician is not rationing care. If it is or may be, then they could be engaging in bedside rationing and they should consider the final question.

The last question is whether the service in question is under the physician's control. If the answer is yes, then the decision counts as bedside rationing. Otherwise, it could be another form of health care rationing based on the availability or choice of insurance plans, for example. It is often unclear when physicians truly have complete control over use of a given resource—due to structural administrative mechanisms, for example.

The authors believe that there are many types of health care rationing, all of them difficult to define due to the variety of causes of resource scarcity. Understanding how to identify bedside rationing practices has important implications for physicians' patient-centered, ethical practice behaviors. A more comprehensive understanding of bedside rationing will enable physicians to better explain why patients do not receive care that is either inappropriate or not under the physician's control. Ubel and Goold conclude that when physicians are able to use a standardized set of questions to determine if bedside rationing is *appropriate*, they will be able to make more informed and consistent decisions about the best care services available for their patients.

References

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4. Ubel, Goold (1997), 78.

Taeho (Greg) Rhee is a research intern for the Council of Ethical and Judicial Affairs at the American Medical Association in Chicago. He is an MA candidate in social welfare and policy at the University of Chicago. In the fall of 2011, he will enter a doctoral program in health services research at the University of Minnesota in Minneapolis, where he will focus on geriatric health care issues. His research interests include chronic diseases, long-term care, Medicare, and the demography of aging.

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