

Physicians' Role in Cost Containment

The authors of a 1995 *Archives of Internal Medicine* article assert that physicians should engage in bedside rationing in order to contain rising health care costs, while some ethicists oppose the practice on the basis that it will disrupt the essential trust between patient and physician.

Renee Witlen

Ubel, P, Arnold R. The unbearable rightness of bedside rationing: physician duties in a climate of cost containment. *Arch Intern Med*. 1995;155:1837-1842.

In their 1995 article, "The Unbearable Rightness of Bedside Rationing: Physician Duties in a Climate of Cost Containment," Drs Peter Ubel and Robert Arnold assert that physicians should engage in bedside rationing in order to contain rising health care costs. They define bedside rationing as "physicians' actions to withhold beneficial care from patients that physicians were free to offer them" and confine their discussion to rationing done "either without patients being aware of the rationing or, less often, with patients being aware but being given no choice" [1]. Many physicians and ethicists have rejected this role for physicians in the belief that physicians must advocate for the individual patient, even acting, if necessary, against the "apparent interests of society as a whole" [2]. Ubel and Arnold contend that if bedside rationing is conducted correctly, it is morally acceptable and, in conjunction with rationing decisions at higher levels of health care organizations, constitutes the only viable way to contain health care costs in the short and medium term.

Ubel and Arnold are careful to specify how bedside rationing must occur in order for it to be morally acceptable. Decisions should be based solely on medical costs and benefits; physicians should not make resource allocation decisions on the basis of discriminatory criteria such as race or gender [3]. Furthermore, only "marginally beneficial" services should be rationed. Ubel and Arnold note that it is difficult to characterize the nature of "marginally beneficial" services. In order to determine which services can be considered "marginally beneficial," they encourage physicians to compare the cost-effectiveness of any particular treatment or diagnostic test to the cost-effectiveness of comparable alternative interventions. They urge physicians to apply cost-effectiveness considerations with caution, given that society is often willing to spend large sums of money treating patients with extreme needs, despite the low technical cost-effectiveness of some expensive, life-saving treatments. Ubel and Arnold also note that the implementation of bedside rationing should involve physician training on the cost-effectiveness of treatments, so that physicians are not left to engage in cost-effectiveness analysis at the bedside [4]. Physicians who are educated to identify marginally beneficial services will be able to make informed and ethical decisions about how best to treat their patients. For example, a physician educated about the cost-effectiveness of 2 diagnostic tests could make an informed decision to order a test with 90 percent sensitivity instead of a much more expensive one with 91 percent sensitivity [5].

For Ubel and Arnold, relaxing the traditional "physician-as-patient-advocate" role is acceptable because other methods of cost containment entail more significant threats to the quality of patient care [6].

"Without bedside rationing," they state, "we can only contain costs with a complex set of rules circumscribing physicians' actions, rules that are likely to harm patients whose specific medical conditions are not adequately captured

by the rules" [6].

If physicians accept a bedside-rationing role, they may be able to contain costs while treating patients according to less complex and limiting rules. After considering the risks to patients posed by restrictive rules developed by health care organizations, Ubel and Arnold find that less restrictive rules (accompanied by the practice of bedside rationing) have the best chance to contain costs while optimizing patient health outcomes. Hence, the comparative benefits of bedside rationing render the practice morally acceptable.

Opposition to Bedside Rationing

Some ethicists have stated that physicians' attempts to advocate simultaneously for individual patient's best interests and for society's financial interests will disrupt the essential trust between patient and physician [2,7]. Ubel and Arnold question this premise, stating that there is little evidence that bedside rationing damages the patient-physician relationship.

Opponents of bedside rationing have also objected to the practice on the basis that it may involve arbitrary and discriminatory treatment decisions. In his article, "Physicians, Cost Control, and Ethics," Daniel P. Sulmasy suggests that 2 patients with the same condition might be offered substantively different care options if their 2 doctors made different bedside rationing decisions. Sulmasy believes that such differences would constitute a serious injustice, and he describes bedside rationing decisions as "arbitrary and inherently inequitable" [8]. Sulmasy believes that this problem could only be addressed by setting allocation rules at higher levels within health care organizations, so that each doctor, following treatment rules, would treat similar patients with a previously established set of services [8].

This solution is vulnerable to the criticism, noted earlier, that predetermined treatment protocols might not accurately capture the nuances of clinical medicine, harming patients whose conditions are not well-described by such protocols. Ubel and Arnold also counter suggestions that bedside rationing could be discriminatory by noting that any form of resource allocation has the potential for discrimination; they observe, for example, that rationing care according to ability to pay discriminates against people with less money [5]. The authors suggest that careful oversight could protect patients from discriminatory decisions rendered during bedside rationing.

Marcia Angell raises a final important objection to bedside rationing in her article, "The Doctor as Double Agent" [9]. Angell asserts that "enlisting doctors as ad hoc rationers presumes that resources saved by denying health care would be put to better use"[10]. Since the United States does not have a "closed system in which funds taken from one form of health care are diverted to another that is deemed to be more important," funds diverted from any particular use could be reallocated to any other sector of the economy [10]. There is no guarantee that resources saved would be used to pay for a more cost-effective health care intervention. Ubel and Arnold respond to this critique by noting that "there is no morally compelling reason to argue that money saved on one health care service must go toward other health care services" [11]. As other social goals equal in importance to health care provision do not currently receive sufficient funding, the authors believe it is both necessary and ethically permissible for physicians to engage in bedside rationing, even if resources saved might not be applied directly toward health needs.

Ubel and Arnold acknowledge that there are moral risks involved with bedside rationing, but they believe that potential problems with the practice have been overstated [11]. They state that failure to control the costs of health care is itself a moral problem which physicians have an important role in addressing. Ubel and Arnold believe that doctors should contribute to the solution of this problem by accepting and openly discussing the practice of bedside rationing, so that they can learn how to balance their roles as patient advocates and stewards of societal resources.

Questions for Discussion

1. Do you think that bedside rationing threatens the relationship of trust between doctors and patients?
2. Given that scarce health care resources must be distributed, do you think that doctors are in the best position to make decisions about their allocation? If not, what individuals or organizations are better suited to make these decisions?
3. Is it necessary for physicians to inform their patients of the range of available clinical services for their

conditions? Alternatively, is it acceptable for physicians to order tests or treatments based on bedside rationing decisions without describing options a patient might pursue with her own funds had she been informed about them?

References

1. Ubel P, Arnold R. The unbearable rightness of bedside rationing: physician duties in a climate of cost containment. *Arch Intern Med.* 1995;55:1837-1842.
[View Article](#) [PubMed](#) [Google Scholar](#)
2. Lewinsky NG. The doctor's master. *N Engl J Med.* 1984;311:1573-4.
[View Article](#) [PubMed](#) [Google Scholar](#)
3. Ubel P, Arnold R, 1841.
4. Ubel P, Arnold R, 1842.
5. Ubel P, Arnold R, 1839.
6. Ubel P, Arnold R, 1840.
7. Sulmasy DP. Physicians, cost control, and ethics. *Ann Intern Med.* 1992;116:920-926.
[View Article](#) [PubMed](#)
8. Sulmasy DP, 921.
9. Angell M. The doctor as double agent. *Kennedy Institute of Ethics Journal.* 1993;3:279-286.
[PubMed](#) [Google Scholar](#)
10. Angell, 284.
11. Ubel P, Arnold R, 1838.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

© 2003 American Medical Association. All Rights Reserved.